The embodied experience of women who suffered from heart attacks: An Existential View

Rana Heiba

Abstract

The purpose of this research is to gain a deeper understanding of the embodied experience of women who suffered from heart attacks. The heart attack is primarily seen as a medical concern and is treated on that basis without giving significant attention to the person's lived experience. Recently, researchers have attempted to bring the two monologues into a dialogue, looking at physical illness beyond its medical or biological causes. This research aims to build on the following idea, with the attempt of coming closer to the understanding of women's embodied experience of a heart attack. Interpretative Phenomenological Analysis was chosen to help explore this phenomenon. Seven women who have experienced at least one heart attack in the past five years were interviewed using semi-structured interviews. The data analysed presented five main themes: experience of the heart attack, the self, loss, roles and responsibilities, and being-with-anxiety. Findings suggest that the embodied experience of having a heart attack is a complex phenomenon, one which impacts the women's entire existence. This research provides an in-depth study to understand the lived experience of these women before the heart attack as well as after. The results add to the work of counselling psychologists when dealing with such a phenomenon, and suggestions on how to integrate it with existential work are discussed.

Key words

Embodiment, heart attack, women, Interpretative Phenomenological Analysis, physical illness, existential

Acknowledgments

I would like to firstly thank the women who took part in this research and spoke openly about their experiences with me. I am also very grateful for my supervisors Simon Cassar and Catriona May for their constant support and encouragement to keep on improving my work.

To my family, without each one of you by my side, this journey would not have become a reality. My father, for being the main and biggest source of support in every aspect of my life. My mother, for believing in me when I didn't, and for pushing me to do the unexpected. My sister, for taking in all my emotions and containing everything I dropped on her, including my son. My husband, for constantly cheering me on and always believing that I have what it takes to complete this. To my eldest son, Momo, you've been so strong and understanding throughout this journey; you've taught me patience and I couldn't have made it without. To my second son, being pregnant with you throughout the last stretch of this journey has been a blessing, and I am grateful that you were able to endure all this energy from within.

I would like to acknowledge my friends who have been there for me and understood my absence throughout this process. Special thanks to my main support, Dr. Mai Kabbani, I am very grateful that I had you by my side through this journey to bounce ideas off and to check in with and make sure I am on the right track. I will always cherish our study dates and trips. Lastly, to my brother-in-law, Dr. Ahmed El Guindi, who always guided me in the right direction and helped kick start my research.

Table of Contents

1. Introduction 7
1.1 Introduction 7
1.2 Research Question 9
1.3 Personal Motivation 9
1.4 Literature Search 10

2. Literature Review 11
2.1 Illness & The Body 11
2.2 Existential View on Embodiment 15
2.2.1 Existential Philosophy 15
2.2.2 More on Embodiment 19
2.3 Existential Theory & Illness 20
2.3.1 Physical Illness & Existential Theory 21
2.3.2 Studies on Existentialism & Physical Illness 24
2.4 The Heart 26
2.4.1 The Medical View 26
2.4.2 Beyond the Medical View: Heart Disease & Psychology 28
2.5 Existential Aspects of a Heart Attack 52
2.5.1 Anxiety 52
2.5.2 Responsibility 54
2.5.3 Being-with 56
2.5.4 Temporality & Death 57

3. Methodology 60
3.1 Introduction to Methodology 60
3.2 Qualitative vs. Quantitative 60
3.3 Methodologies Considered 62
3.3.1 Grounded Theory 62
3.3.2 Narrative Theory 63
3.3.3 Phenomenological Method 65
3.4 Epistemology 69
3.5 Interpretive Phenomenological Analysis 70
3.5.1 IPA and Physical Illness 72
3.5.2 Challenges of IPA 74
3.5.3 Epistemology of IPA 76
3.6 Data Collection 76
3.6.1 Sample 77
3.6.2 Interviews 79
3.7 Data Analysis 80
3.8 Ethical Considerations 83
3.9 Limitations & Challenges 84
3.10 Reflexivity 85

4. Data Analysis 89
4.1 Experience of the Heart Attack 90
4.1.1 Embodiment of the Heart Attack 90
4.1.2 Meaning: Anxiety & Heart Attack 93
4.1.3 Reaction to Heart Attack 96
4.1.4 ICU & Recovery 99
4.2 The Self 101
4.2.1 Strong & Independent Self 102

4.2.2 Self-Care 107
4.2.3 Relationship to Body 112
4.3 Loss 116
4.3.1 Loss to Death 116
4.3.2 Loss of Life 118
4.3.3 Broken Heart 121
4.4 Roles & Responsibilities 126
4.4.1 A Man's Role 126
4.4.2 Being-a-Mother 129
4.4.3 Being-at-Work 135
4.5 Being-with-Anxiety 140
4.5.1 Confronting Anxiety 140
5. Discussion 145
5.1 Anxiety Throughout the Themes 146
5.1.1 Embodied Anxiety through Illness 147
5.1.2 Anxiety and Heart Attacks 149
5.1.3 Being-with-anxiety 151
5.2 Meaning of Illness 153
5.2.1 Meaning of Heart Attack 153
5.2.2 Meaning of Life After Heart Attack 155
5.3 Loss 156
5.3.1 Loss of Life 157
5.3.2 Broken Heart 158
5.3.3 Being-toward-Death 159
5.4 The Self 160
5.4.1 Strong & Independent Self 160
5.4.2 Self-Care 162
5.5 Being-with 163
5.5.1 Responsibility towards others 164
5.6 Relationship to the Body 166
5.6.1 Embodiment (Disembodiment) 166
5.6.2 Misinterpretation of Illness 168
6. Conclusion 172
6.1 Implications for Counselling Psychology 175
6.1.1 Implications for Existential Therapy 176
6.2 Limitations of Study 178
6.3 Recommendations for Future Research 180
6.4 Reflexivity 180
References 184
Appendix I – Interview Question 197
Appendix II – Informed Consent 19896
Appendix III – Participant Information Sheet 200
Appendix IV – Debriefing Sheet 203
Appendix V – Transcript Example 205

1. Introduction

1.1 Introduction

"Before sickness came to be perceived primarily as an organic or behavioural abnormality, he who got sick could still find in the eyes of the doctor a reflection of his own anguish and some recognition of the uniqueness of his suffering. Now, what he meets is the gaze of a biological accountant engaged in input/output calculations. His sickness is taken from him and turned into the raw material for an institutional enterprise" (Illich, 2010, p.170).

This research is a phenomenological exploration of the embodied experience of adult women in Egypt who suffered at least one heart attack within the past five years. It is an exploration that attempts to bring back the uniqueness of one's experience. The question lying at the core of this paper aims to take a closer look at what this embodied experience has been telling them about their being-in-the-world, before, during, and after their attack.

As we struggle through our daily lives trying to reach our goals, or simply the next day, we tend to disregard the essence of our being, which according to Heidegger "lies in its existence" (Heidegger, 2012, p. 67). We are all thrown into this world, and some people pace through life without giving their existence much thought. They might adopt a stance that makes emotions such as anxiety, anger, love, hate, sadness, and so on, get in the way of living. Instead of attending to these emotions, they resent them. Denying these experiences, they end up living in bad faith, one that Sartre defines as "a lie to oneself within the unity of a single consciousness. Through bad faith a person seeks to escape the responsible freedom of Being-for-itself" (Sartre, 2003, p. 649). Therefore, "it is only in facing reality that we open ourselves up to truth and to existence" (van Deurzen, 2012, p. 7).

The building block of this work is based on the assumption that physical symptoms have a meaning that describes and reflects our being-in-the-world, "the idea that human being is essentially always in a world, in context and in relation and never in isolation" (van Deurzen, 2011, p. 54). If we are consciously not being true to ourselves, our body finds a way to tell us. In order to understand the language, or metaphors of the body, we need to learn to understand and listen to our self. "Lived experience – suffering from an illness, for example – is thought to be meaningful in a different way than the theories and results of science" (Svenaeus, 2011, p.334). Science sends us off with a diagnosis of the symptoms and treatment options. However, if we argue that our body speaks and expresses itself through symptoms, can there be more to illness than just a list of symptoms? For instance, if we look at the common cold, our body might be telling us we need to rest and slow down; constipation seems to mimic the act of holding something in, and so on (Shapiro, 2012). When it comes to working with physical experiences, whether pain, illness, or a random bodily sensation, it is important to acknowledge that the client's "somatic aspect is inseparable from his being-in-the-world" (Cohn, 2008, p.62).

Through this research, the aim is to understand the meanings behind the experience of a heart attack. The heart attack can be regarded as only a physical illness without giving the patient's existence and being-in-the-world much thought. Stress can lead to a heart attack if one is susceptible to it, but should we just stop at the word 'stress'? What is the meaning of this 'stress'? How can we work with such physical illnesses in our psychotherapy practice? How can our client's embodied stories be heard, listened to, and made sense of during therapy? The key is to see the relationship between their embodied experience and the meanings portrayed by their heart attacks, and what existential issues stem out of this experience.

1.2 Research Question

What is the embodied experience of women who have suffered from heart attacks?

1.3 Personal Motivation

In the process of exploring and reading about various physical illnesses, I have always found myself drawn to the heart. At first uncertain about the reason why, it slowly became apparent how the story of my father was in most of my readings. I do fear my father's death of a heart attack while away on a business trip; a fear emanating from how his own father, my grandfather, died while away for business as a result of a sudden heart attack. I have never met my grandfather in person, but I did through this story and the way it has impacted my family. father's deepest fear is dying at a young age, of a heart attack, like his father.

In parallel to this concern, my homeopathy practice has also added to my curiosity towards the phenomena of physical illness. During my sessions, I collect a brief medical history and ask the client to list their current physical complaints. With this information, we try to make sense of their symptoms in relation to their 'psychological story'. I find myself combining these two monologues into a dialogue. Initial sessions can last up to two hours, followed by a second session after a certain period of time to assess the impact of the remedy. The follow up session can be scheduled anywhere between one week and two months, and sometimes even more according to each homeopath's school of thought. In my experience as a homeopath, I found that more time is needed to bring together what was said, to get an elaborate understanding of the client's experience, and to build a relationship with the client as intimate and deep as in psychotherapy.

The beauty of psychotherapy is that by meeting our clients once a week for 50 minutes, time and space is given for the therapist and client to build a therapeutic relationship and gain a deeper understanding of the client's story. In my psychotherapy training, I tended to overlook

the physical aspect of the client's story unless it was of significant relevance, such as panic attacks. On the other hand, while taking homeopathic cases, I realized that the client's physical symptoms spoke about their psychological processes to a great extent. Whether they have experienced headaches, tingling sensations, or even a blocked nose that has not been getting better, there seemed to be more meaning to these physical symptoms. The phenomenological descriptions of these symptoms were of value to their story. All these symptoms are our body's way, or more accurately, our own way of talking to ourselves.

1.4 Literature Search

I have used the terms "physical illness and psychotherapy", "physical illness and existential therapy", "embodiment and physical illness", "existential and embodiment", "existential and body". For heart attacks I used the terms "heart attacks" and "myocardial infarction" separately for each search, with "women", "psychotherapy", "existential", "lived experience", "phenomenology", and "medical view". I have also used "cardiovascular disease" along with all the terms mentioned, in order to widen the search. I have searched these terms in *summon, psyc articles, google scholar, sage journals online, and science direct.*

2. Literature Review

2.1 Illness & The Body

"…health is not an objective condition which can be understood by the methods of natural science alone. It is, rather a condition related to a mental attitude by which the individual has to value what is essential for his life. 'Health' appears thus as a value…" (Goldstein, 1959, p.183).

This section looks into the works of authors who speak about illness as a bodily experience. They look at illness from a different viewpoint than science does, and add value to what has already been categorized as physical illness. The body is saying something through the symptoms of one's illness (Shapiro, 2012, p.12).

In his book *The Wounded Storyteller* (2013), Arthur W. Frank adds a new aspect to embodiment and the story that our ill bodies tell. His main focus throughout the book is the story of the ill body, rarely referring to health and those who are not ill. Arguably, most of his writing can apply to the phenomenon of embodiment, without being limited to the ill body. He believes that the stories told by those who are ill are manifested through the medium that is their body. These embodied stories have two aspects: a personal side and a social side. The ill body's story is a personal one. However, the story becomes social when told to someone else; the other. Instead of speaking through our body, we have grown to learn a specific way of speaking about our suffering that would make sense to the other. Our verbal explanation might fail to resonate with our personal bodily story, thus taking away from our authentic voice. Furthermore, Frank proceeds to discuss the medical view stating that it is "unable and unwilling to examine how culture infolds into the body (and, reciprocally, how bodily processes outfold into social space)" (Frank, 2013, p.27); leading to the discrepancy between the personal and

social story of illness. This unwillingness results in a failure to listen to what the illness has to say, or in other words, what the self has to say.

Deb Shapiro writes about how our body holds our journey through life and speaks to us through symptoms, in her book *Your Body Speaks Your Mind* (2012). She explains the interconnected relationship between body and mind, in attempts to guide her readers to understand themselves. "There is an intimate and dynamic relationship between what is going on in your life, with your feelings and thoughts, and what happens in your body" (Shapiro, 2012, p.11). According to Shapiro (2012), our thoughts and feelings are like seeds that flourish; these seeds take root in our body and begin to restructure the shape of our cells, resulting in a physical experience which we refer to as a symptom. Symptoms are messages from the body warning us that we are out of balance. As we grow to observe and understand the language of our body, we come to understand our illnesses, or more specifically what is ignored and repressed into our body. She goes on to explain our perception and reaction to stress. We are bound to experience stress in our life, and this stress is manifested physically, whether instantly or later on in our life journey. Coping with this stress is in itself stressful, however "it is your perception of your inability to cope that causes the stress response in your body" to magnify (Shapiro, 2012, p.23). Throughout the book, Shapiro looks at every part of our anatomy and describes the messages that might be sent through various symptoms experienced, ranging from symptoms of the common cold to diseases such as cancer and cardiovascular diseases.

At first glance, the questions she asks in relation to every disease or symptom are direct and simple. However, these questions can be the starting point to understanding the client's story. Reading beyond each question, one starts to see the symbolism in each symptom, and how for every individual story the same presented symptom could be saying something different, relevant to their particular experience. The value in her writing gives perspective into how one can look at their symptoms and body, thus getting a better understanding of how your

body speaks your mind. “Your difficulties can then become stepping-stones along the way rather than stumbling blocks” (Shapiro, 2012, p.1). This view is similar to existential thought, that through our suffering we can choose to find meaning. The title of this book, along with her writing, suggests a duality between mind and body. However, it can be argued that as she separates them in writing, she tries to bring them together in meaning.

There has been a subtle movement in scientific research geared towards a more holistic view of patients and their illness. Even though, holistic medicine has been around longer than modern medicine, it has been suppressed throughout the years and only recently has there been a growing curiosity for its integration. People started to notice how “scientifically competent medicine alone cannot help a patient grapple with the loss of health and find meaning in illness and dying” (Charon, 2006, pg.3). Charon (2006) writes about the significance of narrative medicine in her book *Narrative Medicine: Honoring the Stories of Illness,* a perspective that has been emerging into the medical field. She defines it “as medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness” (Charon, 2006, pg. vii). The focus point of the book is around the patient’s narrative not just the list of symptoms they present with. There is a strong emphasis on the power of listening to the patient’s story, and how this in itself is part of the healing process. The author assumes that most doctors do not listen beyond the biological medical root of the illness, and end up disregarding the context in which the illness was brought to life.

Norman Cousins (1979) writes about his experience with illness and how he battled the medical model and took ownership of his healing. He grew to believe, from his personal experience, that positive emotions and attitudes produce remedial chemical changes in the body. The human Being, mind and body, has the capacity to regenerate beyond our scientific knowledge. Through faith, love, hope, and courage, physical healing can happen.

Consequently, fear, anxiety, and depression accompany an incurable illness (Cousins, 1979, pg.50).

In both books, the patient's narrative is the key to healing, since science alone cannot holistically look at the illness. The narrative of patients is told through their body, as "the body has become our most legible signature" (Charon, 2006, pg. 76). The body is more reliable than any medical diagnostic handbook. The image of the body as a mechanical feature of the human fails to encompass one's existence, and when one is faced with an illness, their existence is questioned. However, physical illness is an underexplored phenomenon in the field of philosophy. Being physically ill can challenge one's beliefs, values, and meanings in life, leading them into a philosophical space of reflection. An illness can deprive someone of certain abilities, and bring out their vulnerabilities, which in turn affects the picture of the disease (Carel, 2016). The embodied experienced of illness and the meanings of life that are questioned, "can amplify or dampen symptoms, exaggerate or lessen disability, impede or facilitate treatment" (Kleinman, 2020, pg.7). Therefore, naturally, in order to holistically understand the phenomenon of illness, the patient's experience and story should be given the same amount of prominence as that of the medical model.

All books reviewed are in agreement that "the scientific measurement of the body, in other words, overlooks the actual lived experience of embodiment" (Aho and Aho, 2009, pg. 2). In this research, the participants were asked to talk about their embodied experience of having a heart attack, and through their stories, we will come closer to understanding this phenomenon and how their lived experience has been shaped, or not, by this illness.

> *"And, once she told her secret—in tears, in anguish, in fury—her health improved. She slept. Her back pain got better. She stopped the Librium. Her heart had room to expand, not being in the grip of the untold" (Charon, 2006, pg. 65).*

2.2 Existential View on Embodiment

Since illness is a bodily experience, it is essential to look into theories of embodiment. This section takes on an existential view of embodiment, focusing on the works of Nietzsche, Heidegger, and Merleau-Ponty.

2.2.1 Existential Philosophy

"Behind your thoughts and feelings my brother, stands a powerful commander, an unknown wise man – he is called self. He lives in your body, he is your body. There is more reason in your body than in your best wisdom" (Nietzsche, 2006, p.23).

Friedrich Nietzsche gives importance to the unity of the mind and body in his writings. He draws away from the Cartesian dualistic view and emphasizes on the oneness of the body and soul. However, he describes the soul as part of the body as he writes, "body am I through and through, and nothing besides; and soul is just a word for something on the body" (Nietzsche, 2006, p.23). Beyond thoughts and emotions is what he refers to as the self; the self is the body. "The self listens and seeks: it compares, compels, conquers, destroys. It rules and is also the ruler of the ego" (Nietzsche, 2006, p.23). Nietzsche believed that in order to become one with who we are, one needs to observe his body and pay attention to what it is telling them. He described this man as the Ubermensch, the superman (Nietzsche, 2006, p.3). van Deurzen defines Nietzsche's superman as "the force of the body [that] has become eminently reflective and intelligent, where the body, soul and self are truly integrated" (van Deurzen, 2011, p.24). He also talks about how the bodily self relates to the world. If the bodily self is not in unity, then it will express itself to the world in a destructive manner.

According to Cohn, Heidegger believes that the body and mind are "different aspects of Dasein's response to Being, different but not apart" (Cohn, 2002, p.53). Like Nietzsche, he argues against the Cartesian dualistic view of the mind and body, as one cannot exist without

the other. There is no bodilyless mind, or mindless body. He refers to embodiment as an aspect of being-in-the-world; "it always co-determines being-in-the-world, openness, and the having of a world" (Heidegger, 2001, p.97). Heidegger never mentions the body explicitly; it is always through his notion of Dasein or more specifically, being-in-the-world.

Askay (1999) and Escudero (2015) discuss French philosophers' criticism of how Heidegger fails to mention the body sufficiently in his writings, specifically Merleau-Ponty as he writes "in *Being and Time* one does not find thirty lines concerning the problem of perception; one does not find ten concerning that of the body" (Merleau-Ponty, 1983, p. xix). Escudero (2015) attempts to understand why Heidegger overlooked this phenomenon and where it can be found within his philosophy. Heidegger (2001) directly, yet briefly, responds to these criticisms during the course of the Zollikon Seminars. He rejects the scientific and Cartesian view of the body and describes our lived body as "an expressive and communicative one, actively orientated towards the world and interrelated with others" rather than a combination of receptive organs (Escudero, 2015, p.17). Askay (1999) also reflects on Heidegger's criticism of French philosophers, namely Merleau-Ponty for keeping the notion of the body at a subject-object stance, failing to understand his phenomenological description of Dasein and everything it entails. He claims that the French, Sartre and Merlau-Ponty, misinterpret the phenomenon of the body and fail to elaborate on "the fundamentals of existential being-in-the-world" (Heidegger, 2001, p. 157). In his opinion, their attempt to explain and not describe the phenomenon of the body weakens their philosophy (Heidegger, 2001).

Heidegger does not discard the notion of the body, but uses this term with caution so as to not reinforce the subject-object model of the body. The "Heideggerian Dasein dwell in his body" (Thoibisana, 2008, p.2), as there is an interconnected bond between its "embodied, psychological, cosmological, and spiritual nature" (Thoibisana, 2008, p.2). Thoibisana

describes Heidegger's Dasein as an all-inclusive embodied being, meaning that "the human body is always already 'alive', handling, sensing, and perceiving intra-worldly things in a particular way" (Thoibisana, 2008, p.4).

In response to Merleau-Ponty's criticism, Heidegger believed that he "simply failed to truly overcome his philosophical heritage of Cartesian subjectivism" (Askay, 1999, p.33). In fact, Merleau-Ponty does bring up the subject-object relationship, but argues that this dichotomy does not reside within us. Our mind and body are not separate, "thought and sensation as such occur only against a background of perceptual activity that we always already understand in bodily terms, by engaging in it" (Carman, 1999, p.206). He believed that the body is simply our "point of view on the world" (Carman, 1999, p.221), but that to others it is an object in the world. An object appears, disappears, and can be explored; as one considers others in the world as objects, others in turn consider one as an object. Therefore, "my body is an object that is always with me" (Merleau-Ponty, 2014, p.92).

Merleau-Ponty's work mainly revolves around the phenomenological exploration of embodied living and how we exist in this world through our bodies. He writes "the body is the vehicle of being in the world and, for a living being, having a body means being united with a definite milieu, merging with certain projects, and being perpetually engaged therein" (Merleau-Ponty, 2014, p.84). We connect to the world through our body and sequentially the world responds back. Our experience of the world and how the world experiences us is interrelated and intrinsically bound together. "We embody the world and, through our senses, make it come to life in the same way in which we also are brought to life ourselves by being in the world and by embodying it" (van Deurzen, 2011, p.95). Merleau-Ponty describes how our senses interpret and perceive bodily stimuli to give meaning to our lives. We communicate with the world through our body; it is the body that structures our experiences (van Deurzen, 2011).

Merleau-Ponty believes that our body “inhabits space and time” (Merleau-Ponty, 2014, p.140). “To be a body is to be tied to a certain world and our body is not primarily in space, but rather of space” (Merleau-Ponty, 2014, p.149). Our body embraces both space and time; however, the space and time it inhabits is limited by our perception. He also introduces the concept of habit, which manifests itself in the perceptual body. Habit here does not refer to routine behaviors and practices, as understood in lay terms. “Actions in which I habitually engage incorporate their instruments and make them participate in the original structure of [our] own body”, since our body is “the primordial habit, the one that conditions all others and by which they can be understood” (Merleau-Ponty, 2014, p.93). Habit forms “behaviors or forms of conduct that are appropriate for responding to the invitations of the environment” (Moya, 2014, p.2). They are what allow us to develop and relate to the world. Can this process of adaptation explain how illness develops?

van Deurzen (2011) introduces four existential dimensions to explain one’s existence and their relation to the world: the physical, social, personal, and spiritual. For the purpose of this section, the physical dimension will be explained, which is the most essential mode of relating to the world. It is the world that explores the body’s interrelationship with the natural environment (van Deurzen, 2011, p.146). Our physical existence is concerned with survival and reproduction, and ultimately death. Survival entails good health, which can mean that illness serves as a limitation to one’s existence. The ultimate purpose and “challenge of our physical dimension is to gather as much life as we can and express it vibrantly during the short span of time allotted to us on this earth” (van Deurzen, 2011, p.153). van Deurzen (2011) uses a metaphor which likens the physical body to a musical instrument. Each person in this shared world is a different instrument, playing the music unique to them. If you are a violin, for example, you encompass all the strengths and abilities of a violin, but are limited in that you cannot be a drum or a piano. We must learn to tune and master our own instrument, our

instrument being our body, without trying to be another; “the art is to discover what talents one has been given and to make the most of what one is and can be, rather than try to be what one is not” (van Deurzen, 2011, p.149).

2.2.2 More on Embodiment

“The body should be understood not as a constant amidst flux but as an epitome of that flux” (Csordas, 2001, p.2). The body is believed to be a function of being-in-the-world, one that is embodied; meaning present and engaged in the world. “Embodiment is the existential condition of possibility” (Csordas, 2001, p.12), it is the essence of our existence, however it is left indeterminate. The term ‘body’ has been objectified and treated as separate from notions such as intentionality and intersubjectivity.

Taipale (2014) brings us closer to the meaning of the lived-body by reflecting mainly on the writings of Husserl, and incorporating Merleau-Ponty and Sartre’s ideas. The book focuses on the lived-body within an environment as “our embodied condition is originally revealed to us through our awareness of the environment, in the sense that our perception of the environment indicates our lived-body” (Taipale, 2014, p.40). Not only do we have a body, but we are a body that moves in the world.

Madison (2015) spoke at the Society of Existential Analysis 2014 Conference about how existential-phenomenology needs the body’s response, basing his idea on the works of Eugene Gendlin (1982). He explains how “the interaction between the existential and phenomenological takes place in the body and is refined and corrected by the body” (Madison, 2015, p. 240). He involves his fellow therapists to engage in an exercise that brings them closer to an experiential relation with the client rather than just a conceptual one. As the therapist as well tunes into their embodied experience of being-with the client, they open up many possibilities for the client (Madison, 2015). Madison (2015) refers to this as an experiential-

existential model of therapy. If this model of therapy were to be applied to a client presenting with a medical illness, such as heart attacks, their lived experience would be heard and experienced differently to their regular medical care sessions. This model takes us away from the mechanical view of medical illness and closer to the embodied unique experience of the client.

2.3 Existential Theory & Illness

The vast importance of the body and the meaning it portrays is essential in understanding illness. This section brings embodiment and physical illness together through an existential lens.

"To ignore the subjective dimension of the body – the 'lived body' or 'subjective body' – is to ignore what brings patients to doctor in the first place" (Wilberg, 2011, p.307). It was never the objective measure of symptoms that triggers a person to seek medical assistance, but the subjective experience of symptoms. Wilberg (2011) writes about the relevance of existential theories in relation to the philosophy and practice of modern medicine, and critiques with disagreement the division between psychotherapy and somatic medicine. He argued that medical doctors look at and examine the 'clinical body' rather than lived body. The language of symptoms has been unified by doctors into criteria and diagnoses, taking away from the unique language of experience. "The foundations of Existential Medicine lie in an essential non-casual understanding of illness" (Wilberg, 2011, p.307) that views illness or disease as a natural part of leading a healthy life.

The term lived body originated from the German term Leib, which is used when one is referring to living bodies; as opposed to the term Körper which refers to dead bodies (Leder, 1998). The Cartesian model of embodiment, which is the model adopted by modern medicine, never made a distinction between both. To understand the body, modern medicine examined

the dead body as a machine. “The lived experience of illness can be seen as epiphenomenal” (Leder, 1998, p. 120), where a person’ beliefs, wishes, fears, and questions are seen as separate from the body. Twentieth century philosophers, like Merleau-Ponty (2014), started to look at the Leib, the lived body, one which cannot be described by the language used to explain the Cartesian-mechanical body. “The body is not simply a thing in the world, but an intentional entity which gives rise to a world” (Leder, 1998, p.124). In this chapter, Leder (1998) challenged medical practitioners to embrace the notion of the lived body, where disease and treatment would involve a blending and intertwining of biological and existential aspects of the person. Disease should be understood in the context of the person’s existential worldview, as the lived body’s anatomy and physiology are always intertwined with the body’s intentionality (Leder, 1998, p.125). Leder highlights important points about disease and brings about the possibility of examining or exploring the medical disease in a phenomenological way; the meaning of illness instead of just the criteria.

Following an extensive review of existential literature, it appears that the topic of heart attacks remains unexplored in depth, but mentioned as an example illustrating physical illness. Philosophers such as Nietzsche, Heidegger, Merleau-Ponty and others such as van Deurzen and Yalom speak about illness in relation to existential philosophy. Similarly, research about heart attacks lacks papers exploring this phenomenon from an existential perspective. Nevertheless, many existential themes do surface in papers about heart disease, such as death, anxiety, and despair, which are discussed in section *2.4 The Heart*.

2.3.1 Physical Illness & Existential Theory

In his book *Existential Psychotherapy* (1980), Irvin Yalom writes about physical illness. His writing stems mainly from his experience with cancer patients. Through his work, Yalom helps clients “examine their own roles in the disease” to adopt a more “active,

responsible stance towards their disease" (Yalom, 1980, p. 274). In the chapter about death, one of the existential givens, Yalom mentions the notion of specialness. On a deep level, it is believed that "the rule of mortality applies to others but certainly not to ourselves" (Yalom, 1980, p.118); a belief shaken when faced with a serious illness, bringing on existential anxiety. He examines the difference between knowing and truly knowing the reality of death. Some people resort to denial as a way of coping with death anxiety; others may face the fact and truly know, thus awakening them into their therapeutic process.

In Peter Sedgwick's article 'Nietzsche, Illness and the Body's Question for Narrative' (2013), he explores Nietzsche's viewpoint on illness, comparing it to a more conventional medical approach. Illness is "in this way likened to alien landscapes hidden beneath the familiar surface of the everyday self. All identity, Nietzsche thereby tells us, is implicitly expressed through the body and its relation to trauma" (Sedgwick, 2013, p.307). Defined as such, illness is embodied. Sedgwick proceeds with an explanation of Nietzsche's perspective on pain and how it offers one the possibility of connecting to one's self. Where modern medicine perceives symptoms of pain and illness as negative experiences that need to be eliminated, Nietzsche sees an opportunity to embrace this suffering, as "illness is not a terrifying threat of individual destruction, but is the peculiar and anguish-ridden avenue by way of which we discover our own humanity" (Sedgwick, 2013, p.321). Nietzsche sees illness as a possibility, whereas modern medicine negates its importance; illness is no longer yours to connect to and narrate. This article adds value to the research at hand, validating the attempt to understand illness through one's own lived journey, which in turn may open new paths for healing.

Svenaeus takes a similar stance on illness in his article 'Illness as Unhomelike Being-in-the-world: Heidegger and the Phenomenology of Medicine' (2011), straying away from the scientific approach to illness. However, unlike Nietzsche, he views it as a threat or something alien to the body. He writes, "the otherness of illness has been depicted precisely as an

otherness of one's own body" (Svenaeus, 2011, p.335). The term otherness refers to something foreign that penetrates the lived body. This interpretation seems to externalize the experience of being ill and takes away from the embodied experience of illness. Illness is neither authentic or inauthentic, it is ultimately a breakdown of understanding (Svenaeus, 2011). According to Heidegger, "alienation closes off from Dasein its authenticity and possibility" (Heidegger, 2012, p.222), forcing it into inauthenticity. It can be argued that even though illness may be a result of inauthentic living, it is always part of, not alien to, our being-in-the-world. Illness is physical; it is lived within the body, meaning that illness is embodied.

Kevin Aho (2018) draws on Boss and Heidegger's Zollikon Seminars to address Existential philosophy within modern medicine. He introduces the nature of the seminars and marries both philosophical and scientific worlds into what he calls Existential Medicine. In the first part of his book, Aho (2018) discusses medical diagnoses and their relationship to authenticity by trying to understand the patients experience within the context of a life-world. Life-world being the "world of immediate experience" (Husserl, 1970, p.xi), which is different to the objective 'worlds' of science. In the second part of the book, Aho (2018) explores existential and relational issues with anxiety, pain, and death. He then goes on to exploring biomedical ethics and technology, specifically critiquing how technology has power over the interpretation of one's health. Aho (2018) discusses how medicine has built a complex understanding of the human body which "falls short of grasping the true character of the human body, namely, that it is an *existential* reality" (p.191); the human body is intersubjective and expressive not just a mechanical body. With illness, the existential reality cannot be understood only in medical or biological terms. He uses the example of a black eye, and how the experience of a black eye can be one of shame from domestic abuse or one of pride from winning a fight, or something completely different (Aho, 2018). The lived reality of the illness is "*what it is* as a property of the body of this person… illness *cannot be grasped in separation from the lived*

experience of the person who suffers it" (Aho, 2018, p.196). Illness changes and challenges one's entire way of being, including how they make sense of the world, which can be attended too in treatment by listening to their lived experience.

2.3.2 Studies on Existentialism & Physical Illness

A few studies were conducted on physical illnesses taking on an existential perspective, whether looking at themes that came up or the benefits of using existential theory during treatment.

Westman et al. (2006) explored the existential reflections of cancer patients who have undergone treatment, using content analysis to analyse the data. They interviewed 10 participants, five women with breast cancer and five men with prostate cancer. The findings presented three themes: meaning of life, illness, and death. After being diagnosed, some of the participants reported finding more value and importance to things in life, while others were shaken deeply and experienced life as meaningless. The illness made them question their sexuality, relationships, and choices in life. All participants spoke about death in their reflections, whether they were afraid of it, not ready for it, or not scared at all. In theory, these findings could be extended to the reflections of participants with other illness such as heart attacks. Even though cancer and heart illness have a completely difference prognosis, treatment, intensity, and even location in the body, the themes depicted show an existential relationship to what we primary consider a medical issue (Westman et al., 2006). Like cancer, heart attacks are a life changing illness as one is faced with a sudden loss of health, this acknowledgement gives room to explore the experience of a heart attack from an existential view supporting the idea of the proposed research.

Gebler and Maercker (2014) explored the incorporation of existential perspectives within a CBT group program for chronic pain. Conclusions showed that the Existential Treatment Group (ETG), including both CBT and existentialism, was more effective in "reducing self-perceived pain-related disability" (Gebler and Maercker, 2014, p.166) than the CBT group. The existential groups yielded a more emotional and personal space than the control group, where more people were willing to open up and discuss their processes. The existential group "can be seen as only a first step into a process of grief and searching for meaning" (Gebler and Maercker, 2014, p.168). References to May, Frankl, and Yalom's works were used as a foundation to the study. Even though this paper focuses on chronic pain, it shows the importance of adding existential perspectives while treating pain and suffering, also experienced by heart attack patients. The paper does not delve deeper into which existential perspectives were explored in the groups. However, the fact that the existential group benefited more than the control group, opens a pathway to explore existential perspectives in relation to physical illness, specifically heart attacks for the purpose of this study.

Vilchinsky et al. (2019) initiated an existentially oriented group intervention for patients with heart failure to explore their subjective experience. Twelve participants took part in group sessions that took place over seven weeks. The group was existentially oriented based on Yallom's work (Vilchinsky et al., 2019). The participants were then interviewed using the Narrative Evaluation of Intervention Interview, "a semi-structured interview consisting of 16 open-ended questions designed to evaluate participants' experience of a psychosocial intervention" (Vilchinsky et al., 2019, p.143). The data was then analysed using grounded theory. The groups helped participants with personal growth, social support, self-worth, and mastery of coping skills. Heart failure is a life-threating and debilitating illness that can trigger anxiety, depression, helplessness, and despair (Vilchinsky et al., 2019). This research shows the value that existentialism can add to one's psychological wellbeing when working with heart

failure. Though the experience of heart failure is different to a heart attack, both are life-threatening illness that can bring up existential concerns.

The following section will focus in on the heart, defining it from a medical perspective and moving along to the literature that links a person's experience and psychological wellbeing to this medical phenomenon. A general literature review on cardiovascular diseases is included to see the different angles in which psychological research has taken and what themes were depicted. Then a focus on heart attacks, or myocardial infarctions, follows to helps see the gap in the literature and position this research more accurately.

2.4 The Heart

This research is focused on the embodied experience of having a heart attack. Research on medical illness has recently been growing in a different direction, where the holistic view of a person is taken into consideration. The following section explores heart diseases from a medical, psychological, and existential perspective, with a focus on heart attacks.

2.4.1 The Medical View

The most common cause of death globally is heart disease (World Health Organization, 2018). Currently, nearly half of the American adult population are diagnosed with a cardiovascular disease (American Heart Association, 2019). According to the American Heart Association (AHA), in 2008, 30 percent of all global deaths were due to cardiovascular disease (American Heart Association, 2015). By 2017, The World Health Organization (WHO) estimated that 17.9 million deaths were due to cardiovascular diseases by 2017, which represented 31% of deaths globally, 85% of which were due to either a heart attack or a stroke (World Health Organization, 2017).

The heart is described as a muscular organ which pumps blood throughout the rest of the body and maintains blood pressure. It takes in deoxygenated blood from the rest of the body and sends it to the lungs for oxygenation, before pumping it back into the body again (Waugh and Grant, 2010). A heart attack, medically known as myocardial infarction, "occurs when one of the coronary arteries closes down completely, depriving a section of heart muscle of necessary oxygen" (Lowen, 2013, p.129). A blood clot is formed inside the artery which results in a sudden loss of blood supply to the heart muscle. With a decrease in blood supply, the heart muscle is deprived from nutrients and oxygen, and begins to die. This blockage signals the body through symptoms such as extreme chest pain that shoots through the arm and up the neck (BHF Press Office, 2016).

The prognosis for treating acute heart attacks at an early stage are very positive. However, the more one's condition is delayed or neglected, the more severe it can become. Chest pain is the most common symptom experienced, accompanied by shortness of breath. Men usually complain of profuse sweating, while women tend to experience nausea, vomiting, and back and neck pain (Brink et al., 2002; World Health Organization, 2017). Other symptoms include: feeling weak and lightheaded, cold sweats, and discomfort in arms and shoulders (Swanoski et al., 2012). The AHA (American Heart Association, 2015) and the British Heart Foundation (BHF) (Mitchell, 2019) confirm these findings, and add that women can experience nausea and pain that radiates to their jaw.

Heart attacks are usually seen as a male illness, a misconception that has recently started to change. Despite this change, women have a 50% higher chance of being misdiagnosed than men do (BHF Press Office, 2016). The BHF advocate the need to diagnose women correctly to get the right treatment and save them from future recurrences and complications. In addition,

research is needed to "further improve tests for diagnosing heart attacks in both men and women" (BHF Press Office, 2016).

Interestingly, the link between cardiac illnesses and emotions has been around since the 1700s, however it has taken a backseat in cardiac research over the years (Alberti, 2009). Only recently has the patients' psychology been given importance in research concerning medical issues. The section below is a review of the literature on cardiovascular diseases from a psychological point of view, with a focus on heart attacks in the following section.

2.4.2 Beyond the Medical View: Heart Disease & Psychology

The following section explores how the field of psychology views heart disease by linking, what is primarily known as a medical illness, to emotional and psychological aspects of living.

2.4.2.1 Cardiovascular Diseases

When people suffer from heart disease, one is faced with a higher risk of a sudden termination of life. They suffer from various pains but might fail to believe that the latter are related to a heart issue. They probably experience anxiety, anger, and fear the possibility of death (Gruen, 1975). Gruen's (1975) research aimed to question if psychological treatment would ameliorate the client's condition by helping them adjust to their illness, and whether it would promote an interaction between the client's cognitive-emotional systems and their physiological system. The findings showed that participants who were treated with counselling developed feelings of hope and were able to cope with their anxieties, unlike those who did not seek therapy. "Counseling treatment has its most visible impact on feelings of optimism, surgency, and happiness, while either excessive denial or excessive manifestations of anxiety were reduced" (Gruen, 1975, p.229). Psychotherapy sessions allowed the participants to open

up and confront hidden issues. Gruen (1975) discussed the general positive effects of therapy on clients who suffered from heart attacks. However, there was no exploration of the embodied experience of these participants, which is the aim of this research paper.

Gundersen et al. (2017) explored how women experience and interpret their symptoms through their interaction with their general practitioners (GP) after being diagnosed with coronary heart disease. They interviewed 9 women asking them to describe their "experience and understanding of symptoms and the diagnosis-making process" (Gundersen et al., 2007, p.31). Interviews took place at the hospital 1-7 days before their surgery. The data was then analysed using phenomenological methods, specifically Giorgi's (1997) position. Participants expressed frustration towards the GP's ignorance when it came to diagnosis and therefore their treatment. These women have all experienced atypical symptoms such as fatigue, shortness of breath, pain and pressure in their upper gastric area, all of which led to one or more misdiagnoses. In addition to that, prior to meeting with the GP, several women attributed their symptoms to non-cardiac problems, such as digestive illnesses, asthma, or even exhaustion and old age. This goes to show the probability of "inadequate knowledge of gender differences in CHD symptoms and poor doctor–patient communication" (Gundersen et al., 2007, p.38).

Seah et al. (2016) explored the experiences, needs, and coping strategies of 15 participants living with heart failure. They used content analysis to interpret their findings. Most participants believed that the cause of their heart failure was due to external factors. They described their experience of having to live with symptoms of heart failure as restrictive, resulting in a 'handicapped' feeling of uncertainty about the future. They are uncertain of what would happen the following day, let alone today. These limitations result in emotional stressors stemming from the fear of dying a painful death. Ways of coping with this experience are looking back and replaying life successes, adopting a spiritual outlook, and taking charge of their condition by learning to take care of themselves instead of feeling like a burden on their

family members. This paper highlights existential issues such as choice and death, which opens a door for more exploration to try to understand the meanings that the participants give these phenomena. Even though this paper focused on heart failure, the presence of such existential issues can suggest that women with heart attacks would also relate to similar existential notions.

Heart failure treatment requires a shift in the patient's quality of life to maintain physiological stability and reduce risk of deterioration and rehospitalisation. This self-management can become very overwhelming to patients and increase their anxiety levels. Anxiety itself is physically toxic to a cardiac patient, since "anxiety symptoms are linked to pathophysiologic mechanisms that facilitate poorer cardiovascular outcomes" (Rechenberg et al., 2020, p.358). Moreover, other than the physiological effect, anxiety can also lead to the worsening of the patient's quality of life. Therefore, it can be concluded that decreasing anxiety symptoms can improve one's quality of life and reduce medical risks to patients with heart failure (Rechenberg et al., 2020). Rechenberg et al. (2020) conducted a secondary analysis from a study originally designed to compare two group treatments and exercises aimed to improve physical functions and depressive symptoms in patients with heart failure. Mindfulness is known to lower anxiety levels (Rechenberg et al., 2020, p.360), and in this case hopefully help patients with heart failure better their quality of life and reduce medical risks. Seventy patients took part and were asked to complete three questionnaires: The Minnesota Living with Heart Failure Questionnaire (MLHFQ) to measure patient's quality of life, The Hospital Anxiety and Depression Scale, and the Five Facets of Mindfulness Questionnaire measuring their daily level of mindfulness (Rechenberg et al., 2020). Statistical Package for the Social Sciences (SPSS) version 24 was used to analyse the data, and Pearson correlations was used to study the relationship between anxiety, QOL, mindfulness, and covariates. The results highlighted the importance of considering mindfulness as part of a patient's treatment

plan, as a means to enhance their quality of life and therefore their overall prognosis (Rechenberg et al., 2020). This can be seen as another shift in their paradigm, as research encourages the incorporation of other treatments that are not dominantly medical.

Within the past few years many of the cardiac research focused on levels of anxiety and depression in relation to heart disease. Alhurani et al. (2015) and Vongmany et al. (2016) both aimed to examine whether anxiety and depression are associated with mortality and re-hospitalization of cardiac complications in patients with heart failure. Both studies concluded that there is a relationship between anxiety and depression with the patient's mortality rate. Results showed that more than 50% of patients with heart failure suffer from anxiety or depression, and those with a comorbid anxiety and depression are 2.6 times likely to die (Alhurani et al., 2015, p.375). Alhurani et al. (2015) suggested that in order "to improve mortality rates in patients with heart failure, health care providers must consider the assessment and management of anxiety and depression (p.379). A systemic review was done on six studies, exploring the relationship between anxiety, hospitalization, and mortality. The conclusion showed that anxiety is a possible predictor of re-hospitalization, however a deeper analysis is suggested (Vongmany et al., 2016). Anxiety can be seen as "a potential prognostic predictor in chronic heart failure" (Vongmany et al., 2016, p.478).

Within the past few years many of the cardiac research has focused on levels of anxiety and depression in relation to heart disease. All the literature reviewed had similar results regardless of the method or angle the research took. They all suggested that the patient's psychological wellbeing, which includes their levels of anxiety, and quality of life is essential to help enhance their medical treatment (Simony et al., 2015; Aggelopoulou et al, 2017; Greenman et al., 2018; Musey Jr. et al., 2019)

Another aspect that affects a cardiac patients' quality of life and therefore their treatment prognosis is the lack of knowledge across genders and age. There is a stereotype

image for a cardiac patient “a middle aged man who is overweight, has diabetes and smokes” (BHF Press Office, 2016), and for everyone else the research falls short. Walsh et al. (2018) explored the experience of young individuals with heart failure and how it effects their quality of life. They interviewed 18 people from ages 33 to 55 and analysed the data using descriptive thematic analysis. Results showed six emerging themes: “role fulfilment, autonomy, financial impact, perception of self, retrospective life changes, and symptom burden” (Walsh et al., 2018, p.10). Participants either felt a loss of control over their life situation and wanted to take back that control or “were mourning their loss of independence as the unpredictable trajectory of HF [heart failure] continued to take a toll on their overall health and well-being” (Walsh et al., 2018, p.11). Due to the inconsistency or loss of their job, all participants struggled with financial obligations, such as rent/mortgage, utilities, hospital bills and medication. There was a consensus among these young participants that they felt “too young for this” (Walsh et al., 2018, p.13). They would compare themselves with older people’s health situations and with that came an inability to adjust and accept their health situation, their ‘new normal’. They questioned the life choices that might have led to this diagnosis at a young age, and guilt and self-blame accompanied these thoughts. Like previous studies, anxiety and depression were a companion to patients with heart failure and it affected their physical health; in this case they specially reported fatigue and insomnia (Walsh et al., 2018).

Christian Schulz (2015) wrote a case study about one of his clients who lived with a left Ventricle Assist Device (VAD). They had a therapeutic relationship that lasted two and a half years and approached their sessions using existential psychotherapy. Throughout the paper Schulz highlights existential-humanistic themes that came up, for both himself and his client, during the course of therapy. The main existential givens were death and existential anxiety, which are both interrelated according to Heidegger since “being-towards-death is essentially anxiety” (Schulz, 2015, p. 440). After surviving a heart attack, yet still waiting on a heart

transplant, the client and Schulz were faced with the fact that existence matters. This led them to explore future possibilities and the meanings they entail. Within this theme, two more existential issues appeared: the phenomena of waiting, and the experience of despair. There was uncertainty regarding when, and if, the client will receive the heart transplant. This uncertainty and waiting brought upon the experience of existential angst and despair (Schulz, 2015).

Chandan et al. (2020) took a different direction when exploring women with cardiovascular disease (CVD). They conducted a retrospective study of women who had experienced domestic abuse and have had a CVD diagnosis. The data was collected using the Health Improvement Network medical records database, looking for women diagnosed with CVD who have also reported domestic abuse. Their research demonstrated an association between domestic abuse and the development of a CVD (Chandan et al, 2020, p.7). This study goes beyond medical reasons and symptoms of heart illnesses, as it takes a look at how social aspects and psychological stressors of a woman's life can make her more susceptible to CVD. This indicates that CVD, and probably all other illnesses, have more to them than a medical explanation. Therefore, scientific researchers might need to shift their paradigm from their traditional assumptions to a more bio-psycho-social one.

Physical activity and movement can play a vital role in recovering from cardiac illnesses. The goal of physical activity "can be to recover, to be pain-free, to regain a well functioning everyday life, and to survive" (Angel, 2018, p.2). Angel (2018) explored the different meanings physical activity had to people who have spinal cord injuries, lower back pain, and heart disease. She conducted a second analysis of narrative interviews using a phenomenological-hermeneutic approach, with a focus on their experience of recovery and rehabilitation. Patients engage with physical activity differently depending on their severity of illness, and how it is thought about – is it a chore or a source of joy (Angel, 2018)? This research

aimed to address possible physical activities that consider peoples' priorities and bodily limitations (Angel, 2018, p.8). Results showed three different ways to approach patients regarding their physical activity, considering their motivation and illness capabilities: (1) engaging in movement as a source of joy, (2) overcoming the bodily struggle to do their chores, and (3) minimizing bodily functions equivalent to a functional daily life (Angel, 2018, p.4). Each theme looks into how one focus on their illness and how they live their life in order to see which langue needs to be used to motivate and move them. This research adds an interesting spin to physical activity as a treatment recommendation, instead of simply looking at it as a requirement to 'get better'. The idea of listening into the participant's way of living in the world and how physical activity fits into that, brings out meaning and motivation, that inevitably helps in their recovery process. This outlook goes beyond the medical view and priorities the patient's experience first.

Patients with cardiovascular illnesses are advised to change their lifestyle and have a 'healthy new normal' that would help their rehabilitation and recovery. Change in one's lifestyle means change in their diet, pace of life, medical care, and so on. Janssen-Niemeijer et al. (2017) looked into spiritually as a lifestyle change and the role it plays in their treatment. They reviewed literature, using a formal literature review, from the year 2000 to 2015 and ended up with 12 articles that helped yield their themes and conclusions. Three themes were depicted: religion or connectedness to the significant or sacred, relationality or connectedness with others, and meaning and purpose (Janssen-Niemeijer et al., 2017). According to most of the studies, being religious influenced how they handled their lifestyle changes. Religion or spirituality helped some translate fear into hope and optimism, while regaining their self-confidence. In many cases, "spirituality helped to define their sense of being and their way of life" (Janssen-Niemeijer et al., 2017, p.1472). Another important theme was their connectedness with the other. Lifestyle changes due to illness can cause a shift in the family

dynamic, and this support is crucial in helping the patient. The last theme shows how challenging it is for someone to find meaning and purpose in the midst of their illness. The paper does not highlight how spiritualty comes into this theme, however they point out the importance of being aware of this notion as a practitioner. Even though the definition of spirituality and religion vary from person to the other, this review shows that the notion itself needs to be considered uniquely to each case as it can help in their recovery process and overall 'new' existence.

Hasankhani et al. (2014) looked into the lived experience of cardiac patients after having a coronary angioplasty, which is a surgical procedure that aids in the relief of angina symptoms. They interviewed 15 participants and analysed the data using content analysis. Three themes were identified: angioplasty is a milestone in the patient's life, living with a mended heart, and psychological distress as an integral part of the patient's life (Hasankhani et at., 2014). The main theme patients presented with was the shift in their life after going through an angioplasty, as it gave them a "chance to reconsider some of the choices they had made and an opportunity to redefine some life goals" (Hasankhani et at., 2014, p.146). Many participants expressed relief from angina symptoms after the procedure, however they also experienced a sense of loss, vulnerability, and uncertainty. The loss was both physical as well as emotional, and with that loss came vulnerability. They spoke about anxiety as a constant in their life, as they have now been embraced by death (Hasankhani et at., 2014). This research adds value to the movement towards a patient-concerted model of treatment. Understanding the experience of these participants can help allow practitioners to engage with the magnitude of their experience and explore how it impacted their lives.

A few more studies explored the experience of heart failure. Results showed that most participants spoke about their fear of death, uncertainty towards the future, losing control, and trying to find meaning in their present life (Allen et al., 2009; Jeon et al., 2010; Strömberg and

Jaarsma, 2008; Thornhill et al., 2008; Hansen et al., 2018; Simeone et al., 2015; Shaw et al., 2016; Sampaio et al., 2018). Other themes such as beliefs, social influences, role and identity, being a burden on family members, vulnerability, and responsibility came up (Hansen et al., 2018; Simeone et al., 2015; Shaw et al., 2016; Sampaio et al., 2018). Again each research took a different angle, but all added to the richness and possibilities of exploring the experience of cardiac illness.

The experience of people who live with heart failure or VAD is different from those who have suffered from heart attacks. However, the research above goes to show that a focus on patients psychological wellbeing should be a priority in their treatment plan regardless of the type illness. Considering that the medical explanation and physical experience of heart attacks if different to heart failure and other cardiac illnesses mentioned above, it is important to understand that these near-death illnesses have an impact on the patient. Their experiences, beyond the categorical symptoms, need to be heard. Moreover, the research shows a richness in existential themes when it comes to these illnesses; a domain meriting deeper exploration.

The following section will focus more on literature found specifically on heart attacks, or myocardial infarctions.

2.4.2.2 Heart Attacks

Alexander Lowen takes us a step closer to the lived experience of heart disease patients in his book *Love, Sex, and Your Heart* (2013), with a focus on heart attacks. Lowen developed Bioenergetic Analysis, a therapeutic process that aims to understand the human personality in relation to the body. In his book he examines the physiological process of love and other feelings, in relation to heart disease. He looks into the type of person who is vulnerable to having a heart attack, as he noticed similar patterns of destructive behaviours in his participants. He takes on a more categorical stance and calls this ‘kind’ of person a Type A personality; he

who is “extremely tense, suffering from a sense of time urgency, harboring free-floating hostility of which he was unconscious, and struggling with low self-esteem, for which he compensated by achieving” (Lowen, 2013, p.111). As this person struggles through life, tense and submitting to stress, they do not process their emotions. Over time this way of living increases blood pressure levels and decreases prostacycline levels, causing platelets to stick together to form a clot that might eventually close down an artery, thus resulting in a heart attack (Lowen, 2013). His ideas can be seen to be very controversial, as he correlates one’s psychology and lifestyle to a biological phenomenon. As Lowen writes, there is a split between the mind, emotions, and the body as he defines the Type A personality. However, as he describes how one affects the other, he attempts to lessen the gap and bring them both together as one.

Kathleen Neill (1987) also refers to Type A behaviour patterns in her research, which is a coping mechanism “characterized by competitiveness, striving, assertiveness, a sense of hurriedness, and responsibility” (Neill, 1987, p. 26). As she reviewed previous literature on the psychosocial, behavioural, and environmental patterns of those who suffered from myocardial pain, she found that people who suffered from myocardial infarction experienced stressful life events and dealt with them using Type A patterns. Neill (1987) and Lowen’s (2013) description of a person susceptible to heart disease, the Type A personality, is very categorical and lacks the experiential aspect of the participants, which is what this research paper aims to further explore.

Joekes et al. (2007) compared the psychological wellbeing of participants who suffered from heart failure to those who suffered from myocardial infarction. Heart failure occurs when the cardiac muscle fibers increase and enlarge, resulting in the thickening of the walls of the heart chambers. Blood flow is decreased or even blocked, which “increases blood volume and cardiac workload” (Waugh and Grant, 2010, p. 119). Eighty-two participants, either suffering

from heart failure or myocardial infarction, were asked to complete a questionnaire at recruitment and then a follow up questionnaire after three months. The questionnaires covered questions related to the participants' demographics, self-management, anxiety and depression, quality of life, overprotection and self-efficacy. Patients with heart failure scored higher on depression and anxiety levels. Whereas they showed similar results for self-efficacy and self-management; pointing out that they are also "strongly associated with psychological well-being and health-related quality of life" (Joekes et al., 2007, p.12). This research supports the idea that cardiac illnesses, including myocardial infarction, play a role in the patient's psychological wellbeing. This gives room for counselling psychologists to engage with such a phenomenon and learn to work with the effects of the illness on their lived experience.

Affleck et al. (1987) interviewed 287 men, heart attack survivors, 7 weeks after their attack and then again 8 years later. This quantitative study is aimed to link their illness to cognitive and psychological processes and to identify psychological reasons behind any recurrence. Results showed that people who attributed their initial heart attack to their own personal stress-responses to life were less likely to get another heart attack. Those who blamed other people or external factors to their attack were more likely to experience a reoccurrence (Affleck et al., 1987). With a sample this wide, Affleck et al. (1987) were able to depict results in regards to the reasons for a reoccurrence, and the notion of existential responsibility surfaces. It seems that people who assumed the heart attack as their own responsibility and acknowledged their personal responses to stress were less likely to experience a reoccurrence. With fewer participants and a different methodology, one can explore participant's choices and experience around these findings.

Brink et al. (2002) used the grounded theory approach to get a better understanding of 22 participants' feelings, thoughts, and actions during the onset of their heart attack. Of the 22 participants, there were 11 women and 11 men, all between the age of 48 to 83. They were

selected from a group of 130 patients who had survived their first myocardial infarction at Uddevalla Hospital in Sweden. Results showed that participants initially misinterpreted their symptoms as something other than signs of a heart attack. They were amazed at the fact that this is actually happening to them. This amazement led them to disregard and delay treatment (Brink et al., 2002, p.537). Whether participants delayed seeking treatment or not depended on their health beliefs. Those who understood the consequences of heart attacks were more likely to seek immediate treatment. The findings above were more specific to those who were not aware of the symptoms and risks of a myocardial infarction.

Roncella et al. (2013) conducted a randomized control trial with 101 patients after being treated for acute myocardial infarction (AMI). The sample was randomly assigned to either receiving the standard contemporary treatment of AMI, or having additional short-term psychotherapy (STP) alongside the standard treatment. Participants in the STP group showed better results in their medical as well as psychological outcomes. Lower recurrences of severe chest pains, medically referred to as angina, and other comorbidities were reported in the STP group versus the control group. The re-hospitalization rate was significantly higher in the control group during the course of the study. Though not statistically relevant, there were three life-threatening arrhythmia incidences in the control group, whereas the STP group experienced none. “Three controls were administered psychiatric treatment for major depression and generalized anxiety disorder” (Roncella et al., 2013, p. 135), when none of the participants in the STP group needed psychiatric drugs. The Beck Depression Inventory (BDI) was administered to all participants during enrollment and again after one year. Results showed an improvement in the BDI scores of the STP group and a deterioration in the control group’s scores. Psychotherapy showed a significant benefit to participants with AMI, which adds to the relevance of the current research being proposed. Even though this paper does not discuss the content of the sessions, it concludes that psychotherapy shows promising results to patients

with heart attacks. This supports the idea that counselling psychologists and psychotherapists can play a role in the treatment process, and this research paper aims to delve deeper into the content of such sessions by exploring their lived experience.

Allison and Campbell (2009) studied the lived experience of seven young men, below the age of 60, who survived a myocardial infarction (MI) within a timespan of 12 months. An hour long semi-structure interview was carried out to each of the men, and thematic analysis was used to analyse the data from the interviews. Four main themes were depicted from the content of the interviews: disillusionment with life, tension and stress, keeping up appearances, and invincibility. All participants expressed disappointment with and anger towards their lives before the MI, mainly in relation to work. Their expectations were not "being lived up to", and they felt "let down by their own bodies" (Allison and Campbell, 2009, p.120). Such experiences left them with feelings of uselessness, disappointment, and disillusionment, which in turn caused an increase in tension and stress levels. None of the participants were able to identify ways in which they could ease or release pain and tension. It seemed as if stress was seldom processed or expressed, but instead amplified. The stress and tension were eventually manifested through physical symptoms, in this case a heart attack. Participants likened their experience to that of a coiled spring becoming tighter with time, and ultimately breaking. "When the spring has broken, there is a sense of relief. This spring breaking can be used as a metaphor for the MI" (Allison and Campbell, 2009, p.120). The last two themes seemed to be specific to the fact that the participants were men, not women. It seemed that these men needed to appear strong, not weak, making it difficult for them to believe or even show that what they were experiencing a heart attack. This study is similar to the aim of this research paper, except for its exclusive focus on men and its shortened time frame.

In their study, Andersson et al. (2013), aimed to elucidate the experience of participants younger than 55 after a myocardial infarction (MI). They interviewed and analysed 17 participants, 6 women and 11 men, using a phenomenological–hermeneutic method inspired by Paul Ricoeur's (1976) theory of interpretation. The meanings elicited from the participants' experiences following an MI were embodied in five themes: (1) energy: constantly lacking, (2) fear: a constant companion, (3) demands: constantly present, (4) threats: an unreliable body and mind, and (5) outlook: life will never be the same. Participants described their constant lack of physical and mental energy, which hindered their social life, their personal hobbies, and even their everyday duties towards their household, children and spouses. Fear became a constant after becoming more familiar with mortality following their MI; "suddenly and unexpectedly, the notion of the fragility of life could strike them" (Andersson et al., 2013, p.765). Recommendations from their health care practitioners to schedule regular follow ups, attend educational sessions, and physical training became stressful and turned into a demand creating pressure. In addition, activities with friends, family, and work also became demanding. They had to fit all these demands into their everyday life, a life that has become exhausting after the MI. Alongside, participants were no longer able to trust their body. Their body became unfamiliar and a threat. The MI was seen as a "warning that made them aware of the very thin line between life and death" (Andersson et al., 2013, p.767). Their outlook on life changed; participants valued quality time with their family, instead of more materialistic things in life. This study highlights the significance of the proposed research to explore this phenomenon further and either strengthen the themes depicted or see if anything else comes up. It is important to consider the duration of time since the MI and the time of the interview, as time can have an impact on the processing and interpretation of their experience.

Even though the physical experience of an MI can be very short, the ramifications and effect it has on a person can be ongoing for years after, as it requires a change in one's lifestyle.

The medical model of dealing with people who had an MI suggests a treatment pathway that helps heal the damage and prevents a reoccurrence. Bardsgjerde et al. (2019) explores patients' experiences in different phases of the MI treatment pathway. They identified three phases: acute, discharge, and rehabilitation. The acute phase starts with the onset of their symptoms until they receive treatment; the discharge phase is when they are discharged from the hospital; and the rehabilitation phase refers to their enrolment in rehabilitation programs that help with secondary prevention (Bardsgjerde et al., 2019, p.4). Ten participants were interviewed for this research, 8 men and 2 women. After their interviews were analysed using narrative analysis, four themes came up: (1) lack of verbal communication in the acute phase, (2) trust in healthcare professionals and treatment, (3) lack of participation and coordination at discharge, and (4) shared decision-making in rehabilitation (Bardsgjerde et al., 2019, p.11). The participant's narratives showed how they were trying to understand the situation since most of them did not experience any warning or alarming symptoms. Along with the dilemma of trying to understand, they received little verbal information about their condition and were transferred to the hospital without any explanation. Even with this minimal information, most of the participants conveyed trust in the healthcare system and felt they were "in safe hands" (Bardsgjerde et al., 2019, p.12). There was a consensus regarding the benefits of the rehabilitation programs after discharge; most of the participants learnt more about their condition during this phase then at the hospital (Bardsgjerde et al., 2019, p.14). This research adds a new dimension to looking at the experience of having an MI, as it is more specific to every step of their treatment pathway. Experiencing such a life-threatening event and receiving treatment for months after, can have an effect on the participants that is not attended too by medical practitioners. Medical doctors already have a lot of responsibility to cover the biological and physiological aspect of an illness, which leaves room for counselling

psychologists to explore the patient's lived experience of that illness. This research aims to explore the experience of an MI from a phenomenological perspective.

The aim of cardiac rehabilitation programs is to support patients through their recovery and life changing challenges. Simony et al. (2017) interviewed 11 heart attack survivors who are enrolled in a rehabilitation program, to explore how they experience their life situation when following cardiac rehabilitation. Focus group as well as individual interviews were carried out, and the data was analysed using a phenomenological-hermeneutic approach, more specifically Paul Ricoeur's (1976) theory of interpretation. This approach aims to understand "what the text as a whole addresses and it benefits from the dialectical movement between explanation and understanding" (Simony et al., 2017, p.234). Three themes were concluded from the analysis: difficulty accepting the disease, understanding that life has become frail, and an altered life (Simony et al, 2017, p.235). Participants expressed a sense of surrender to the "fear of death and feelings of vulnerability and helplessness" (Simony et al, 2017, p.237). At first, it was difficult for most participants to accept or understand what was happening, as they hoped that the symptoms will eventually subside. The day of the heart attack marked a tremendous shift in their life, as now their lives are frail. The ramifications of a heart attack are long lasting, as participants reported physical deterioration and loss of social privileges. They were 'weaker' than before, which was to be considered in their social affairs and job fulfilment. All the participants appreciated the support they were getting from the rehabilitation program, and credited it for a better understanding of the illness (Simony et al, 2017).

Qualitative research found that illness perceptions and health beliefs played a vital role in patient recovery and self-care, "from being well, fully recovered and having a zest for life; to being ill with constant concerns, and uncertainty about the future" (Hanna et al., 2019, p.2). Hanna et al. (2019) focused their research on the experience of adherence to medical recommendations from the perspective of patients who went through an MI. They used a

phenomenological inductive approach and content analysis to understand this phenomenon. Twenty-two participants were interviewed, focusing on their experience of what can be considered a facilitator or a barrier to their adherence to treatment. The results yielded two main categories, intrinsic and extrinsic factors, with six sub-themes. Intrinsic factors included the participants' willpower, self-competency, and personal preferences. All three subthemes were interrelated; in order to have the willpower to get better, one must have a sense of self-competency, also keeping in mind that there are different personal preferences in life that effect their lifestyle. The extrinsic factors depicted were: the threat of a recurrence, family and significant others, and health care providers (Hanna et al., 2019, p.6). Both the intrinsic and extrinsic factors were also interrelated, if one is supported by their families and health care providers the willingness and self-competency is effected positively. This research showed the different motivators that can help a person deal with health related behaviours. The fact that external factors help move a person's treatment in a specific direction, gives importance to the social dimension of one's existence, which is covered in the interviewing process of the proposed research.

Seeing that emotions such as stress (Allison and Campbell, 2009) and fear (Andersson et al., 2013; Simony et al, 2017) came up in previous research, taking a closer look at their experience of anxiety can add value to working with MI survivors. Geiser et al. (2017) assessed anxiety and depression levels in 148 patients that had just went through an MI. The participants were asked to complete the Hospital Anxiety and Depression Scale right after the MI and then again three months after. Immediately after the MI, 38.5% of the anxiety and/or depression, which decreased to 31.8% after three months of the MI. They correlated these results with the participants' haemostasis profile and found nothing too significant, but they suggested that the relationship between age and anxiety should be further investigated (Geiser et al., 2017). Another quantitative study that looked at anxiety in MI patients was conducted by Smeijers et

al. (2016). The aim was to examine whether age and gender are correlated with an increase in mortality following an MI preceded by negative emotions, specifically anxiety and anger. Results showed a correlation between anxiety and anger with younger participants, they had reported a heightened sense of anxiety or anger two hours before the MI. High levels of anxiety prior to the MI, was also reported by women more than men. Over a 10 year follow up period, results indicated that high levels of anxiety are associated with mortality (Smeijers et al., 2016). Even though these two studies (Geiser et al., 2017; Smeijers et al., 2016) take a quantitative approach, they show the presence of anxiety, depression, and anger at different stages of the MI, which can be used as a head start for qualitative research exploring this phenomenon.

2.4.2.3 Women & Heart Attacks

The research above was tailored more towards men. Initially a heart attack was seen as a male illness, and only recently, over the past two decades, has this idea shifted (Sjostrom-Strand et al., 2011; Pelliccia et al., 2020). This gender bias stems from the fact that "women tend to be older, with more co-morbidities, and with a more complex vascular anatomy" (Pelliccia et al., 2020, p.18). Statistics show that women that have had an MI have a higher mortality rate than men in both Western and Eastern countries (Collins et al., 2017; Bakker, 2018; Pelliccia et al., 2020, p.19). Women presenting with symptoms of a heart attack "experience disparities in evidence-based treatment strategies, including delayed reperfusion times, and more procedural complications" (Rodriguez et al., 2015, p.1). The British Heart Foundation has been geared towards raising awareness about women and heart attacks to ensure equality in their diagnosis and therefore their treatment (Bakker, 2018). With this movement there is room for research about women and heart attacks to emerge. The following section reviews the current literature from a psychological perspective rather than a medical one.

Jones et al. (2019) explored the lived experience of African American women who experienced a myocardial infarction. They interviewed seven women focusing on their experience after the MI and used IPA to analyse the data. Six themes were depicted from the analysis: life before the MI, causes of the MI, warning signs, life after the MI, cardiac rehabilitation, and family support (Jones et al., 2019). Participants spoke about their life before the MI and how they made lifestyle changes after to reduce the risk of reoccurrence. Some believed that "their MI was stress related, attributed to by the demands of juggling work and family responsibilities" (Jones et al., 2019, p.507). Results showed the lack of knowledge women had concerning MI symptoms, risk factors, and rehabilitation options. All participants showed the importance of their immediate and extended family support, motivating them to get better and take care of their health. This research was aimed to help healthcare practitioners understand where the lack of knowledge is, so they can educate their patients about the risks of MI and help them through their recovery (Jones et al., 2019). The results of this study open a gateway to explore these women's lived experience, seeing that the results show how their lives have been affected by an MI. However, the aim of both researches are different, one aims to help the healthcare system, while the proposed research aims to add to the counselling psychology field. Specifically, how can one understand this phenomenon, in order to work with women who experienced a heart attack.

Bowles et al. (2018) looked into the experience of Mexican American women who had an MI. They interviewed eight women and used qualitative content analysis to analyse the data. Even though this research is similar to Jones et al. (2019), they came up with four different themes: perception of the MI, having a heart attack, MI symptoms, and actions taken (Bowles et al., 2018). The women spoke about their perception of a what a heart attack is, what they knew and understood it can be from stories they have heard. Their perception was different to their own heart attack, as most women claimed they did not think that they were having one.

All the women experienced a loss of energy, chest pressure, shortness of breath, and some mentioned leg pain. They used terms such as "harder to breathe, couldn't breathe, not getting enough air, short of breath, and a drowning sensation" (Bowles et al., 2018, p.65). All women, with the exception of one, attempted to self-manage their symptoms and not seek help. Even the one woman who sought help, did so after some delay. For the rest of the women, their family members were the ones who pushed them to seek help. It would be interesting to see if the theme 'family support', from the research mentioned above (Jones et al., 2019), is also relevant to Mexican American women, hence other cultures as well. In this research, the descriptions seemed to be embodied, whether the description of the MI itself or their self-management attempts. There was also a relational aspect in theme 'action taken', all of which add to the aim of the proposed research. It would be interesting to see if culture plays a role in the themes that come up, seeing that the proposed research focuses on Egyptian women.

Sjostrom-Strand et al. (2011) used an explorative and descriptive method to explore how women perceive their life and health five years after having an MI. This research takes a long term view on heart attacks, by looking at their life experience five years post-MI. Two main themes emerged from the analysis: consequences of a myocardial infarction and adjustment to a new life situation. Within each theme are seven subthemes. Consequences of a myocardial infarction describes the limitations women experience after an MI, the subthemes being: fear and anxiety for the future, suffering from other serious illness, medication and secondary effects, rehabilitation, fatigue and other health complaints, fearing another MI, and downgraded and not taken seriously by the physician (Sjostrom-Strand et al., 2011, p.461). After accepting the diagnosis, women need to adjust to a new life situation. Within this theme came: moving forward with difficulties, gratefulness, taking responsibilities for lifestyle changes, recovery process, interaction with family and friends, being aware of the heart, and financial stress (Sjostrom-Strand et al., 2011, p.463). It was concluded that even after five

years, women experienced difficulties with moving forward with their life. There was an ongoing feeling of fatigue along with other health complaints that hindered their ability to continue with their usual routines (Sjostrom-Strand et al., 2011, p.464). Again this research shows how the experience of a medical illness, the MI, has many other avenues to explore in order to help paint a more holistic view of the patient and tailor their treatments accordingly.

A meta-ethnography was carried out by Madsen and Birkelund (2016) to identify women's experiences during a myocardial infarction. Fourteen qualitative studies were analysed and synthesized, with a total sample of 231 women between the ages 36-87. The studies used were a collection from the years 1995 to 2013. Three themes were identified from the data: (1) feeling the changes in my body, (2) understanding the changes in my body, and (3) acting on the changes in my body. All women felt a change in their body, in their chest, back, arms, stomach, or head. Due to the stereotype of how a heart attack is supposed to feel like, some women minimized the changes they felt and interpreted the symptoms as indigestion or aging (Madsen and Birkelund, 2016, p. 602). Others with stronger symptoms might seek help from a significant other or friend before a medical professional. Women's response to their MI was determined on how threatening they felt their symptoms were. Not only has this paper summarized 14 studies exploring the experience during an MI, but their main focus was women. Each study will be looked at separately, for the purpose of this research, in order to pick up on the difference among them, if relevant. This meta-ethnography highlights what can be considered main themes of the experience of women during an MI. However, since 14 studies were summarized in one, factors such as demographics (age and culture), time between the interview and MI, and other medical illnesses in parallel were not considered.

Women usually hesitate to seek medical treatment and prefer to wait for their symptoms to change by self-medicating (Madsen and Birkelund, 2016). Isaksson et al. (2013) used content analysis to interview 20 women between 65 and 80 years of age about their experience

of going through a myocardial infarction, focusing on the time before they seek medical treatment. Two themes were derived from the data: (1) perceived symptoms: undergoing unfamiliar and strange development of discomfort and pain, and (2) response to symptoms: struggling against intrusive symptoms to maintain control and responsibility. The progression of the symptoms takes from days to weeks and sometimes months. Women usually never associate their symptoms with the heart and choose to seek the support of family and friends when they reached the maximum point of distress before seeking medical advice. The reason to why they delay asking their family and friends is so they do not bother them, in turn they end up "downplaying and doubting their perceived ill-being" (Isaksson at al., 2013, p. 364). It is hard for them to believe that this is happening to them, and that they are in fact experiencing an MI.

Gyberg et al. (2019) explored how women's experiences influenced their decision to seek medical care after their first MI. They interviewed 17 women asking them about their experience of the MI leading up to their decision to seek treatment, while also considering their social circumstances as part of their experience. Constructivist grounded theory was used to analyse the meanings behind their actions or decisions and understand how they were constructed (Gyberg et al., 2019, p.671). Results showed that women were more likely to seek treatment if their symptoms were intense and persistent. They prioritized and pushed through their daily activities normally until their body could not handle it anymore (Gyberg et al., 2019, p.675). They divided their symptoms into three categories depending on their severity: non-intriguing symptoms, symptoms interfering with normal activities and symptoms intruding on life (Gyberg et al., 2019, p.672). In most cases, only when symptoms were intruding on life, where nothing helped and symptoms were beyond recognition, did these women seek treatment. The relationship of a women to her illness and body is shown in their research through the delay in seeking treatment. It would be of great value to ask these women about

the meaning behind the results found, to get a closer understanding of this quality or need to persevere until they can no longer function normally. Why is it that they have to delay, what can't they allow themselves the 'right' to feel ill and seek help? This proposed research can bring us a step closer to understanding their lived experience and put their treatment decisions into perspective.

Sjöström-Stranda and Fridlund (2008) interviewed 19 women two or three days after they had a myocardial infarction, to explore the experience of their symptoms and reasons for delaying treatment. Content analysis was used to collect and analyse the data. Results showed how women had difficulty interpreting the symptoms as ones that could lead to an MI. They described their pain as a pressure, that was not necessarily painful, but that increased over weeks or months. For this reason, they misinterpreted their symptoms and related them to less severe ailments. They described how their symptoms caused anxiety; "the anxiety provoked the pain and the pain was perceived as severe when it was linked to anxiety" (Sjöström-Stranda and Fridlund, 2008, p. 1006). As a result of these experiences, women delayed seeking treatment as they believed that they could manage these symptoms on their own, they did not want to burden their family, and were influenced by their support system when deciding to seek help.

Similarly, Arslanian-Engoren and Scott (2017) conducted a second analysis examining the experience of women with symptoms of acute myocardial infarction. Fourteen participants took part in this study, four of which were health care professionals. Results showed that nine participants delayed seeking treatment due to: lack of association of symptoms with an MI, personal and/or professional obligations, and refusal to arrive to the hospital in an ambulance. Out of the nine participants were the four health care practitioners, "despite their professional and experiential knowledge these participants failed to recognize their own symptoms of MI" (Arslanian-Engoren and Scott, 2017, p. 301). Results concluded that women tend to

misinterpret and minimized their symptoms and in turn they chose to self-medicate rather than seeking medical or even family support. When they reached their maximum distress level, which can be after weeks or even months, they chose to resort to family and friends before seeking medical advice. This all stems from reasons such as disbelief that this can actually be happening to them, or for prioritizing their family's needs over their own (Davis et al., 2013; Dempsey et al., 1995; Gallagher et al., 2010; Higginson, 2008; Rosenfeld et al., 2005).

LØvlien at al. (2016) took on a different avenue with women who experienced a myocardial infarction. They conducted a cross-sectional study with 142 women, examining the relationship between physical activity, health-related quality of life, and sense of coherence after an MI. Results showed that even a low level of physical activity had a significant effect on the participants' health-related quality of life. Whereas the participants sense of coherence was related to their age; women above the age of 75 had significantly higher scores than those younger than 75. Unlike the previous studies about the experience of women, this adds a new outlook on what effects the quality of life of women after an MI, as it takes a look at the physical world of the women.

Cole et al (2012) looked into the prevalence and correlation between women's sleep disturbance and their MI. A secondary analysis was performed to analyse a dataset assembled from two studies that aimed to evaluate women's symptoms of the MI. The data was initially collected from 15 different locations throughout eight states in the Southern region of the United States. A total of 1270 women's experiences were analysed; 50.2% of these women showed sleep disturbance before their MI. Medically the "pathways between MI and sleep disturbance are unclear" (Cole et al., 2012, p.442). However, authors of this study argued that with these results, it is important to acknowledge women's sleep patterns when at risk of a cardiovascular disease.

The results from the research mentioned above shows the diversity of information that can be illustrated from the experience of having a heart attack. The main reoccurring themes throughout the research showed how women tend to misinterpret their symptoms for something other than an MI and for this reason they delay seeking treatment. In addition to that, they do not want to burden their friends and family so they keep their experience to themselves, sometimes self-medicating, resulting in a further delay in attending to their pains (Isaksson et al., 2013; Madsen and Birkelund, 2016; Sjöström-Stranda and Fridlund, 2008). LØvlien at al. (2016) and Cole et al. (2012) looked into the effect of the MI on the body, specifically their sleep patterns and physical activity.

Existential aspects depicted from the research above will be discussed in the following section to further explore and understand the experience of having a heart attack.

2.5 Existential Aspects of a Heart Attack

The literature above takes a look at the experience of heart attacks for different angles. From a broader look into the experience of having a heart attack, to more specific aspects like, seeking treatment, levels of anxiety and depression, and the interpretation of their symptoms. Though none took an existential direction, many themes came up that reflect existential concerns. The themes discussed are: anxiety, responsibility, being-with, and temporality.

2.5.1 Anxiety

Anxiety is defined by the BPS as “a feeling of profound agitation and unease about an imminent unpleasant experience” (BPS, 2020). The more lay usage of the term anxiety tends to compartmentalize it into an emotion, creating a mind and body split. It is a feeling that ‘should’ be reduced or solved. However, existential thinkers view so much opportunity in anxiety. It is “considered the starting point of a well-lived life” (van Deurzen, 2011, p.13).

Rollo May (2015) defines anxiety as, "the apprehension cued off by a threat to some value that the individual holds essential to his existence as a personality" (p.190). Anxiety is not a feeling that can be remedied by leaving a certain situation or thinking of it differently; it is a threat to one's existence, shattering the essence or core of one's self. According to Søren Kierkegaard (1980), this threat is a possibility, as he writes "in anxiety there is the selfish infinity of possibility" (p.61). Possibility stands for 'I can…'; I can delve into the unlimited possibilities that the world holds, the eternal; it is ultimately freedom. Therefore, anxiety is the state of the human being when he is confronted with his freedom.

May builds on Kierkegaard's philosophy of anxiety, and compares anxiety with fear to show its immensity. Fear is a reaction to a specific situation, a threat directed to an aspect of the self. He gives the example of crossing a highway, in which the person is fearful from the cars as he crosses. When he crosses safely this fear subsides. Anxiety, on the other hand, is the "human being's basic reaction to a danger to his existence, or to some value he identifies with his existence" (May, 2009, p.23).

Tillich (2000) introduces three types of anxiety: anxiety of death, of meaninglessness, and of guilt. He writes that anxiety is "the state in which a being is aware of its possible nonbeing" (Tillich, 2000, p.35), and therefore it cannot be eliminated as it belongs to existence itself. Death, meaningless, and guilt are givens of life, it is inevitable for us to be faced with such phenomena's. Death is inescapable, we are always being-toward-death from the moment we are born. It is inevitable, and whether we are momentarily thinking of it or not, it is embodied within us. As we are always being-toward-death, we constantly try to make sense of the world and find our purpose. Anxiety of meaninglessness is the anxiety that comes from the loss of direction or answer to the meaning of one's existence (Tillich, 2000). Yalom (1980) discusses how meaninglessness is related to illness; illness is a manifestation of the absence of meaning or purpose (p. 421). The constant battle of trying to find meaning in life prompts

anxiety of guilt, which is the experience of someone who is not living up to their potential. May (2015) and Yalom (1980) added a fourth type of anxiety, that of freedom. The freedom to choose reflects our responsibility and choices. Within the limitations of life, we are free, "freedom is nothing but contingency: in order to affirm it I have to dare engage in the relationship with the other that allows me to create and develop a different way of life" (van Deurzen, 2011, p.125); that in itself yields anxiety.

The theme anxiety was apparent in many of research papers mentioned above. A heart attack or an MI is a threat, the person is faced with a near-death experience that awakens anxiety. Anxiety, along with fear, was noted to be a constant companion, one which evokes the fear of having a reoccurrence (Andersson et al., 2013; Hanna el at. 2019; Sjostrom-Strand et al., 2011; Hanna et al., 2019). Two studies indicated that personal stress and anxiety resulted in an MI (Affleck et al., 1987; Jones et al, 2019), and some expressed how anxiety was manifested through physical symptoms (Allison and Campbell, 2009). Though the experience of anxiety itself was not explored, its prevalence in the research shows its importance. The prominence of anxiety throughout the literature supports the idea of this research, as anxiety will be explored in relation to the embodied experience of having a heart attack.

2.5.2 Responsibility

"Man is nothing other than his own project. He exists only to the extent that he realizes himself, therefore he is nothing more than the sum of his actions… responsible for what he is…free… condemned to be free… committing himself to life" (Sartre, 2007, p.10).

As mentioned above, freedom is an unescapable reality. We are condemned to be free, to choose, and we are responsible for all that is. When discussing freedom, the conception of responsibility and choice come hand in hand. Responsibility is simply authorship, it is "to be aware of creating one's own self, destiny, life predicament, feelings and, if such be the case,

one's own suffering" (Yalom, 1980, p.218). We are responsible to choose how to live and relate to life, and we have to accept the fact that everything we do is chosen. In fact, the only choice we do not have is not to choose, meaning that not choosing in itself is a choice (Sartre, 2007). Therefore, when we deny our responsibility and freedom, we negate all our possibilities to choose and actually actualise "our own most potentiality for being…we lose the possibility of a life infused with passion, creativity and vitality" (Cooper, 2003, p.25). Can this denial hinder one's potential in the world?

In some articles, participants attributed their heart attack to external factors and responsibilities (Affleck et al., 1987; Jones et al., 2019), namely work and family stressors. On the contrary in Sjostrom-Strand et al. (2011) research, participants discuss the difficulties of taking responsibility for their recovery process and lifestyle change. To add to this notion, others spoke about how willpower, self-competency, and personal preferences effected one's recovery (Hanna et al., 2019). Though this theme is not directly linked to responsibility, it sheds light on the participant's choices, which is referred to as personal preferences, and indirectly their perception of responsibility.

Many articles highlighted the tendency for women to delay seeking medical treatment and resort to self-medicating at first (Brink et al., 2002; Bowles et al., 2018; Madsen and Birkelund, 2016; Gyberg et al., 2019; Arslanian-Engoren and Scott, 2017), as they did not want to burden their family and friends with their complaints (Sjöström-Stranda and Fridlund, 2008). It is almost as if these women took too much responsibility for their illness and chose not to ask for help; in a way denying or not recognizing their limitations.

The articles above all showed different examples of the expression of responsibility. All these outcomes open an avenue for exploring the phenomenon of responsibility, hence freedom and choice, in relation to physical illness.

2.5.3 Being-with

"The world is always the one I share with others. The world of Dasein is a with-world" (Dreyfus, 1991, p.149); 'I' am always is in relation to the 'other', and anything who is not 'I' is an 'other' (van Deaurzen, 2005, p.128). Heidegger (2012) introduced the notion Dasein-with or being-with (p.149), an aspect of being-in-the-world, in which Dasein is in constant engagement with and encountering the other, as "Dasein is essentially being-with" (Heidegger, 2012, p.156); the world of Dasein cannot be understood in isolation. As we are constantly being-with, we are faced with the continual challenge of how to respond to the world, the other.

Martin Buber shares a similar view to Heidegger, even though he criticized part of his writings. He also believes that the human is not a separate entity, he is never in isolation but in relation to 'It' or 'Thou' (Buber, 1970). In his book, *I and Thou* (1970), he discusses the nature of human relating. We are intrinsically connected to the world and everything around us, "we generate a different sense of self in accordance with the way in which we encounter these things and people" (van Deurzen, 2011, p.70). As soon as the word 'I' is used, it immediately becomes 'I' in-relation-to, and according to Buber we either relate to You (Thou) or It. I-You or I-Thou refers to a binding relationship with the other, one that is personal, mutual and subjective. He writes, "I require a You to become… All actual life is encounter" (Buber, 1970, p.62). I-It, on the other hand, is functional relationship that which is objectified.

Even though both philosophers believe that we always exist in relation to the world, regardless of the terminology used, Buber criticises Heidegger's work to be lacking the essence of the I-Thou relationship (Novak, 1985). Heidegger talks about the notion of being-with, but in Buber's opinion, he fails to show the quality of the interpersonal realm of being. This makes Heidegger's philosophy seem more individualistic, which opposes the idea of always being-with (Novak, 1985, p.129).

van Deurzen (2012) introduces the phenomenon of relationships under her concept of the social dimension, which "represents our insertion into a public domain where cultural norms, social conventions and the power relations of interpersonal dynamics influence our behaviour and experience" (p.107). We are all thrown into this world, into a world with others like us who are also thrown, and we are left to live life by relating with the other and the world. Our experiences in life are interlinked with the social world, and how we do so reflects our being-with.

Many of the research papers above mention the notion of relationships, whether not wanting to be a burden on their loved ones (Arslanian-Engoren and Scott, 2017), or how family support has helped them through recovery (Hanna et al., 2019; Jones et al., 2019). Bowles et al. (2018) showed that their family and loved ones were the ones who pushed them to seek help. Participants in Allison and Campbell (2009) research depicted the importance of how they appeared in front of the other, they needed to appear strong to the world, highlighting their quality of being-with. Other research showed how participants trusted the healthcare practitioners (Bardsgjerde et al., 2019; Hanna et al., 2019); this 'surrender' to the other also brings out an aspect of being-with. Though different, they all highlight the element of being-with in patients with heart attacks, showing the significance of this phenomenon with illness.

2.5.4 Temporality & Death

As previous research studies elicited, when faced with a life threatening illness, participants start to question their meaning of life as death becomes an undeniable reality. They ruminate about how they spent, and will spend, their time, which brings about the phenomenon of temporality. The "primordial ontological basis of Dasein's existentiality is temporality" (Heidegger, 2012, p. 277); temporal means simply being in time. Existentially, time is not

experienced as linear; the past is an aspect of the present which points towards the future; the future being ultimately death.

With life comes death; it is an existential given that cannot be escaped. Those who embrace their being-toward-death awaken anxiety and open their selves up too authentic potentiality-of-Being (Heidegger, 2012, p.277). Coronary heart diseases, which includes heart attacks, is the leading cause of deaths globally, affecting 9.43 million people in 2016 (World Health Organization, 2017; British Heart Foundation, 2020). In the UK, 7 out of 10 people diagnosed with a heart attack survive it (British Heart Foundation, 2020). A heart attack being a near death experience for these survivors, brings about anxiety and a tension between authentic and inauthentic living arises. Even though death did not come up in any of the qualitative literature on heart attacks, temporality and death are inevitably linked, as "our temporality and thus our mortality is the ultimate truth of our being" (van Deurzen, 2011, p.59).

One of the themes in Allison and Campbell (2009) research was invincibility. It was difficult for participants to believe that what they were having was, in fact, a heart attack. They questioned how it could have happen to them of all people, and at this point they are faced with temporality. In Andersson et al. (2013) research, one of the themes depicted illustrated temporality. Participants expressed their body as unreliable, their body was a threat, it was a ticking time bomb that can go off at any time. There were faced with death and with that the experience of time surfaced.

The literature review shows that heart attacks have been explored from more holistic and psychological perspectives. Research acknowledges a gap when it comes to women's experiences of heart attacks, however there are a few attempts to bridge that gap as shown above (Sjostrom-Strand et al., 2011; Rodriguez et al., 2015; Madsen and Birkelund, 2016; Bowles et al., 2018; Gyberg et al., 2019; Jones et al., 2019). Within the reviewed literature

many existential themes surface, such as anxiety, responsibility, being-with, and death. Even though the literature was not designed specifically to bring out existential themes, it was inevitable since a heart attack threatens one's existence. This current research delves into exploring the lived experience of women who suffered from heart attacks, taking on an existential view.

The following section discusses the methodology used for this research, including other methods considered, the data collection and analysis process, ethical considerations, and reflexivity.

3. Methodology

3.1 Introduction to Methodology

There is an evident growth in the use of qualitative research in the medical field. Even though this is not a scientific paper, it does explore a medical concern, the heart attack. There has been a spilt in the literature between medical and psychological research. This split has recently been coming together, starting from a more general analysis of how has illness effected their life (Geiser et al., 2017; Smeijers et al., 2017), to a more experiential perspective (Westman et al., 2006; Gebler and Maercker, 2014; Schulz, 2015; Vilchinsky et al., 2019). This dissertation aims to marry both fields, as I aim to explore a medical concern, the heart attack, from the patients' perception, in hopes to learn more about working with physical illness in psychotherapy.

The following sections will discuss the research methods. Starting with a discussion about quantitative and qualitative methods, then a brief description of the considered qualitative methods, and narrowing it down to the chosen method for this research, which is Interpretative Phenomenological Analysis (IPA).

3.2 Qualitative vs. Quantitative

Quantitative methodology comes to mind when thinking of medical research, a scientist aims to measure the success of various treatments, the effects of medications, or reasons for the development of certain illnesses. All of which can be transformed into numbers and percentages to indicate the most effective way to treat certain illnesses. Quantitative research has succeeded in developing scientific knowledge regarding various medical concerns. The research conducted has always taken a positivist philosophical stance, assuming that there is

one “stable reality ‘out there’” (Green and Thorogood, 2004, p.12). Therefore, the phenomenon being tested exists in the same way whether it is understood or not. For example, a bacterium is a bacterium whether we understand it or not, and the same can be said about a heart attack. Quantitative research adds empirical knowledge to how we identify, measure, and understand illness. However, this ‘one reality’ limits the researcher from understanding the full picture of the phenomenon, one with the potentiality to get a descriptive and/or an experiential understanding. In the 1990s medical researchers started to question ‘why?’ and ‘how?’, which led to the use of qualitative methods that showed to “provide important insights into health issues that complement knowledge derived from quantitative research” (Huston and Rowan, 1998, p.2458).

Qualitative research covers “an array of interpretative techniques which seek to describe, decode, translate and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world” (Al-Busaidi, 2008, p.11). While quantitative researchers are trying to prove or disprove a hypothesis, qualitative researchers allow a hypothesis to emerge. Qualitative researchers are looking to understand how their participants make sense of the world and the meaning attributed to their experiences; there is a quest to explore what is it like to experience a certain phenomenon (Willig, 2013). The aim isn’t to generalize the results to a certain sample like with quantitative research, but to broaden our knowledge of a certain phenomenon by interpreting the data rather than calculating it. Even though the sample for this current research are women who suffered from heart attacks, which is purely a medical concern, developing a quantitative study will defy the purpose of this paper. This research aims to “understand experience rather than to discover what is ‘really’ going on” (Willig, 2013, p.16) or what caused the heart attack.; it is concerned with how these women experience and perceive their world. A quantitative method will only

objectify their experience and the meaning of their experiences will be lost in the data. For this reason, this research will adopt a qualitative method that will allow the participants to explore the lived experience of having a heart attack and draw upon their subjective meaning of this phenomenon.

A few qualitative methods were considered to carry out this research: grounded theory, narrative theory, and phenomenological methods. The next section will discuss each method, the reasons for why they were considered, and why I decided to go with a phenomenological method.

3.3 Methodologies Considered

Qualitative research aims to understand the phenomenon by exploring meaning and experience, using verbal data instead of numbers and statistics. The researcher needs "to be open-ended and flexible enough to facilitate the emergence of new, and unanticipated, categories of meaning and experience" (Willig, 2013, p.23). For this research, Grounded Theory, Narrative Theory, and Phenomenological Methods were considered when picking out the methodology. All of which, if applied, would broaden our knowledge about the experience of suffering from a heart attack. Each method would explore this phenomenon from a certain angle. The following section will discuss each method in relation to the research, finally leading up to the chosen method.

3.3.1 Grounded Theory

Grounded theory was developed by two American sociologists, Barney Glaser and Anslem Strauss, in 1967. At the time, sociology research was dominated by quantitative methods. Both Glaser and Strauss argued that is was time for their research to move from numerical data to theories (Willig, 2013). They described grounded theory as a method that

promotes "the discovery of theory from data" (Willig, 2013, p.77). Glaser and Strauss believed that the strength of grounded theory lies in the process of collecting and analysing data. The researcher is at first a witness, observing and collecting data, allowing themes to emerge rather than imposing ideas. The data is analysed and used to suggest further sampling, which again is analysed. This process is repeated until "a point of 'saturation' is reached [and] no new constructs are emerging" (Green and Thorogood, 2004, p.181), and what is left is a new rich theory. Therefore, this method was developed as a way for researchers to use the data in order for new theories to emerge. Rather than exploring and researching other theories already available, grounded theory allows the researcher the space and opportunity to develop new and more contextualized theories (Smith, 2008). For this reason, grounded theory adopts a more logical and systematic approach to the research with a realistic epistemological orientation; it is "what is, not what should, could, ought to be" (Willig, 2013, p.79). This approach provides an explanatory framework that allows us to understand the phenomenon being researched.

Grounded Theory was considered for this research, since the literature out there falls short of theories that bring physical illness and psychology together. Only recently have researchers tried to fill the gap between scientific and numerical evidence, and the patients personal experience, so there is room for developing new theories. However, the aim of this research gradually moved away from 'what is' and from an attempt to come up with a theory, to an exploration of the phenomena of the experiencing of having a heart attack.

3.3.2 Narrative Theory

Another methodology that came across when exploring the epistemological position of the research was Narrative Theory. According to Narrative Theory, "we are born into a storied world, and we live our lives through the creation and exchange of narratives" (Smith, 2008, p.113). Narrative theory assumes that the human life can only be explored as a whole through

hearing their stories, and that the human's life cannot be reduced to just an event or two (Langdridge and Hagger-Johnson, 2013, p.492). The narrative maps out one's life and brings their life events together to make a story. Only when a story is expressed, can we interpret and try to understand it. The aim of narrative theory is not to look into the lived experience, but to bring "order to disorder" and give it meaning (Smith, 2008, p.114). Narratives are listened to in a way to try to organize the story into meaningful plots, and help make sense of the events. The participants' stories can tell us a great deal about their embodied experiences. More specifically to this research, Willig writes that 'illness narratives' can provide a person experiencing an illness with the chance to find a new purpose and meaning in life (Willig, 2013), and help them work through unresolved feelings.

Frank (2013) assumes that "illness is a loss of the 'destination and map' that has previously guided the ill person's life" (p.1). In his book, *The Wounded Storyteller*, he identifies three kinds of narratives told by a person who is ill: (1) the restitution narrative, (2) the chaos narrative, and (3) the quest narrative (Frank, 2013; Willig, 2013, p.144). Each kind describes a way in which the person is telling their story. The restitution narrative reflects the desire to get well with a storyline that follow this sequence, "yesterday I was healthy, today I'm sick, but tomorrow I'll be healthy again" (Frank, 2013, p.77; Willig, 2013, p.144). The chaos narrative illustrates a life that is never getting better; there are elements of hopelessness, despair, and anxiety that accompany the story. The quest narrative, on the other hand, illustrates illness as part of the person's life journey, allowing them to accept their illness and face it with hope that they will gain something from their experience (Frank, 2013; Willig, 2013). Each narrative serves a purpose to that wounded storyteller.

These types of narratives are written specifically to explore the phenomena of physical illness, which shows how narrative theory can be considered for this research paper. However, the aim of this research is not to bring order to participants' experience. The aim is to

understand their lived experience and see which themes emerge, in order to highlight ways to approach illness in our psychotherapy practice.

3.3.3 Phenomenological Method

Phenomenology is concerned with how human beings experience the world within a specific context, "the phenomena that appear[s] in our consciousness as we engage with the world around us" (Willig, 2013, p.84), and how we make meaning out of that. We make sense of our world and create meaning in the context in which we exist in. Phenomenological research focuses on the participant's perspectives, as they describe in detail their experience of their world. This description brings us closer to the understanding of their lived experience and the essence of the phenomenon at hand.

Edmund Husserl first developed the idea of phenomenology in the early 1900s, recognizing the world as a life-world, a "world of immediate experience" (Husserl, 1970, p.xi), rather than a world with an objective truth. He attempts to move away from the science of fact towards a science of essence, where "man becomes a nonparticipating spectator, surveyor of the world; he becomes a philosopher" (Husserl, 1970, p.285). He develops Franz Brentano's notion of *intentionality*, a key quality of consciousness, which means that our consciousness is always 'of' something; every experience is an experience 'of' something (Husserl, 1970). Consciousness, from a phenomenologist's perspective, is not inside our mind like the psychoanalyst's position it (Freud, 2005). It is "already turned out on the world through our internal relationship with the world" (Langdridge and Hagger-Johnson, 2013, p.436). Our perception of the world is intentional, meaning that consciousness is always directed towards the world and our intentionality is what creates meaning, it is "what dictates the way in which we are in the world. We create meanings out of our connections to the world and apply these meanings to other parts of the world" (van Deurzen, 2011, p.37) The basis of existence assumes

that the "self and the world are inseparable components of meaning" (Moustakas, 1994, p.28). With this philosophy comes the idea that each person will experience the same phenomenon differently. Phenomenology, being the study of the essence of conscious experience (Finlay, 2011, p.44), aims to delve into the essence of existence by turning away from man's opinions and "turning toward 'the things themselves' (zu den Sachen selbst) (Husserl, 1970, p.xxx).

Since phenomenological research is concerned with the diversity and uniqueness of human experience, Husserl introduced the notion of *epoché*, phenomenological reduction, and horizontalization to bring us closer to the 'things themselves'. Epoché means that the researcher much set aside, or bracket, their preconceived ideas and assumptions about the world in order to listen into the participants experience. As we bracket our assumptions, we being to see the 'things themselves', and in order to better understand this phenomenon the researcher must describe what is being presented, and stay away from interpretation. Husserl named this process phenomenological reduction (Husserl, 1970). By describing, after bracketing, we aim to capture the experience without clouding it with our own experiences and biases. Description allows the researcher to see the phenomena from different angles in ways interpretation can halt this exploration. This brings about the rule of *horizontalization*, which means that the researcher "should not rush to produce vertical hierarchies of meaning, assuming that one thing is more important than the other" (Langdridge and Hagger-Johnson, 2013, p.439). All three rules complete one another in attempt to understand the essence. According to Husserl (1999), the task of phenomenology is "to exhibit the essence of knowing within the framework of the phenomenological reduction. Thus it must remain entirely a matter of reflection, direct intuition, analysis, and description" (p.6).

Heidegger took Husserl's work and shifted its focus to one that seeks to examine existence rather than essence. Langdridge (2007) explains how Heidegger challenged Husserl's notion of reduction; that all people are inseparable from the world and therefore it is not

possible to bracket our experience to identify the essence of a phenomenon (p.27). There is an ongoing debate about how much can someone actually achieve epoché; is it humanly possible to transcend and reach that clean slate? Philosophers, such as Heidegger and Merleau-Ponty, believe that while we should attempt to bracket our experience, we can never fully transcend beyond our experience.

Heidegger (2012) coins the term 'Dasein' to refer to the human being; in colloquial German, 'Dasein' means "everyday human existence" (Dreyfus,1991, p.13). Dasein is in a constant state of Being-in-the-world, as we are always 'being-there' and cannot be separate from the world we exist in. Existence is imbedded in being-there. Heidegger writes that "Dasein always understands itself in terms of its existence" and that "the question of existence never gets straightened out except through existing itself" (Heidegger, 2012, p.33). In order to understand, Dasein constantly interprets itself to make sense of itself, as well as everything else (Dreyfus, 1991). With this explanation came the idea of hermeneutics, meaning "an interpretation of Dasein's Being" (Heidegger, 2012, p.62); we are bound to interpret the phenomena being presented, as it is impossible not to.

Merleau-Ponty goes on to add the importance of the *embodied* nature of our relationship to the world as he writes, "I am conscious of the world by means of my body" (Merleau-Ponty, 2014, p.84). For Merleau-Ponty, we are not subjects with bodies, but we are *body-subjects*, where our existence is not reduced to just consciousness. Here "the person is understood as a *body-subject*, with consciousness embedded in the body and intentionality that of the body-subject, rather than simply one's consciousness" (Langdridge, 2007, p.37). For Merleau-Ponty, the body and the world are intertwined, it connects us to the world we live in and allows us to understand it and create meaning; it is our means of communication with the world (Smith et al., 2009). Therefore, no matter how 'well' we can observe or experience empathy for the other, we can never entirely share their experience, "because their experience belongs to their own

embodied position in the world" (Smith et al., 2009, p.19). When it comes to phenomenological research, Merleau-Ponty's view of the body is essential in understanding one's lived experience, since we know the world through our body (Smith et al., 2009).

Regardless of how phenomenologists approach or define the body, they all agree that "the body discloses the world just as the world discloses itself through the body" (Finlay, 2006, p.19). Linda Finlay (2006) critiques the phenomenological method by pointing out the absence of the body in the research process. She identifies three qualities a phenomenological researcher can notice in order to reflexively attend to the body in the research: bodily empathy, embodied self-awareness, and embodied intersubjectivity (Finlay, 2006, p.20). Bodily empathy requires the research to observe the participant's "expressive bodily gestures, as these may reveal something more about their lived experience and intentionality" (Finlay, 2006, p.23). These gestures can be seen as a reflection of the participants feelings. Embodied self-awareness is the importance of reflecting on one's own bodily experience throughout the research process, and how that might help in gaining insight into the participant's embodied experience. Lastly, the idea of embodied intersubjectivity brings both the research and participant's bodily experiences together. It allows the researcher to highlight the 'in between' that happens between them and how their experiences can "intertwine in empathic connection" (Finlay, 2006, p.20). These three ways of attending to the body during research add a different dimension to phenomenological research.

Phenomenological methodology branched out into different methods, each highlighting a different aspect of the philosophies discussed above. The two methods discussed are descriptive and interpretative phenomenology. Descriptive phenomenology is a method developed mainly, or one can argue solely, on Husserl's philosophy. The core of descriptive phenomenology is to return to 'the things themselves', by describing the phenomenon rather than explaining it or trying to find the cause (Langdridge, 2007, p.86). Even though, descriptive

phenomenologists acknowledge that interpretation is enviable, they attempt to minimize it as much as possible in attempts to reach the essence of the phenomena, using epoché and phenomenological reduction (Langdridge, 2007; Willig, 2013). On the contrary, interpretative phenomenology admits to interpretation as part of the research process, in fact they argue "that all description constitutes a form of interpretation" (Willig, 2013, p.56). Even though, epoché and phenomenological reduction are also practiced by the interpretative research, they work with their biases and use them as they try to understand the phenomena (Willig, 2013). There is less emphasis on description, and along with interpretation there is room for engaging with psychological literature (Langdridge, 2007, p.107).

Since the purpose of this research is to explore the embodied experience of women who have suffered from heart attacks, the method chosen will adopt a phenomenological approach to knowledge, more specifically an interpretative phenomenological approach. The following section will discuss epistemology and validate the use of IPA for this research.

3.4 Epistemology

When coming up with this research question it was essential to consider the epistemological position that it takes. Epistemology is the theory of knowledge, how can we know and what is there to know about this topic? (Willig, 2013, p.12). With every research question comes a set of assumptions in which the researcher must first notice and use it to pick a relative methodology. In order to take an epistemological stance, one must answer the questions: (1) what kind of knowledge is being produced?, (2) what kind of assumptions are made about the world that is being studied?, and (3) how is the role of the researcher in the research process? (Willig, 2013, p.67).

Epistemological stances can be seen as a spectrum. On one end of the spectrum, is the realist approach, which assumes that there is only one reality or truth. The spectrum continues

towards a phenomenological approach and a social constructionist approach. The phenomenological approach “aims to understand experience rather than to discover what is ‘really’ going on or what causes social and/or psychological events to take place” (Willig, 2013, p.71). It assumes that the same phenomenon is experienced in different ways from one person to the other, implying that “there is more than one ‘world’ which can be studied” (Willig, 2013, p.72) within the same phenomenon. The social constructionist approach listens into the way people construct and talk about their experiences. This approach assumes that “it is language (‘discourse’) that constructs reality rather than reality that determines how we describe or talk about it” (Willig, 2013, p.76).

This research adopts a phenomenological epistemological stance, seeing that the main aim is to explore the lived experience of women who suffered from heart attacks. Even though the participants’ language and how they construct their narrative is important to their lived experience, the focus point is the quality of their experience rather than how it unravels through language. More specifically, this research is carried out using IPA.

The next section will explain IPA, its position in research on physical illness, challenges of using this method, and finally my epistemological stance.

3.5 Interpretive Phenomenological Analysis

IPA is a phenomenological method that aims to explore the participants’ lived experience and tries to adopt an insider’s perspective on how they make sense of their world. The term ‘experience’ is a complex idea that can be explored, understood, looked at, and heard in various ways, but only lived and given meaning by the participant. Experience is subjective and unique to each individual, it is not a criterion or a fact, since “what we experience is a phenomenal rather than a direct reality” (Eatough and Smith, 2017, p.196). As a branch of phenomenological methods, IPA attempts to look closer at the essences of that unique

experience, with an emphasis on meaning-making. IPA assumes that humans are "sense-making creatures, and therefore the accounts which participants provide will reflect their attempts to make sense of their experience" (Smith et al., 2009, p.3). Meaning-making is a key aspect when using IPA, and for this reason this method was chosen to explore the meanings behind each women's individual embodied experience of suffering from heart attacks.

IPA brings together phenomenological philosophy and hermeneutic theory and creates a balance between Husserl's and Heidegger's views. It is built on three key ideas that come together to create this method: phenomenology, ideography, and hermeneutics. As mentioned in the section above, phenomenology is concerned with lived experience. An attempt to explore one's subjective experience and how they ascribe meaning to these experiences in the focal point of IPA making it a *phenomenological* method.

"The human realm essentially entails embodied, conscious relatedness to a personal world of experience" (Smith, 2008, p.12). The phenomenological approach disregards the generalized assumptions that people tend to live by. As mentioned above, phenomenologists assume that each person experiences the same phenomena differently. Each experience is unique, and each heart attack, though diagnosed using one criterion, is experienced and lived differently. IPA values a detail account in order to understand a 'particular' phenomenon and reach a certain depth in the analysis, accordingly the participant's perspective becomes the focus of the research. For this reason, IPA adopts an *idiographic* approach to the research, which is concerned with what is particular. It ensures that each individual is to be studied as a unique case and not seen as an outcome of the general scientific laws that apply to everyone (Smith, 2008; Smith et al., 2009). Each participant is looked at separately, as a single case, before bringing them together to highlight the similar themes. Through this process it is assumed that "the very detail of the individual also brings us closer to significant aspects of a shared humanity" (Smith, 2004, p.43).

IPA recognizes that the research is a dynamic process, as the researcher attempts to interpret the lived experience of the participants, their own view of the world and their interaction with the participants will inevitably be part of the experience. As a result, "the analysis produced by the researcher is always an interpretation of the participant's experience" (Willig, 2013, p.87), making it a *hermeneutic* approach. In order to make sense of the data collected and understand the phenomena at hand, the content is interpreted. An added step is taken, as the participants interpret their experience, the researcher interprets their interpretations, making it a 'double hermeneutic' (Langdridge, 2007, p.159). Through interpretation the researcher's own assumptions and conceptions will be present in making sense of the participants' personal world view (Smith, 1996; Smith et al., 2009), and one cannot help but look at anything presented in the light of their own personal experiences. Thus, IPA combines phenomenology and hermeneutic philosophy in order to get a closer look at the lived experience of the participant. "Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenology would not be seen" (Smith et al., 2009, p.37).

3.5.1 IPA and Physical Illness

Illness can be seen as a complex phenomenon, one that breaks down and shatters the ill-person's meanings in life. Studies on physical illness have been investigated from a scientific stance, aiming to get evidence-based results that can help with newer treatments, diagnosis, clinical governance and so on. This kind research was never intended to explore the patient's lived experience (Biggerstaff and Thompson, 2008, p.214). The development of IPA started to fill the gap between these scientific outcomes and the patient's lived experience as it aims to "explore, describe, interpret, and situate the participants' sense making of their experiences" (Tuffour, 2017, p.3). There is a recent acquired interest from practitioners to try

to understand the experience of physical illness rather than test the predetermined constructs and quantify the results. Today, the focus on how patients perceive and are psychologically affected by their illness is given importance in research. IPA originated in the 1990's to fill a gap in the field of health psychology. Smith (1996) noticed psychologists' shift from focusing on the external and observable behaviours to having a deeper concern with the 'inner' mental process of their clients. While there are many "valid explanations for the distribution and transmission of illness, the individual body still provides an exemplary unit for determining the existence of, and possible boundaries for, the illness" (Smith, 1996, p.264). In order to get a closer look at the participants' own personal experience, researchers resort to using IPA. IPA was first established in the field of health psychology, and due to its success in bringing a new aspect to the understanding of illness, the main subject area in most IPA studies have to do with exploring the lived experience of illness (Smith, 2011). To explore illness from a phenomenological stance gives the researcher an idiographic understanding of the participant's experience as a bio-psycho-social phenomenon, focusing on "what it means to them, within their social reality, to live with a particular condition" (Biggerstaff and Thompson, 2008, p.215).

Smith (2011) reviewed and evaluated 51 IPA studies on physical illness. In his review he evaluated the use of IPA and how it has, and can further contribute to upcoming research in health psychology. Smith acknowledges the novelty of IPA and the use of qualitative research in general. However, while reviewing the selected papers, he expects a certain quality of work and sophistication in order to set a bar for future IPA research papers. He identifies a list of qualities that a 'good' IPA paper should entail. The paper should have a *clear focus* providing a detailed search and analysis of the phenomena being studied. The researcher must provide *strong data* that can be acquired through good interviewing, since the quality of the interview sets the tone for the rest of the paper. The paper should be *rigorous*, allowing the reader access

to the depth of the themes by proving extracts from the participants to support the analysis. Each theme must be given its weight through *elaboration* rather than written as a list of findings. Analysis of the interviews should be *interpretive not just descriptive,* as the researcher engages with and interprets the data, making it a double hermeneutic. *Convergence and divergence* is key in the analysis process, as there should be a "skillful demonstration of both patterns of similarity among participants as well as the uniqueness of the individual experience" (Smith, 2011, p.24). Lastly, the paper should be *carefully written,* in order to engage the reader and add merit to the field. Smith concludes that there is an evident gap in the research topics as well as an underdeveloped use of the methodology in regards to the experience of illnesses (Smith, 2011). Like the gap in health psychology suggested, the field of counselling psychology can greatly benefit from more 'good' IPA research exploring physical illness.

3.5.2 Challenges of IPA

IPA is a relatively new method that is still developing in the field of psychology. Not only is it introducing a new research method, but it is also enlightening psychologists with a new philosophy and way of looking at the human being. Unless you come from a philosophical background, IPA's theoretical implications are considered a foreign concept.

Considering IPA's novelty, there are a number of challenges and limitations one needs to look at when choosing to use this method. In order to explore a chosen phenomenon, the researcher analyses the participant's lived experience through interviews, meaning that the phenomenological analysis relies on language. However, can language capture experience? It has been argued that language constructs reality rather than describes it as it puts together a particular version of an experience. Words add meaning, making it impossible to reach the rawness of an experience (Willig, 2013). As a result, the richness of one's experience can be

lost in language. In light of the above, IPA considers experience to be always intertwined with language, and it accepts that "meaning making takes place in the context of narratives, discourse, metaphors etc" (Tuffour, 2017, p.4).

IPA is concerned with cognition as it assumes a "connection between people's talk and their thinking and emotional state" (Smith, 2008, p.54). It has been questioned whether cognition has a place in phenomenological work (Langdridge, 2007; Willig, 2013). Cognition insinuates a subject/object view of a person which is rejected by phenomenological philosophers, as it suggests a mind/body dualism. Cognition focuses on one's mental process or thoughts, automatically creating a split between mind and body. However, in Smith's writings it can be argued that the weight of social cognition, or what he meant by it, is diverted to a more experiential account of the phenomenon rather than the categorical view of 'thoughts and feelings', or cognition, of the participant (Smith, 1996, Smith et al., 2009). It can be seen as an attempt to bring both words in one sentence. Before the development of IPA, the terms health psychology, phenomenology, and cognition would have never been seen together.

With these two limitations in mind, Tuffour (2017) debates whether IPA can, in fact, "capture the experiences and the meanings of experiences rather than opinions of it" (p.4). This depend on the researcher and participant having the communication skills and whether their synergy can paint the richness of the experience. Smith (2011) stressed the importance of the interview taking process and highlights that a good interview yields good data, in this case an understanding of the meaning of experience. That being said, one can easily fall in the trap of gathering opinions rather than meanings.

IPA is considered a subjective research approach, and acknowledges that each researcher will bring out different results even if they are studying the same exact phenomenon (Tuffour, 2017). Therefore, the transparency of the research process, successes and limitations, is key to overcoming the limitations mentioned.

3.5.3 Epistemology of IPA

After exploring the epistemological position of this paper, Interpretative Phenomenological Analysis (IPA) was chosen to be used to collect and analyse the data for this research. IPA's interest in one's subjective world experience and how each participant experiences the same phenomena differently highlights an important aspect of this research. In order to understand women's embodied experience of heart attacks, this research will adopt a phenomenological approach to knowledge. This paradigm can take on a descriptive or an interpretive approach, one focusing on the description of the experience and other attempting to understand the meaning of one's experience through interpretation (Willig, 2013). However, they are not mutually exclusive.

For the purpose of the research a more interpretive stance was adopted. While listening into the participants description of their experience, this methodology aims to position "the initial 'description' in relation to a wider social, cultural, and perhaps even theoretical, context" (Willig, 2013, p.73). The following section will explain the data collection process of this research.

3.6 Data Collection

In order to start collecting data, I identified the sample and prepared a semi-structured interview. A sample is "selected on the basis that they can grant us access to a particular perspective on the phenomena under study" (Smith et al., 2009, p.49), namely the embodied experience of a heart attack. The selected sample is then interviewed, using a semi-structured interview, in order to 'collect' the data needed to follow through to the analysis. The following sections will explain the sample selection and interviewing process.

3.6.1 Sample

The sample for this research consists of seven women who experienced at least one heart attack during the past five years. Purposive sampling was used to recruit participants, as IPA looks for a more homogeneous group to interview for whom the research question will be of significance to (Smith, 2008). Participants were to be 21 years old or older in order to take part in this research, and those who participated were between 44 and 66.

Name	Age	No. of Heart Attacks	Language
Jasmine	66	2	English (Arabic used)
Farah	66	1	English (Arabic used)
Nicky	44	1	English
Mary	Above 50	2	Arabic (English used)
Diana	66	1	English
Sarah	55	1	Arabic
Jane	55	1	English (Arabic used)

The participants were diagnosed and treated by a Cardiologist for a Myocardial Infarction. The aim is to keep a homogeneous group to get a clearer picture of the embodied experience of the heart attack as the primary illness without it being a part of other diseases. For this reason, any participant with possible existing conditions that have a high risk of leading to a heart attack were excluded. Participants who suffer from the following diseases were excluded from the recruiting criteria:

- Congenital diseases
- Debilitating disease: Rheumatoid Arthritis, Poliomyelitis, Muscular Dystrophy Cerebral Palsy, Chronic Obstructive Pulmonary Disease, Cystic Fibrosis,

Scleroderma, Multiple Sclerosis, Parkinson's Disease, Amyotrophic Lateral Sclerosis, Alzheimer and Dementia

- Other cardiovascular diseases: Strokes, Deep Vein Thrombosis, and Heart failure.

At the beginning of the research journey, one of the criteria was English speaking participants, since the interviews were to be conducted in English. During the first two English interviews, Arabic was used on occasion as a substitute for words such as 'I mean', 'and', 'that's it', 'so', and so on, or an Arabic saying was used to express an experience. Being focused on Egyptian women, it was inevitable that Arabic would be used, no matter how fluent the participant is in English. In addition to this reason, it proved difficult to recruit English speakers, ones who were fluent enough to carry out an entire interview in English. Therefore, to expand the participant pool, Arabic was added to the criteria.

Flyers about the research were distributed to several cardiology clinics and foundations, therapy, and wellness centres in Egypt. They were asked to forward the flyer to their client database, and display a copy in their clinics. After distributing my flyers and talking openly about starting my research, I found that snowball sample naturally occurred. Women contacted me through others who have heard about my research. Snowball sampling is when the researcher makes contact with a small number of potential participants who will then use their contacts to help recruit more participants (Langdridge and Hagger-Johnson, 2013, p.57). However, in this case, the people I initially spoke to were not potential participants, but colleagues and acquaintances who I shared my research topic with, who then spoke to others who fit the sample criteria. Evidently, most of the women interviewed came to participate through word-of-mouth.

3.6.2 Interviews

There are three kinds of interviews that can be administered for research purposes: structured, semi-structured, and unstructured. Structured interviews are guided questionnaires mainly used in quantitative research projects, as they bring out more straight forward data that can be transformed into numerical analysis. With these fixed questions there is no room for exploration or eliciting meanings (Langdridge, 2007, p.65), which is why qualitative researchers use semi-structured or unstructured interviews. Qualitative research interviews can be explained as “a conversation with a purpose”, one that facilitates an interaction between the researcher and participant (Smith et al., 2009, p.57). The aim of the interview is to allow the participants to tell their stories in their own words. A semi-structured interview “represents a trade-off between consistency and flexibility” (Langdridge, 2007, p.65), where the researcher prepares a list of questions and prompts that they follow to help guide them through the interview. These questions are open-ended and flexible enough to allow the participants to elaborate and give a detail account of their experience. An unstructured interview is one with a single core question which is asked at the beginning of the interview, and the rest is a conversation that is led by what the participant unfolds (Smith et al., 2009).

Both semi-structured and unstructured interviews provide a space for the participant to share their unique story and allow the researcher to collect ‘rich data’ (Smith et al., 2009). While unstructured interviews provide more freedom for the conversation to move in any direction, it can also be challenging to manage, as the story can stray away from the intended phenomenon being explored. Even though it can be debated that everything mentioned by the participant is relevant, as it is their story, the interview can stray away from the research topic. On the other hand, a semi-structured interview, while being flexible, can miss out on important parts of a participants’ story as the researcher goes back to the questions prepared (Langdridge, 2007). However, the structure provided by semi-structures interviews is intended to be open

enough to allow unforeseen experiences and meanings to emerge. As mentioned above, in order carry out a 'good' semi-structured interview, Smith (2001) stresses on the importance of the researcher's interview-taking skills.

For this research, a semi-structured interviews (Appendix I) was conducted on seven participants who fit the criteria above. The questions asked were specific to their experience of the heart attack, yet open enough to allow each participant to voice their uniqueness. IPA requires flexibility during the interviewing process to give room to the participants to explore their own personal world in relation to the phenomena being explored, and not limit their answers to the questions being asked; in attempts to get a better understanding of their meaning-making (Smith, 2008).

The interviews took place at a medical polyclinic, in a rented room for the duration of the session. Each interview took up to 60 minutes, with the exception of the pilot study. The first interview went up to 90 minutes, as I found it challenging to guide the participant back to the interview questions. The interviews were recorded using a digital recorder so that the material can be accessed when transcribing. Following each interview, I wrote my experience of that interview. All data, whether recordings or written documents, are stored in a secured locked drawer at my home office. Documents on my laptop are secured with a password, and I used initials to file my documents instead of full names, to ensure their anonymity.

3.7 Data Analysis

The aim of IPA is to explore how participants make sense of their world; it involves a "detailed examination of the participant's lived experience" (Smith, 2008, pg.53). During data analysis it is important to "try to understand the content and complexity of those meanings rather than measure their frequency" (Smith, 2008, p.66). Each participant's interview is to be transcribed separately before moving onto the next interview, which are also transcribed

separately before bringing them all together. The researcher starts off by immersing themselves into the interview by listening to the recording, typing it up, then reading and rereading the transcript a few times. This process attempts to allow the researcher to engage with the participant and give space for their uniqueness to be analysed. Rereading also familiarizes the researcher with the participant's experience allowing them to listen in more and "gain an understanding of how narratives can bind certain sections of an interview together" (Smith et al., 2009, p.82).

The next stage requires the researcher to identify their initial comments on each sentence of the transcript, using the left margin to document these thoughts, and bringing them together into themes using the right margin (Smith, 2008; Smith et al., 2009). To engage with each sentence requires focus, familiarity, rapport, and interpretation. "It is important to engage in analytic dialogue with each line of transcript, asking questions of what the word, phrase, sentence means to you, and attempting to check what it means for the participant" (Smith et al., 2009, p.84). There are no rules or requirements on what is to be commented on, as the aim is to try to bring out any meaning elicited. This process brings the double hermeneutic into play, as participants make sense of their experience, I too attempt to understand and make sense of how the participants are trying to make sense of their world (Smith, 2008, p.53). I found that both the first and second stage were not separate, as I started to write my initial comments from the first reading, and add more notes as I reread.

Smith et al (2009) highlight three different types of comments: descriptive, linguistic, and conceptual comments. Descriptive comments are ones that describe the content, linguistic focuses on the language used, highlighting repetitive terms or phrases, and conceptual comments focus on the concepts signified in the transcript, which requires interpretation (Smith et al., 2009, p.84). Grouping comments in this way has helped me focus in on sentences I would have seen superficially, and with that focus came more interpretation and analysis allowing me

to capture a more detailed account of the participant's experience. Below is an extract from an interview showing the second step of the process.

Describes the ICU as a time out from the world	P: I was so happy being in the ICU, because I needed time out alone I: can you tell me more about that	ICU Space and Time
Pressure God saved her by giving her the heart attack – it's a wakeup call Laughter – jokes – light-hearted She went to the hospital laughing and singing with the second heart attack ***I noticed the importance of laughter in her stories even when the story/even isn't funny… Does she need to make others laugh?*	P: I was so pressured that I felt the heart attack was the saver from God, God saved me with the heart attack, it was a wake-up call, and I loved it, and when I had the second one I was going to the hospital laughing, and I made everybody in the hospital laugh and they can't believe that I was singing and telling them in Arabic, I will translate later, [snaps her fingers as she laughs and sings in Arabic] and the doctor himself, he is a very serious doctor, he was laughing like, he told me stop it because I have to focus, stop [laughs], I was soo happy	Pressure Responsibility Meaning of heart attack – Perception Laughter
When she is in the ICU she doesn't need to take care of anyone or anything – nobody can bother her or hurt her Brother wants to see her perfect *Expectations*	coz I'm alone, I don't have to take care of my kids, or my mom because I'm her mother you know, or of work, or my shitty drunk husband, or my brother who always wants to see me perfect, or, I'm in the ICU and nobody can bother me, so it was a gift from God I: wow, okay P: plus it was a wake-up call, take care of yourself	Taking care of others Responsibilities Others Meaning of heart attack – Perception Self-care

The third stage of analysis is to develop emerging themes. Initial thoughts bring out themes, "a concise and pithy statement of what was important in the various comments attached

to a piece of transcript" (Smith et al., 2009, p.91). During this step, the narrative is broken down and seen as fragments of the participant's experience in order to come up with the themes, which is why the several readings of the transcript at first is essential (Smith et al., 2009). Like the first two steps, each transcript is done separately so that the themes are specific to each individual interview, without referring to previous ones.

After identifying the themes that have emerged, I then grouped them together, again each interview is done separately at this stage. It is important here to include all themes even if they do not seem to be relevant to the research question. Smith et al. (2009) suggested writing the theme chronologically at first before grouping them together into themes and subthemes (p.95). Each interview is then written up separately as if it were the pilot study, before moving on to the next interview and eventually bringing them all together.

During this process, inevitable to keep referring back to previous interviews and trying to find the similarities early on. For this reason, I considered my biases at each stage during the research process, by discussing them with my research supervisors and keeping a journal throughout the course of the research. There is an ongoing challenge to stay focused with the current transcript being analysed. All the steps mentioned above help keep focus, however it is essential to keep this point in mind throughout and notice when I find myself going back to other interviews.

The next section will clarity the ethical considerations of this research, which encompasses everything to do with the participants wellbeing starting from recruitment, throughout the analysis, and even after submission.

3.8 Ethical Considerations

I will follow The British Psychological Society (BPS) Code of Human Research Ethics (2014) and BPS Code of Ethics and Conduct (The British Psychological Society, 2018) while

conducting my research project. The recruitment form will include a description of the research and the aims of the project, confidentiality procedures, method of data collection, the expected time of interview and involvement, and the right to refuse information or withdraw from the study at any point. As mentioned above, the participants will be aware that all the data I gathered will be locked in a secured drawer, and files on my laptop will be password protected. All this information will be kept and secured by NSPC for 10 years according to the GDPR and NSPC's data retention policy. Participants will be told that I will share the information I gathered with my Research Supervisors using their initials, as part of my requirements.

One of the principals of the BPS Code of Human Research Ethics (The British Psychological Society, 2014), is to maximize the benefit of my work, and minimize harm to participants and guarantee their autonomy. Understanding that the interviews can bring up emotional issues, it is crucial to respect the participants during the research, and provide them with a debriefing letter afterwards, and the choice to withdraw from the project at any time before submission. During the timespan of the research it is crucial to protect the participants from any risk. The questions asked in the interview might bring up undesirable emotions that may lead them to relive the heart attack. I needed to make sure that they have space to process everything that came up, especially if it entailed risk. I did so by providing them with a list of psychotherapists they can contact.

3.9 Limitations & Challenges

As this research aims to look at the story behind a physical illness, I assumed at first that participant might find it challenging to reflect and find meaning in their experience of the heart attack, as they are more familiar with listing their symptoms to their medical doctors. In fact, a few participants would always go back to the heart attack, which was all useful information. However, it was challenging to move away from the heart attack and explore other

aspects of their life without always going back to 'what the doctor said'. At times I felt that they could be assuring me that they are listing to the doctors 'orders'. Accordingly, the assumption of the split between mind and body cannot be ignored.

Another challenge I faced was my age and gender. In Egypt, there is an expectation to what a practitioner should be like; older and more experienced, and in some cases a man is better than a woman (a stereotype I believe is fading, but still has some power). With the exception of one participant, I was the same age or younger than the participant's children. The women expressed how proud they are of me and how interesting my research was, similar to the way my parents and their friends spoke to me. In retrospect I wonder how that might have effected their narrative, did they refrain from sharing something because I was their children's age?

Another challenge I faced during the analysis was the language. Even if the participants were English speakers, Arabic was used on occasion to describe an experience more accurately. After the interview, Arabic statements were sent to a certified translator for translation. Even with the translator at hand, I questioned if the exact meanings of these words were depicted, as I am looking for the experience of that word and not only the translation.

In the next section, I include my reflexivity process throughout the data collection process. I pointed out my assumptions before I started the research, and others that came up along the way.

3.10 Reflexivity

Reflexivity "involves reflecting upon the ways in which our values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research" (Willig, 2013, p.10). From the start of this research process I noticed some of my biases. As I voice them, I am aware that there were a few more blind spots that I might, or

might not, have notice along the way. The first assumption I recognize is the belief that the body has a story, and that every symptom has a meaning. However, I needed to accept that there may be symptoms without any meanings. As a Homeopath, I go through every part of the body with the client and see how the symptoms that appear might be linked to their psychological state. There is room for many assumptions here; I tend to link problems with the heart to emotions such as love, hate, anxiety, and grief. Nonetheless, I must not limit it only to that or, more specially, to emotions. If I were to look for these emotions, rather than listen to the themes that will come up from their lived experience, it might influence my interview and transcribing process. I believe that through my readings I am steering away from that, but it is important to notice if I go back to that frame of thought. I had a specific image of how a person who has heart problems would be like: an older man who has a high-ranked pressuring job. For this reason, among others, I chose to interview women. At first, I decided that I will not limit my sample to age or gender, which came to be a choice I made based on fear that I would not be able to find eight women to participate. However, I noticed this fear, asked a few Cardiologists in Egypt if I would be able to find seven women, and decided to change my original decision.

Noting the personal reasons for choosing the heart, it was important to keep that in mind while interviewing participants. However, at first I could not imagine how my feelings can affect the interview process or how I would be affected by the interview.

It was important for me to write my experience in my family, specifically with cardiac illness, and process them before I had started. While reading the literature on illnesses, I would see my father in many articles and books. My father is careless when it comes to his health, although it is one he should attend to with the lifestyle he is leading. He lacks a healthy diet to support his rhythm, and allows himself only few hours of sleep at night. Along with that he suffers from diabetes and high cholesterol that only worsen by time. As the hard-working man

he is, borderline workaholic, he immediately starts working upon waking and goes on frequent business trips, which is exhausting. He also carries all of the nuclear and extended family's responsibilities. At a young age, after his father's death, he took over responsibility, and is driven by that role until today.

This fear exacerbated after he fell ill on a business trip, experiencing severe chest pains and a drastic increase in sugar levels. Yet he failed to consider any changes to his lifestyle following this incident. Shortly after, I witnessed him getting extremely angry as he turned red, started shaking, and ended up having severe chest pains. My father is my backbone. It is he who has been pushing me through life since I was a girl. Through any struggle, emotional or financial, he is there to 'take all my worries away'.

In the middle of my research, my mother was hospitalized for a cardiac complication. During the hospital stay, I seemed calm and collected. However, I felt frustration towards anyone who caused my mother to tense up, whether a family member, a friend, a nurse, or a doctor. I noticed how I wanted to understand all the details of her case, and know all the medication she was taking and why. I kept asking questions, more than once, to understand what is going on with her, and secretly I felt that the hospital was overprescribing and conducting more check-ups then needed just because they can. I was not worried about her, she was going to be okay; I believed that this was an accumulation of the past few stressful months she had. It was the power aspect in doctors that got to me, I needed to understand and not be kept in the dark. The main biases I need to keep track of throughout are the conclusions I make about the reasons to why that person might have had a heart attack – like the one I made about my mother's case.

This, however, is not how I feel towards my father. I feel more frustration towards him. He can see his health deteriorating and chooses not to do anything about it. Over the years, my reaction has become very numb towards him. When I hear him complain about his health or

even about how tired he is, I usually point out that he knows what he needs to do to feel better. This frustration might come up in interviews if I see a resemblance between the participant and my father in their carelessness towards their health.

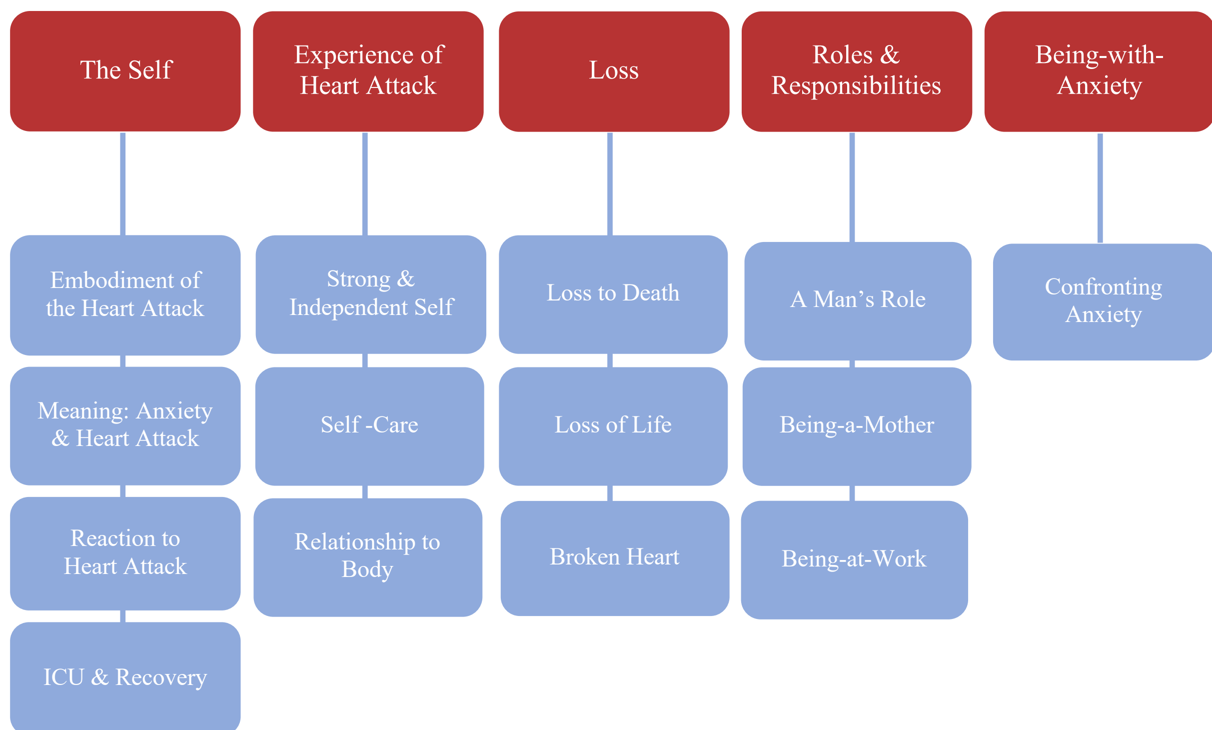
During the first interview, and the process of transcribing, many thoughts and questions came up. At first I felt intimidated, I realized I was hesitant as I explained the research and the forms. She signed the consent form without reading it and at first I let her do that, but quickly realized it is important for her to understand it so I took some time to verbally explain it. I eased into the interview quickly, however looking back, I realized I did not ask all the questions I had planned. The second interview was a bit nerve wrecking. It had been a while since the first interview and I felt out of touch with the interview process. During the interview, she said so much yet so little, which can be said about a few more of the interviews.

After the first two, starting the interviews became more natural. However, the feeling of intimidation was a constant, especially with the women who had a high-ranked job title. I left the interview always feeling that I was missing something, even if I asked all the questions I had prepared. I paused at times during the interview when I felt that what I asked was too painful, firstly to give them the space to share or not, but also at times I was stuck. What should I say next? How do I move onto the next question? When it came to things like losing a loved one or a past trauma, how far should I go knowing that this is not a therapy session? My researcher role verses the therapist was always at play. It was also always a struggle to not instantly compare the current interview with previous ones. Not only during the interview, but also while transcribing and analysing.

I process best through writing freely, which is where the journal comes in. I keep a reflective journal to monitor my biases throughout the research process, as well as a research supervision notebook showing the development of the research from when I started.

4. Data Analysis

This chapter presents the findings and analysis of the seven women who were interviewed for the purpose of this study. The interviews were recorded and then typed up for transcribing purposes. The transcribing process entailed hearing and reading the interviews a few times, each one separately. While doing so, comments and repetitive matters were noted in the margins for the purpose of coming up with relevant themes, which are introduced in this chapter. The five main themes that came up included: Experience of the Heart Attack, The Self, Loss, Roles & Responsibilities, and Being-with-Anxiety. Each major theme has three or four subthemes that explain each phenomenon more specifically. Below is a diagram showing all the themes and subthemes depicted.



4.1 Experience of the Heart Attack

Each interview started off with the question, 'tell me about your heart attack', opening a space for the women to share their experience of going through one or more heart attack. They each express their embodiment of the heart attack, giving a detailed account of their bodily experience, with the exception of one participant. With their experience came their perception of the heart attack and how they made sense of what they have been through. Six out of the seven women explicitly attribute their heart attacks to stress and pressure, and each lady goes on to describe the source of that stress. After the heart attack, each woman reacted in her own unique way; from an eagerness to take care of their health to a complete detachment from their experience. Four of these women describe their experience of being admitted to the Intensive Care Unit (ICU). Their experiences range from one of hope and relaxation, to being scared and needing to leave immediately. Within this theme are four subthemes discussed below: *Embodiment of the Heart Attack, Meaning: Anxiety & Heart Attack, Reaction after Heart Attack, and ICU & Recovery*.

4.1.1 Embodiment of the Heart Attack

Throughout the interviews each woman gives a descriptive image of her bodily experience during the heart attack. Five of the women give a detailed description of their embodied experience during their heart attacks, with an intense and unique description of their pain that was embodied in different ways. The remaining two mention their experience without going into much detail.

Jasmine describes how her pain was located in specific areas of her body, her chest, shoulder and neck. She gives a visual description as she says, *"It was such a pain in my chest and in my shoulder, and the worst thing is like you feel a rope is around your neck, somebody as if he is pulling out the rope from your neck and [that's it] your gonna die, it's like something*

getting tighter and tighter around your neck you can't even breathe". The feeling of a rope around her neck is a powerful metaphor illustrating the intensity of her experience.

Nicky also provides a powerful description of her experience, describing her heart and chest feeling constricted. Similarly to Jasmine, the pain was located in her neck and arm. This is shown when she says: *"I was standing and all of a sudden uhh I felt my heart, my chest constrict very very much and then pain shoot up my neck and then pain shoot down my arm and I couldn't breathe it took [she pauses] about 10 minutes to calm down I didn't know I was having a heart attack"*. She repeatedly uses the word 'constricted' as she says again, "*it's not pain it's constriction",* further emphasising the strength and immensity of her experience. She went on to describe how weak her body was, "*my body was very weak… I wasn't able to get up and do all of the things that I regularly do without getting a little dizzy or out of breath"*.

Sarah also spoke about her embodied experience of the heart attack and the pain she had to endure. She explains how the simplest task would aggravate her pain and cause a 'crack' in her chest that led to all the pain. This is shown when she says, "[*I would be doing my bed for example, meaning I did a bit of an effort… I felt as if there was a crack in my chest from my throat, from my throat to my stomach… I felt that something has hit me like that… a fracture … horrible pain from my throat to my stomach]"*. Her pain was located in her chest, throat, and stomach, and she uses the word 'suffocating' to elaborate the intensity of her experience, as she says, *"[I would feel terrible pain… as if I were suffocating… and and and pain from my throat to my stomach and I would be tired, very very tired… pain pain in my chest which was very severe]"*.

Jane's pain was embodied in her arm, and it was aggravated every time she would walk or move. This is shown when she says, "*I started feeling pain in my arm [so] I thought it was my neck"* and then again when she says, "*the problem is in when I walk I feel very painful strike in my arm… when I walk, every time I walk I feel that"*.

Mary's main struggle was the need to breath and survive. She was drowning underwater and needed to come out for air, to breathe:

> *"I wanted to breathe... [you know when you feel that I want, that I want to live [took a deep breath] I want] oxygen... [it's like I don't want surgery, nor do I feel pain on my heart, nor do I think about the] pain, I want to, [you know it's like you are underwater [she takes a deep breath] I want air] ... I need to breathe!"*

Mary uses the word 'crippled' to describe her pain levels as she says, *"[it used to make me feel like I am] crippled, [you know]"*.

All these women, with the exception of Mary, experienced pain in their neck as well as their arm and shoulder. Shown by the language they use to describe their experience, Jasmine, Mary, and Sarah share a struggle to survive. Jasmine's description of the rope around her neck, mentioned in the quote above, led her to feel that she was going to die; Mary explicitly says, "[*I want to live]"* as she describes her struggle to breath; and Sarah uses the word *'[suffocating]*' to describe her pain levels. Though experienced differently, each of these three women were faced with their mortality during their heart attack. All these descriptions highlight the participant's embodied experience during the heart attack. For them to describe it so graphically shows the intensity of this phenomenon in their lives. It was clearly an embodied experience rather than a checklist of medically known symptoms.

Diana's description is short and to the point. She felt pain in her back and immediately believed that she was having a heart attack, "*suddenly I became very uhh [I mean] I was I had my back hurting my left back was hurting and uh I was all water… and I just got dressed and I went to my husband and I told him 'I'm having a heart attack'"*. When asked to describe the heart attack more she personified it as a kind man that gave her a second chance at life. This is shown when she says, "*it's a man... it's a hard man... but with me he was a very kind man... he just shook me up but he stood beside me and uhhh I was there, the next morning I was there"*.

The way she initially describes her experience is similar to how she communicated the news to her family at the time, as she says, *"'I only have few minutes to talk… I don't think I will be able to talk later... I'm having a heart attack'… and I don't know why I said so, but this is how I said it"*. She was certain that she was having a heart attack without any prior signs. The fact that Diana explicitly says it was a heart attack, is only unique to her and Jasmine. The rest of the women thought it was something else, which resulted in delaying their treatment.

Unlike the rest, Farah describes how she felt no symptoms or signs prior to her heart attack as she says, *"never never nothing... [except for that day like I told you] I woke up in the middle of the night [she takes a deep breath] I couldn't breathe"*. She had a silent heart attack, with only one bodily symptom, the difficulty to breath. She did not give any importance to her experience as she says, "*I went to see a doctor and uhh my daughter came with me I was sitting there discussing where are we going for dinner very casually*" and shortly after that she says, "*he sent me to the intensive care… I couldn't even go out… on the spot… I I wasn't even allowed to go home to get some clothes*". This shows the discrepancy between her embodied experience and what was actually medically going on.

As they embodied their heart attacks, they place meaning on their experience. Each experience encompasses meaning, or an understanding of their heart attack. The next subtheme will point out the women's meanings of their experience.

4.1.2 Meaning: Anxiety & Heart Attack

This subtheme illustrates how these women view their experience of having a heart attack. The meaning of their experience is shown through their perception of it. Six women associate their heart attacks with external factors and stressors. Although not all women use the word 'stress', each one describes a stressful aspect of her life. Three women blame their

heart attacks on the emotional turmoil caused by their family. Three of them explicitly say that work and responsibilities added to their stress.

Jasmine believes that her heart attacks were due to pressure experienced from external factors, as she clearly states that "*the heart attack was due to pressure… not due to any health issues*". She goes one to explain how the pressure she has been experiencing was from her life with her husbands, "*first marriage was a mess having 2 kids, so I got high blood pressure*" and then again when she says, "*he was very nice at that time with me coz I just had the second heart attack because of him*". There seems to be an aspect of blaming others for her heart attacks, whether it was stress from her husbands or her job. She believes that the stress and pressure she experienced from her marriages and work caused the heart attack; it was not a biological issue that caused it. Jasmine says, *"people get sick because they are down, people get sick because they are depressed they are stressed",* showing that she believes illness is only 'psychological'.

Sarah blames her heart attack on her psychological state after her husband cheated on her, which is shown when she says: *"[I really was in a very bad emotional state, I mean… I really went through an extremely severe emotional crisis, so… right afterwards, I felt pain in my heart and and I suffered from an attack]",* and also when she says, *"[of course this affected me deeply and at that moment I felt that my whole world has collapsed on my head]"*. Sarah's world fell apart because of her husband's indiscretion, which will be further discussed in the subtheme *4.3.3 Broken Heart*.

Mary views her heart attack as an accumulation of emotional pain, she believes that she was supposed to experience the attack earlier in life, yet it happened after she had dealt with all her emotional pain. This is shown when she says, *"[the heart attack happened later than expected... I think it should've happened from the beginning... it happened when I found peace] [she laughs]*", and then again when she says, *"[an accumulation… the] heart attack [was an*

accumulation, I mean, that's it, I've had enough!... too many hits… I mean, a very tough life]". She repeatedly uses the word '*broken'* and its synonyms in her dialogue to illustrate the intensity of her pain. Interestingly, she describes her physical heart attacks as a result of her emotional heart being broken. This is illustrated when she says, *"[all the] pain [and the emotional suffering I went through... because really the heart was whole and then it keeps breaking, breaking, breaking]"*, and then again when she says that her heart is now *"[broken, shattered], cracks cracks cracks everywhere [I mean, and these] cracks… [if you translate it, you will translate it too] pain and sadness and [tears, I mean] tears"*.

Diana associates the stress in her life and responsibilities with having a heart attack. Similarly to Mary, she uses the word '*accumulation*' to describe the level of pressure and stress. This is shown when she says, "*number one, it's stress… I've been working since I was 19 years old… I've been having very very big responsibilities*", and then again when she says, "*these pressures with time are things that accumulate*". She believes that women get heart attacks as a result of their pressures and responsibilities. This is shown when she explicitly says, "*I think women get heart attacks not because of the heart attack but because of the life that they passed through since their youth… which is pressure responsibilities and whatever happened in the family during*". She believes that all women who have big job titles should get regular check-ups on their heart to avoid any damage from the stressors that come with the position and responsibilities. This is shown when she says, "*my conclusion is women in institutions and with responsibilities must have a general check-up about their heart*". More about what Diana passes through in her life is mentioned below in the subtheme *4.3.3 Broken Heart*.

For Nicky, the heart attack was a wakeup call. It gave her some perspective on how she has been taking on too many responsibilities. This is shown when she says, **"***the feeling itself was an overinflated sense of responsibility and the heart attack kind of put that into perspective because as soon as that happened, I was like 'why did I push myself so hard?' it wasn't worth*

it". Her body had enough as she says, "*then my body went 'no we are not gonna do that anymore' yeah*". She has pushed herself too hard throughout her life until her body reacted, and in her opinion the reaction was in the form of a heart attack.

Jane attributes the pressure from work to her health issues, which is shown when she says, *"[all my health issues came from] work pressure… I totally believe that*". Jasmine and Diana also mention pressure and stress from work when discussing their perceptions of the heart attack. Their relationship with work will be discussed further in the subtheme *4.4.3 Being-at-Work.*

The meanings associated with the heart attack came with a certain reaction after having experienced it. The following subtheme will delve into each participant's response to their heart attack.

4.1.3 Reaction to Heart Attack

After experiencing a heart attack, six of the women describe a shift in their embodied experience. Each one reacted to the heart attack in a different way, except for two women who shared a fear of reoccurrence. Three of the women share a sense of disembodiment after the heart attack.

Jasmine lost trust in her body, after experiencing two heart attacks. She makes a clear distinction between both her soul and her body, highlighting that she can no longer rely on her body; she shifted all her energy into feeding her soul as she says, *"you start to not relay on your body… I don't want to rely, I am relying my soul"*. For this reason, Jasmine decides to live her life and enjoy every moment, in order to nourish her soul. This is shown when she says, *"I am gonna live my life I am gonna do everything to the full everyday if I die tomorrow it's okay but at least I am happy today"*. Her lack of trust in her physical body after the heart attack is shown in the acceptance of her mortality, as long as she is happy she does not fear her

death. In this expression, there is an intensity to how she is choosing to live her life, to the extent that the inevitable, death, is not a concern, in fact it is almost welcomed

Though a completely different experience, Farah also splits her body from her soul. Her embodied experience after the heart attack seemed disembodied. She uses the word '*detached'* to describe her experience as she says, "*but you you, [you feel that you, what I felt was that I] I detached from my body… okay [my body was one thing], okay, [walking alongside] my soul*". She goes on to describe further her detachment as she says, "*even talking to you it's as if I am telling you about my best friend [you know], not me"*. For Farah to accept the heart attack she has to relate to it as a problem that is now fixed and gone, again showing a detaching quality. This is shown what she says, *"[I was upset] and then until I realized… and it's my daughter that made me realize…I had a problem and its fixed [that's it, case is closed]"*. It is interesting that Farah does not provide any view or perception about her heart attack like all the other participants. In addition, she gives a very brief description of her embodied experience. These can be seen as a detachment from her entire experience.

Nicky describes how her physical body was knocked down by the heart attack and it took a while for her to recover, or '*get back up'*. This is shown when she says, "*it took it took my body a a while to get back to where I was",* and then again when she says, "*it knocked me down… yeah yeah I couldn't I didn't have the ability to just get back up*". She spoke about how she felt like a failure for having gone through such an experience, which made her revaluate her priorities in life, and try to figure out where she went wrong. This is shown when she says, *"after the heart attack I felt like a failure… I wanted to know you know where did I go wrong so I don't do it again"*.

Diana expresses hope after recovering from her heart attack. She accepts it as part of her life journey, which is shown when she says, "*I was fine, psychologically I felt that everything is okay, I had a uhh all the hopes and uhh I wasn't sad for myself at all… I thought*

its part of life, because I passed through a lot of difficult things in my life soo uh it was okay". Her hope is also shown when she compares her heart attack to a kind man who gave her a second chance at life, as she says, *"I cannot remember anything that was bad about this experience… He was a very kind man because I am alive [thank God]*". She goes to her cardiologist regularly, sometimes more than recommended, just to make sure that she is doing well. This is shown when she says, "*I go and see him every 15 days uhh and he doesn't want to see me but I go and see him because I want to be good*".

After the heart attack, Jane was very emotional; she felt sorry for herself for going through this at such a young age. *"I am soo young, [I cannot finish a sentence, you know… every time I would talk, I couldn't talk, I cry, I mean there was] emotional turmoil"*. Jane expresses a fear of reoccurrence, not because she is scared of the experience itself but because she does want to leave her children motherless like she was; *"[the idea that I] I might die and leave my kids, [like what happened with me and my sister]"*.

Like Jane, Sarah expresses a fear of reoccurrence, almost as if she is sure that it will happen again. This is shown when she says, *"[I still feel for sure that the attack will happen again… but praise be to Allah it doesn't happen like before]"*.

Even though each woman responds in a unique and different way to the other, they all reacted to the heart attack. Each response created a shift in their embodied experience; from not trusting their body and detaching, to taking it as a sign of hope, to constantly fearing its reoccurrence. The next subtheme will discuss the women's embodied experience of being admitted to the ICU.

4.1.4 ICU & Recovery

Four of the participants painted a vivid picture of their experience in the ICU. Two of them had a horrible and traumatic experience where they demanded to leave immediately, and the other two had a refreshing and rather healing experience.

Both Farah and Jane had a terrible experience in the ICU. Ironically their experience of the ICU was worse than during the heart attack itself. Farah had planned to go out after the doctor's appointment, and was taken by surprise straight to the intensive care, *"I went in to the doctor, he made an echo and the stress test and everything they had to do and from his clinic he sent me to the intensive care… I couldn't even go out… on the spot… I I wasn't even allowed to go home to get some clothes"*. She felt claustrophobic and could not stand being there, to the extent that she pulled all the medical equipment and ran out without the doctor's permission:

> *"It was my first time ever in a hospital let alone let alone intense care [and then] the place was [tight] and I am claustrophobic [you know… unfortunately], and I remember when I stayed for 3 nights and one night I couldn't [I got up and pulled off everything and went and sat outside] and the nurse [ran after me and called the doctor and told him she is sitting outside] … I told them I'll just sit here… I was sitting with the gown and from the back it was open... I did not give a damn [you know] I was I was about to have a heart attack"*.

Ironically she felt she was going to have a heart attack from her experience in the ICU, whereas when she had her 'real' heart attack she did not feel it. She went on to describe the place as a dark and horrible place with painful sounds all around, *"was dark and people are right next to you 'ahh ahh' [she makes sounds of pain] it was horrible horrible"*.

Jane also describes the sounds of pain she heard in the ICU. She could not move after her operation and all she can look at is the ceiling, and all she can focus on are the sounds of

pains around her, *"[I remember that day well, looking at the ceiling without moving, like this one] [she looks up at the ceiling] [and I hear the… moans of pain ahh ahhh ahhhh… people doing that and you don't… so you hear the sound and you keep imagining how is this person doing, how old is he and what's his life like I mean]"*. The intensity of her experience is mentioned again as she says, *"[there were sick people around me, they were very sick, and I heard them moan in pain and I heard the doctors, so I was scared for myself], I felt that I might die here, so let me out"*. Again ironically she felt closer to death in the ICU, which can be considered a place of recovery, more than during the heart attack itself. Jane could not stand staying in the ICU for long, and took full responsibility for her transfer to a regular room, *"[but] I had I stayed a couple of hours [like that] in the intensive care, it was miserable [to be honest] it's a horrible experience, intensive care [uhhh I couldn't spend the night], I asked them to move me to a regular room, [and I indeed] went to a regular room [because I was very very very scared to spend the night]"*.

Jasmine had a completely opposite experience. The ICU for her represents a place without stress or responsibilities, *"I was soo happy coz I'm alone, I don't have to take care of my kids, or my mom because I'm her mother you know, or of work, or my shitty drunk husband, or my brother who always wants to see me perfect, or, I'm in the ICU and nobody can bother me, so it was a gift from God"*. Interestingly she is happy and comfortable in a place where people are usually at their worst health. She elaborates by saying the heart attack was a gift from God, and being sent to the ICU was something she really needed. This is captured when she says, *"I was so happy being in the ICU, because I needed time out alone… I was so pressured that I felt the heart attack was the saver from God, God saved me with the heart attack, it was a wake-up call, and I loved it, and when I had the second one I was going to the hospital laughing, and I made everybody in the hospital laugh and they can't believe that I was*

singing". Her sense of responsibility is lifted, as she finds peace in not having to take care of anything or anyone.

Diana also describes her time in the ICU from a more positive view. Though she is not as happy as Jasmine, she is grateful to be given a second chance at life. There seems to be a certain calmness in the ICU, even though she did not explicitly use the word 'calm'. She was not scared nor sad, she was hopeful, which is captured as she says, *"I was not scared I just felt it's a moment and I actually all the nurses we all became friends",* and then again when she says, *"I felt I was recovering… I felt I was gonna be good and I just wanted to sit in the bed and they wouldn't let me they wanted me to sleep all the time"*. She was taken care of by nurses who she befriended, *"I took a shower on the 5th day and the nurses made my hair and made my look okay and I didn't look okay… but I was fine… psychologically I felt that everything is okay"*. She felt supported by family and friends, as well as the hospital staff, which made her accept all the time she had to spend in the ICU, "*let me be in the ICU for the next 3 days… uhh because I know everybody and we have become good friends and I'm having fun with all the stories around me"*.

In most of the women's stories, the heart attack is associated with a major pillar in their life. They all attribute it to their own experience of stress, whether it is related to work or family issues. Even though they shared similar symptoms, each woman was shook in a different way, from the time of the heart attack until today.

4.2 The Self

The women's relationship to their self is portrayed throughout their interviews. They identify themselves as strong women, with the exception of one woman. Their strength is what helps them go through their life struggles, and is also the reason for their success. Most of these women are the main source of care for their family, yet lack their own self-care. Six of these

women talk about their relationship to their body, most of whom speak about it in relation to their heart attack. Within this theme are three subthemes discussed below: *Strong & Independent Self, Self-Care, and Relationship to Body.*

4.2.1 Strong & Independent Self

All of the women spoke about their self-image. Six out of the seven women use very powerful words to describe themselves, and with that came their self-image in relation to their heart attack. They describe themselves using words such as strong, sensitive, and independent in efforts to portray themselves within their story. One of the patricians describes herself through others, namely her husband and children. She portrays a very dependent self, which is the opposite to the rest of the women.

Jasmine's self-image is portrayed through her dialogue at various times during the interview. She describes herself by saying, *"my character is a free character at the same time I like to be conservative, I like to be down to earth, I like to be practical, and I like to fly, so it's a combination of very different weird character"*. As she spoke about her life experiences, she uses the words positive, cheerful, funny, sociable, and strong to describe herself. She also explains how she has always been a giver and has taken on responsibility for others since a young age, *"I was the one responsible, since 12 years old, till now, taking care of everybody and working and bringing money and everything, enough!"*. She describes herself as a child who is honest, direct, and open, and in turn brings up her children to be that way. This is highlighted when she says, *"I don't know how to lie, I don't have the tool, because I am too open, too transparent, and I am too direct, and I am like a little kid, so my most important thing is to preserve my little kid uhh spirit"*. There is a need to feel young and keep the 'child' in her alive, *"I am like a little kid, so my most important thing is to preserve my little kid uhh spirit"*. With these descriptions, comes the shock of her having a heart attack. She could not understand or grasp that, in fact, she can be depressed or have any other problem, namely a heart attack.

This is expressed when she says, *"I can endure a lot of pressure all of the time, I am a very strong woman, very successful in my career",* and again when she says, *"I thought I am not depressed because I am a very cheerful and funny person".*

Throughout Farah's dialogue, she describes herself as active and strong as she explicitly says, *"I am a very active person*" and "*I am a strong person, I know I am strong person*". She highlights how active she is a few more times during the interview when she says, "*its within me I cannot slow down, it's how I am… like my daughter yesterday told me 'mommy you are a bomb ready to explode' [she laughs] but I am like that*", and then again when she says, "*I am always very very active and uhh uhh [all my life, you know]… even everybody would tell you 'she moves mountains'*". The image of her moving mountain indicates immense strength. As she speaks about her pace in life, she mentions the importance of always needing to be doing something. This is highlighted when she says, "*I always feel like in the morning you have to do something… I don't know why [but that's the way it is]… you have to do something you have to go out you have to buy you have to cook".* Farah goes on to explain how nothing affects her, even the heart attack, which adds to her strong character, "*it didn't it did not affect me… [I mean, you know] uhh because maybe I am a strong person, I know I am strong person… uuum… I went through a lot throughout my life… [so] I'm I am tough [you know]… I know how to handle situations".* With this strength there is this need to keep things in, or walk away from stressful conditions, almost as if she is walking away from situations that might make her weak. This is portrayed when she says, *"I always used to hold things in… regarding to her regarding to him my father… regarding to society… I used to be scared to upset anyone [so I don't end up alone, you know]"*, and when she says, *"if somebody stresses me I walk [I mean] I walk away [you know] I will see you another day [that's it]".*

Similarly to Jasmine, Mary has a young soul, but also one that holds a lot of responsibility, *"[my soul is like the soul of a] child, [which has always been the case… totally*

like a] baby, [not not in my actions... I mean I'm very rational, very balanced, I take on way too much] responsibility... [but on the inside the soul wants to live]". The heart attack threw her body and soul off balance, she feels young on the inside but her body is old, which is highlighted when she says, *"[I always feel very] young [on the inside… but I don't know how to reconcile this with the] body*". She also describes herself as a sensitive person as she explicitly says, "*[I am a] very sensitive person"*. To avoid burdening her children with her troubles, Mary puts a strong façade in front of them. She believes that she needs to provide them with the care, not receive from them. This strong front is shown when she says, *"[I'm this type of person… I go through life with a] heart attack, [I go through life with all sort of stuff like that I mean]",* and again when she shows concern for her sons and says, *"[the two boys keep on waiting like this at the operating room, what is that?! No, that's it, I won't do it… I could've done it and recovered quickly, and I would've done, you know that thing, physiotherapy afterwards and stayed home… I was unable to stand up… why? because I'm in a time of] giving and responsibility it wasn't possible for me to rest"*. Even though Mary does not explicitly describe herself as strong and independent, all her stories portray a strong and autonomous woman.

Diana's self-image is expressed on many occasions throughout the interview. She describes herself as an independent, responsible, and diligent person who loves success, which is shown when she explicitly says, "*I am very diligent",* and then again when she said, "*I am a success freak, I love success, I love to be there in in all the [big stories] in the country, and I was everywhere"*. Being independent is an extremely important quality for her as she says, "*independence, freedom of of decisions, and economic independence is very important for a woman*". She also expresses a sensitive side, while describing how she accepts things in life and moves on. This is highlighted when she says, *"I am a very sensitive person, I care very much... I am a very responsible person",* and then again when she says, "*I am a person who*

accepts things and life for me goings on… I am more of a fun person rather than a sad person, although I keep the sadness inside me". These descriptions match how she reacted to the heart attack as mentioned in the theme above, *4.1.3 Reaction to Heart Attack*.

Jane also shows strength and independence in her self-image, though these exact words are not used. She is a very driven and successful person, like Jasmine and Diana, which is shown when she says, *"I am very very much results oriented, so I have to have a target, [and I have to work] towards that target [and achieve it]*", and then again when she says that she is "*task oriented, [when I want to do something, I don't want anything to delay me… either you will push me forward or this is goodbye… I don't ask for anyone's opinion]"*. This also shows her independence which is explored in the theme *4.4 Roles and Responsibilities* below. Her strength, or need to appear strong, is also shown when she explains how she stayed at work even when she was in pain, *"[I stayed at work, very normally… and wearing a neck brace and everything… until I reached a point where] even if I take a couple of steps [I can't]"*.

Nicky also describes a very independent, driven, strong and responsible woman, and like Jane, she does not explicitly use these words to describe herself, but through her dialogue this can be depicted. She believes that being weak will not get you anywhere in life, *"I realized through my mother and my brother that if you are going to be weak you're not gonna make it*". She spoke about many different events in her life that taught her how to handle any situation that comes her way. She is strong and can handle anything, "*I was more able to handle sticky situations emotional situations desperate situations than most of the others around me… umm I felt I was stronger and I was able to take in that energy"*. There is a certain rhythm in her life that she embodies in order to stay strong, she just keeps going and does not allow herself to rest. This is highlighted when she says, *"the way that I dealt with that was not to sit down and rest but to have a routine where I just wake up early and keep going because when I would rest I I felt very weak"*. She has a high tolerance for pain and stress, and explains how she just puts

all this aside and keeps going. This is how she got to where she is in life, whether her success at work, or her dealing with life's hardships. This is depicted when she says, *"I'm used to being tired I am used to being in pain I am used to getting anxiety"*, and she has been like this since childhood, *"this automatic default where I shut I just shut off and keep going… I'm I've been tired since I had my first kid do you know what I mean?"*

Sarah does not provide a description of herself like all the other women did. There is no sense of self in her dialogue, her life is dedicated to her entire family, almost as if she lost herself along the way. Even after the mishaps with her husband, she refuses to look at herself or even share her grief and pain with her family, as to not appear weak. This is shown when she says, "*[I didn't want to look weak in their eyes, me complaining to my younger siblings, I can't have that]"*. The only thing she relates to on a personal level is her devotion to God. Her language throughout the interview is of a religious basis. She mentions God every step of the way, as her faith in religion is her guidance. This is shown when she says, *"[any religiously devoted woman, as it seems to me I mean, for her it's a done deal, I mean, she has devoted herself to Allah, glorified and exalted be He, and she wants to please her husband because she knows that after marriage this represents one of the biggest doors by which she can enter heaven]*". This phenomenon in her life will be explored further in the next subtheme, *4.2.2 Self-Care*. Like Farah, Sarah chooses to keep things in, instead of confronting her experiences, which is understandable since she has chosen to cancel herself out and dedicate her life/self to her family. She would never bother anyone with her pains and struggles as to not upset or burden anyone. This is portrayed a few times throughout the interview as she says, *"[so this is really how I am, that that I don't like to bother anyone even if it's over something uhh for me, that I'm in need of, no I can forget about it for his sake]", "[I kept everything to myself, I mean… anything that caused me pain or bothered me I kept it away from him so that it wouldn't upset him or tire him]"*, and even when she is sick, *"[sometimes I would be sick but I wouldn't*

say that I was sick so that he wouldn't go through the trouble of taking me to the doctor and paying money]".

With their self-image came the description of their self-care, or rather lack of it. These strong and independent women did not appear to have had the time to care for themselves. For some, the heart attack shifted that experience, and for others it stayed the same. The following subtheme will discuss this notion in more detail.

4.2.2 Self-Care

All women spoke about the notion of self-care, whether they lack it or they care for themselves in some way. Two women realize the importance of self-care after going through the heart attack. Two women acknowledge self-care after their children have grown up and settled down on their own, giving themselves space to do so. Three of the women describe a general lack of self-care, and spoke about how their life situations have shaped the way they care, or not care, for themselves.

As mentioned above, Jasmine believes that illness can be psychological, caused by stress or depressed. In order for her to get better physically she needs to take care of her psychological state, *"I have to make any good change in my body to make my psychological being know that I am getting better*". This is also shown when she says that she will live her life to the fullest and be happy, *"I am gonna live my life I am gonna do everything to the full everyday if I die tomorrow it's okay but at least I am happy today"*. On various accounts she mentions her travels and how it helps her, *"I wanted to heal myself from the outer world, just stop it, coz when I go to [a city in Egypt] I do that, I seldomly talk, I don't talk on the phone except with my daughter and all what I do is delivery of the lunch to bring me food [that's it], I don't talk with anybody, it's like my serenity time, so this helped me a lot"*. She also mentions how, after the heart attack, she chooses to take care of herself first, and then cater to others as

she says, *"I have to cure myself first and take care of myself"* and again when she describes how the heart attack *"was a wake-up call, take care of yourself"*.

Diana spoke about her life before the heart attack, when there was no time for self-care. She had many responsibilities that took up all her time, whether family or work related, "*I don't have time... all my time was [at work]... uhh from 7 to 7 at night... I never had time [I mean] to to do all these check-ups and all that"*. As mentioned above, Diana craves success, to the extent that she forgot about herself, "*I am a success freak, I love success, I love to be there in in all the [big stories] in the country, and I was everywhere… but I forgot about myself"*. After the heart attack, she understood the importance of self-care to the extent that she is encouraging all her friends to do so. This is captured a few times during the interview when she says, *"I think these are very important things that women must adjust their life that there is a percent that belongs to them",* and then again when she says, *"it's a pity that women who work forget about themselves and its very important... all my friends when they came I told them 'you must have your own doctor'"*. After the heart attack she gets regular medical check-ups and follows a healthy lifestyle, as she says, *"I take care of my body I [I mean] I I take care of my weight of the way I eat for the first time in my life I'm eating salads… uhh I'm choosing the things that are healthy"*. She also started to give herself time to enjoy the small things in life, which is shown when she says, *"[indulgence, I like to indulge myself] … they taught me now how to put the music while I'm swimming.. so I now do the music while I swim, I enjoy the swimming and the music at 7 in the morning for an hour by myself with lovely music... little things that I never did before"*.

Farah spent her entire life working to provide for her family, and would move countries according to her daughters schooling and best interest, putting herself aside. She is a single mother, who worked very hard to provide a good standard of living for her daughter. This is captured when she says, "*I had to work very very very very hard for [my daughter] so she*

doesn't feel less than anyone". In her daily life, she expresses how she gives little importance to her physical appearance, as long as she looks neat and clean. She describes how she has been working from a very young age which set her pace for the day, *"I don't put make up I never got used to it because I was always I working women…I used to wake up, [I just] take a shower and go down… it's not [not] I am not a tomboy when I go out sometime I put mascara [you know] …what is its importance? as long as you look neat and clean*". She started looking and caring for herself after her daughter was settled and married, *"then [my daughter] got married and uhhh [I married off my daughter as they say and I stayed home] [she laughs]"*. She stopped working and chose to start enjoying life. This is highlighted when she says, "*I want to live in peace [that's why] I avoid anything that can upset me"* and then again when she says, *"I said enough is enough! I did enough I have worked for uhhh zillion years now I don't want to… even is my standard of living isn't the same, [you know], because you don't have a steady income, I didn't care I said no [that's it] …I'm going to enjoy life I am going to start going out having friends and having lunches and uuuhhh"*.

Mary describes how she never had time to take care of herself, she had to take care of her family first. She lost her main support system and had to face the world on her own, making it impossible for her to give herself any form of self-care. This is captured a few times during the interview when she says, *"you need care... [where will the care come from? you are a complete mess…you can't think about sitting down to have a proper meal because there is no] system…[the world is upside down]"*, and then again when she says, *"[I was really messed up in that area, in order for me to do] emotions [I ate wrong and I slept and I didn't feel like doing sports]"*. She had to put everything aside and take care of her children, it was a time for her to give care, not take, as she says, *"[but please take into account that I was at a time where] I had to give not to take… [it was a time of] giving not taking"*, and again, *"[I was unable to stand up…why? because I'm in a time of] giving and responsibility [it wasn't possible for me*

to rest]". She could not fathom the idea of burdening her children with her worries, which is highlighted when she says, *"[I mean I feel very sorry when I have something, I mean, I feel that] their lives have to go on… [it's not possible for them to stop and to be considerate about what I have and what is happening and stuff like that I mean]"*. At some point in her life, after settling her children down and adjusting to the many changes that happened to her, Mary found Dhikr, a spiritual group of people who follow the Sufism philosophy. She describes how it was difficult to be thrown into the real world after being sheltered within her family for so long. Dhikr provides a safe space for her to heal from all her emotional and physical struggles. This is the only form of self-care mentioned by her, as she says *"[you know when you are part of a] family [and you are married, it's very rare when you are exposed to the world… different people and a different way of thinking… so I struggled with that a bit until I found Dhikr] … then I started really healing"*.

Sarah mentions a discussion she had with her daughter, where her daughter told her she needs to start taking care of herself and living her life, *"[you haven't lived your life at all… and now you are still consumed by him… you have to let go]"*. This sums up her being-in-the-world. This is captured a few times during the interview as she explicitly says, *"[I dedicated my entire life to my husband and my kids]", "[I isolated myself from the whole world]",* and finally when she says, *"[I loved my family so much and I have really scarified a lot for their sake… I mean I have deprived myself from everything that I loved, in order to make them happy… and in the end I got nothing good from him]"*. She dismisses all her needs so she would not be a burden on anyone, *"[I never burdened him with anything, I mean… do you know that sometimes I would be sick but I wouldn't say that I was sick so that he wouldn't go through the trouble of taking me to the doctor and paying money, so as not, to so as not to bother him nor make him feel burdened with any responsibility towards me]"*. This is also generalized to everyone else around her, not just her husband; she prioritizes everyone else's

wellbeing and needs before her own. This is captured when she says, "*[my kids, I mean, even they always tell me you put others needs ahead of your own, to please others… it's true that this is a habit of mine]",* and when she says, *"[this is really how I am, that that I don't like to bother anyone even if it's over something uhh for me, that I'm in need of, no I can forget about it for his sake]"*. The only thing she has ever done for herself is her religious practice, *"[my hobby now is Quran, praise be to Allah, and it's the best and the most beautiful thing in the world, praise be to Allah, when I hold the book of Allah I'm filled with with with such joy, happiness and contentment which I haven't felt before throughout my lifetime, praise be to Allah]"*. However, even though her practice brings her joy, it is the only thing she allows herself to do, *"[I do nothing for myself except prayer… that's just it, praise be to Allah, prayer and the Quran, these are the only things that I do for myself, aside from these, I mean, I don't don't, I mean, I don't love myself to begin with]"*. This lack of self-love explains her inability to care for herself.

Nicky lost herself in her responsibilities towards her family, and had no space for self-care. As mentioned in the previous subtheme, *4.2.1 Strong & Independent Self*, Nicky tends to push her anxiety and pain aside in order to keep going on. She is a single mother who also takes care of her parents, *"I am one who takes care of my parents and I am the one who completely takes care of my children"*. For this reason, she felt like she could not afford to slow down and take care of herself, or else she will not be able to get back up. This is captured when she says, *"I have an automatic like you know go go go… umm and I never cared to stop that because I felt like if I sat down I might not get back up"*. She has always prioritized her children and gave more importance to everything else over herself. After the heart attack she realized the importance of taking care of herself in order to be able to take care of her children. This is shown when she says, "*my kids come first which means I come second […] now I am second on the list… I wasn't even on the list to be honest"*. Even with this realisation, Nicky shares

how she never valued her body and never gave herself the time to rest, which is shown when she says, *"I don't uhh value my physical body… I don't take care for it like I should… I don't give myself time to rest I don't… [I am detached from it]"*. This phenomenon will be further discussed in the following subtheme, *4.2.3 Relationship to Body*.

Jane did not explicitly talk about the notion of self-care, but through her dialogue she shows little importance to her wellbeing. She is consumed by her work and has to succeed in order to provide for her family. When asked what she does for herself she said, *"[no, nothing, neither sports nor anything else]"*. She casually says that she is on her medication which can be considered self-care as she says, *"I am checking up on myself every now and then, and I am on my medication"*. The only glimpse of self-care mentioned by Jane during the interview, is when she spoke about how she loves to indulge in movies and TV shows. It is time for her to shut off from the rest of her day, as she says, "*movies, Netflix, series, it's very important… [this for me is] total indulgment"*.

Self-care proves to be an important notion in all the women's lives. They all understand its value, but none give themselves the luxury to do so until they were either faced with a heart attack or finished all their obligations towards their family. Self-care seeps into some of the participants' relationship to their body, which will be discussed in the next section.

4.2.3 Relationship to Body

Six participants spoke about their body image, each one with a unique description. Two women give importance to their body and describe how they take care of it. Two women express a negative relationship with their body, feeling either old or ugly. The other two women express a sense of disembodiment.

After the heart attacks, Jasmine believed that in order for her to get better physically she needs to take care of her psychological state, *"I have to make any good change in my body*

to make my psychological being know that I am getting better". This belief is portrayed again when she says, *"I have to care about my psychology and then my my my physical will be fine"*. Another example that shows how her psychological state affects her body is her belief that depression leads to weight gain as she explicitly says, *"when my brother tell me to stay at home, then I harmed my body and I gained weight"*. However, even though she takes care of her psychological state in order to better her body's condition, she also mentions losing trust in her body after the heart attack. As mentioned above in the subtheme *4.1.3 Reaction to Heart Attack*, she says, "*you start to not relay on your body… I don't want to rely, I am relying on my soul"*.

Before the heart attack, Diana never gave much thought to her body. As long as she looked presentable, she gave no importance to her weight. This is captured when says, "*nothing important... it was just dressing up well and dressing nicely*". She always had too much work to think of her diet, so she ended up eating anything available in front of her, "*it's more what you develop with time while you are in your office… sandwiches, biscuits, cakes, everything"*. After the heart attack, like Jasmine, Diana gives importance to her body. She started eating healthy and loving her body as she says, "*I take care of my body I [I mean] I I take care of my weight of the way I eat for the first time in my life I'm eating salads... I'm uhhhh I'm choosing the things that are healthy"*.

Jane uses strong words to describe how she views her body. Even though she acknowledges that she is a good looking woman, she hates her body to the extent that on some days she cannot even look in the mirror before she leaves for work. This is captured when she says, "*I hate my body, I hate my looks! [I know that how I look, maybe my face is okay… but I hate… my body… totally]",* and then when she says, *"[and I don't do anything about it, I mean I don't do anything, I lose weight and I gain weight, I lose weight and I gain weight and when*

I gain weight I don't look in the mirror… I mean these days I don't look in the mirror, I get dressed and I don't even know what I put on, I can't look in the mirror]".

Mary spoke about how her age is not in sync with her body, which is not in sync with her soul. Her body's condition makes her feel older, and her soul is even younger than her age. She compares her soul to that of a child, or even baby, which is out of balance with her medical condition. This picture is captured a few times during the interview as she says, *"[I always feel very] young [on the inside… but I don't know how to reconcile this with the] body", "[my soul is like the soul of a] child, [which has always been the case… totally like a] baby, [not not in my actions]",* and when she explicitly talks about her age as she says, *"the condition [was making me feel old because] to feel myself… [it made me feel detached from myself]".* Mary also mentions how she pushes her bodily pain aside to take care of her family, to the extent that she ignored her head injury after a major accident, in order to go check on her husband. This is shown when she said, *"[my face was, I mean, like like all injured from the glass and stuff] [she points at her entire face] ... okay, [I can't feel anything at all... when I was at the hospital] I insisted that I go finish all my husband's the procedures, okay".* This also shows her lack of self-care, the fact that she had to take care for her family before even considering herself.

Farah expresses a sense of detachment from her body, a disembodiment, as mentioned in the subtheme *4.1.3 Reaction to Heart Attack*, *"but you you, [you feel that you, what I felt was that I] I detached from my body... okay [my body was one thing], okay, [walking alongside] my soul*". She went on to explain how she would not bare the idea of looking at her operation scar, a form of disembodiment as well perhaps. This is captured when she says, *"[I mean], at the beginning I couldn't really look at my scar... [what's this?] that's me? [what's this?] what happened?".* In contrast to this experience is her sense of embodiment before the heart attack. She briefly spoke of her relationship to her body, describing how she never thought to change anything in her body, she would not even apply makeup. This is shown when she

says, *"I always saw that I had a great body because I uhh I am who I [I mean, I don't know] I never I never thought to look at myself".* She was more in sync with her body then, it was who she is, as she explicitly says, *"my body is uhh is me… it's just me… it's me… [I mean] ahhhh it's me it's how I am".* The weakness that came with the heart attack experience led to a disembodiment.

Nicky had always joked about having a heart attack one day, due to her way of life, as she explicitly says, "*I always joked that I am gonna go with a heart attack*". Her relationship with her body had been a harsh and disembodied one. Nicky says, *"I don't uhh value my physical body… I don't take care for it like I should… I don't give myself time to rest I don't… [I am detached from it]".* There is a strong element of detachment which is shown a few times throughout the interview as she says, *"I would actually have the experience of leaving my body"*. With this experience came a sense of safety outside her body, which reinforced her disembodiment, *"you jump out of your body… in the space I realized there was a space you can go outside of your [body]"*. These experiences were ones that happened after extreme circumstances. However, there is also an element of embodiment in her dialogue, as she describes how pain and stress is expressed in her chest. Since she was a young girl, her chest would constrict at any sign of stress.

The body here can be considered an expression of their self-care as well. Each women's relationship with their body goes hand in hand with their self-care, or lack of it. More specifically before the heart attack, there is a general insignificance in their relationship with their body. There was no time to take care of themselves, no time to eat well, exercises, have medical check-ups, and so on. Moreover, some women could not relate to their body even after the attack, portraying a sense of disembodiment.

4.3 Loss

Loss is a common factor in all the women's stories. It comes in from different angles, whether it is the loss of a loved one, loss of family, loss of time, etc. Each story comes with a loss that shifted and shaped their lives in a way. The three subtheme discussed below are: *Loss to Death, Loss of Life, and Broken Heart.*

4.3.1 Loss to Death

Though a minority of the women interviewed have experienced losing a loved one to death, for these three women this theme is an immense part of their story. Each woman, lost a significant person who represents an important aspect of their life, and with these deaths, a part of the women is lost.

Mary lost two of the most important men in her life, her brother and husband. After losing them both within a short period of time, Mary felt her world collapse. She had to face the world alone and fend for herself and her children. She lost her brother to cancer and her husband in a car accident, that she survived. She describes her brother as the happiness in her life as she says, "*my brother, I lost my brother long ago [he had] cancer… [he was the laughter in my life]".* The car accident happened after her brother's death by a few years, which she was still recovering from, *"[it was a very difficult phase… uhh and afterwards the] car accident and [I was in it and] I lost my husband [and then it was like… this also caused me] trauma".* Mary spoke about how she was the one that was supposed to die, but she survived and continued in this world, "*I was dying actually… [I mean, I was supposed to die not him... and I mean the doctors said so, I mean they said] 'we don't think that she will make it'… [and I held on] and I survived".* She experiences the world she survived to be a very tough one, where she lost her two main pillars; her brother who gave her love and care, and her husband who gave her a family and took care of her. This is captured when she says:

> *"[I mean an extremely difficult life]… the love of my life [who is my brother, my brother and my beloved and my whole world… because I was the type of person who didn't know how to communicate well] with my parents because they weren't emotional [like him and I… so in terms of] emotions it was the two of us… [so imagine when this is gone and I'm struggling with] my marriage [to begin with, so the combination of the two was very difficult for me… and afterwards the death of [my husband], yeah ok, there were] no emotions [but there is] a lot of responsibility*".

She provides a powerful metaphor describing this experience, that of a broken pillar or backbone, *"[you get like the main pillar and you break it and you have to live like that with yourself, with the kids], with the responsibilities, with life and with everything".* This experience will be further discussed in the theme *4.3.3 Broken Heart.*

Diana was also hit by a sudden death of a family member. While talking about problems at work, she briefly brought up her son's passing. This is captured when she says, *"it was the same year that I lost my elder son... he was studying [abroad] and I lost him… uhh uhh and of course all this uhh has helped the fact that I passed through a difficult time… and I think women get heart attacks not because of the heart attack but because of the life that they passed through".* She did not go into much detail, however the weight it had on her life was extremely heavy as she directly links her son's passing to the build up leading to her heart attack.

The notion of loss came up for Jane in relation to the death of her mother, which intensified her own death. Her mother died at a young age from an unknown heart problem when Jane was a young girl, as she says, *"my mother died with a heart problem…. unknown until now".* This resemblance between her mother and herself brought out her own fear of leaving her children motherless like she was left. This is captured when she says, *"I think I think I think [the idea of the] unknown [the idea that I] I might die and leave my kids… uhhh*

experience [again what happened to my sister and I, that this would happen to me again with my kids… that I die and leave my kids, like what happened to my sister and I]".

The deaths mentioned shifted an aspect in each of these women's lives, one that changed their embodied self. From their stories it seemed that, Mary lost love, Jane lost security, and Diana's loss added to her difficult life. Each woman indirectly links the effect of these deaths to their life stressors, which in a way is associated with their heart attack.

The following section will add onto their experience of loss by exploring other aspects that were lost in their life. Though not all are linked directly to the heart attack, they set the tone for their story.

4.3.2 Loss of Life

Loss of life is a big part of all of the women's stories. Somewhere along the way they lost a substantial part of their life that they could not get back. Two women lost her families and had to face the world alone. Two of the women spoke about how they lost their children's childhood, which can also be seen as loss of time. One of the women describes about how she lost herself dedicating her life to others. Another participant discusses her lost time during her working years. Two of the women did not explicitly talk about their experiences in relation to loss, however it can be depicted from their language. They are both divorced, single mothers, working hard to provide for their family. Loss comes into play indirectly in their case.

Farah was raised by her grandparents from a very young age. After her parents' divorce each one left to start a new life. Along the years she seldom engaged with them, *"I grew up with my grandparents [because my dad and my mum got a divorce… and my dad left and my mum said why him? so she left]".* She erased them from her world to the extent that she thought her mother was dead, as she told her, "'*last time we talked was 25 years ago and then you disappeared… [so, I mean] I thought you were dead'".* As for her father, their encounter did not go too well either, as she says, *"it was horrible, I couldn't stand him, I barely knew him".*

In her opinion, the loss of her parents is the reason why she keeps things in, as she says, *"this is why one of the reasons that I always used to hold things in… regarding to her regarding to him my father"*. It set the pace of her life, and the quality discussed in the subtheme *4.2.1 Strong & Independent Self* emerged; she held things in and kept going because she 'had' to. Farah is divorced and a single mother, working and living solely for her daughter, *"I brought [my daughter] up alone"*. With that set up, Farah spoke about how she had to work to provide for her daughter, missing out on her childhood. For this reason, now she wants to enjoy her grandchildren. This is captured when she says, *"I want to enjoy my grandkids I want to enjoy my daughter which I never… I did but not as much as I should have because I was not very often around… I was around physically as a mother but and I saw her grow up but uuh I was all the time working"*.

Similarly to Farah, Jane also spoke about missing out on her children's childhood. She lost that part of their life, and can never get it back. She was immersed with work that she did not have the time or energy to engage with anything else. This is captured when she says, *"as a mother [she pauses] [I mean, look, not the most successful… because I was] uhh distracted, like I was just telling you, [during work I was very focused and very anxious because I had to keep going… so I was worried about them but I didn't give them enough time]",* and shortly after when she says, *"[so I missed things that I really shouldn't have missed, despite my love for them and they know it]"*. Jane stresses on how upset and regretful she is to have lost this time, as she says, *"[I really feel a lot of guilt, a lot of guilt, I mean I remember instances… I'm upset, I'm upset that I used to lose my temper at them, I'm upset that I didn't give them time, that I didn't have patience for them, I mean I came home completely drained and I wanted everything to be over and done with quickly… so there were none of the the tenderness I gave them later]"*.

After the death of the two main pillars in her life, Mary had to go out into the world and face it on her own. This loss resulted in many challenges and frustrations, which is shown when she says*, "[I was going crazy, I moved from one family to another to hanging in mid-air alone completely completely] completely… [I used to bang my head against the wall because I couldn't [she takes a deep breath] my God 'what is this?! Why am I completely alone like that?]'"*. Mary lost the sense of a family, felt completely alone and nobody felt her pain, *"[nobody feels what you are going through, nobody… I kept] struggling with that [they don't feel what I'm going through? They don't this or that…?]*". At first, this thought consumed her until she realized she needs to carry on with life for her children and adapt to the loneliness that resulted from her losses. This is shown when she says, *"[afterwards I was very busy with the kids so I didn't have time to think about anything else in life… but life was very hard on me]*", and also when she says*, "[me getting used to] loneliness [was something that I did because I had to, but] this is not me".* This way of living is what Mary spoke about in the subtheme *4.1.2 Meaning: Anxiety & Heart Attack*.

The notion of loss is apparent throughout Sarah's story. She lost herself in her marriage, by sacrificing everything for her husband and children. This phenomenon also brought out many other themes, as discussed previously in the subtheme *4.2.2 Self-Care*, and later on in *4.3.3 Broken Heart*. The intensity of this experience resulted in a life that is wasted. She lost her current life, but has hope to be rewarded in her afterlife, as she says, *"[I mean, I felt that my whole life was wasted, if truth be told, I mean… but it's true that I have wasted my life on earth, but if it's the will of Allah, He will make it up to me in the afterlife]".* As mentions in the subtheme *4.2.2 Self-Care*, Sarah gave up everything in her life for her family, which she believes is her religious duty as a woman. However, in return all she got is misery. This is captured a few times throughout the interview as she says, *"[I dedicated my entire life to my husband and my kids]",* more specifically she lost contact with her friends as too not upset or

bother her husband. She describes how she cut all ties from the world as she says, "[*I stayed away from the whole world… I stopped having any friends]",* and again when she says*, "[so as far as friends are concerned, it's a closed subject because uhh I didn't want to bother my husband by telling him that I'm going to visit someone or that someone is coming over or anything of the sort… so I put a stop to the whole thing and I dedicated my entire life to my husband and my kids]".*

Nicky and Jasmine are both single mothers. Like Farah, they are the sole providers for their children. Though loss was not explicitly linked to this experience throughout their dialogue, their divorces and experience of being single mothers have a strong element of loss. This aspect of their lives will be discussed more in the next subtheme, *4.3.3 Broken Heart*.

Diana's loss of life is specific to time. She never had time for anything in her life due to her work's pressures and demands. Her lack of self-care was a result of not having time to do so. This is captured when she says, *"I don't have time... all my time was [at work]... uhh from 7 to 7 at night... I never had time [I mean] to to do all these check-ups and all that".* She gives the example of her business trips, where she would go just for work and not give herself time to enjoy the city, "*I forgot about myself and that's very important you have to really [I mean], I in business trips in business trips... I didn't put a day extra where I can enjoy a movie or something".*

Each loss represents a phenomenon in the women's life which, like the subtheme *4.3.1 Loss to Death,* shifted their being-in-the-world. Whether the lost love, family, themselves, or time, this loss can be considered an added weight on their anxiety.

4.3.3 Broken Heart

Interestingly, six of the women use the term heartbroken to describe their experience with love. Two of the women deliberately link their broken heart to their heart attacks. Each

participant describes her relationship with her husband and the effect it had on them. One participant also adds her brother's death as the source to her broken heart.

Mary was heartbroken many times in her life, from men who either cheated on her or did not love her back, *"I was heartbroken [many times so that's it I got sick of it]"* and then she explains more by saying, "*[I love someone and he doesn't love me back, I love someone and he cheats… I love someone with all what this entails… in the end it's all a build up]".* She continues to describe how she lost all the love and care when she lost her brother and has been seeking for some sort of love and care ever since. This is captured when she says, *"[I mean] already I was heartbroken with my brother [and every time I keep trying to find a replacement for this tenderness]".* She links her heart attack to being heart broken, and believes that a heart attack can be a result of emotional heart break, *"the heart attack, and I believe in it very much… [when he says] heartbroken, really the heart [becomes] broken… [it becomes] broken for real".*

Sarah dedicates her entire life to her husband and in return she was betrayed by him, *"[he didn't cherish our married life, and he went and got married behind my back]".* This betrayal crashed her world and caused her extreme emotional pain, as she says, *"[it has very deeply affected me and caused me a great deal of emotional pain that I still feel till this day, if truth be told I mean… I mean he says that he has divorced her… but emotionally, I mean, the damage was already done, do you know that every time I used to see him it felt like I could read nothing but betrayal and treachery on his face]".* She explains how she can forgive anything, even physical abuse, but never unfaithfulness. This is captured when she says, *"[I mean I can bear everything and bear… he used to hit me! he used to hit me! he used to hit me! I mean I was able to bear it and forgive him for hitting me, I was able to forgive him for hitting me, but as far as this is concerned I can never ever forgive him… never!]".* She gives a very powerful description of how this betrayal affected her. She felt devastated and her world went

completely dark. Even though her husband divorced the second lady, she still feels heart broken, to the extent that she hates everything around her, even the air she breathes:

> *"[He hurt me really bad, he hurt me really bad! You know… I mean I can't describe to you, I can't describe to you… I mean the bitterness, the bitterness that has filled my life, my heart, my world when I discovered his betrayal to me… I was devastated, devastated, so devastated … you know, I mean, during the first years following my discovery of his betrayal, I felt that my world has gone dark, you know I hated everything in life… I swear I started hating even the air that I breathe… I didn't want to breathe, I saw nothing but darkness darkness extreme darkness in my life I mean! I mean I didn't see any beauty in it… I didn't see anything in it at all, at all! I felt that I was isolated from everything, everything]".*

Since the beginning of her marriage, her husband always mentions how he deserves a better wife than her. She questions herself and obsesses over her flaws. This is captured when she says, "[*since the day I was married to him and he, I mean, I don't know, he wasn't satisfied with me, despite the fact that when we uhh got married, he pursued me and he was the one who wanted me]",* and *"[he always makes me feel like he wants someone else, that he doesn't want me… maybe I'm short, he is taller than me, taller than me, I am short!]".*

Jane's relationship with her husband has diminished completely. Even though they are still married, they lost the emotional aspect of the marriage a long time ago, *"I am not there… I am not there [at all since a long time ago… no no] I checked out [a long time ago]".* She forgot what it means to be a wife as she says, "[*but I forgot that part about being] a wife, [it was completely lost along the way, completely]".* This relationship, or lack of one, has brought a sense of emotional emptiness or loss, which is shown when she says, *"[it's causing me] emotional voidness [in a certain area… sometimes… I feel] emotional, [you need someone to give you a pat on the back, you understand]… I think I get this from my kids".* The image she

provides of him, is a man who is sitting on the couch while she goes out into the world and deals with life's demands, *"[my husband] [is sitting on the couch… for example he doesn't tell me 'I'll come with you'… nothing, this sort of stuff never happens]".* She lost him as a husband and gained a third child to maintain the family image for her children. Being a dependable person, her husband fell into that role and she allowed it to happen so life can go on. This is captured as she says, *"[like you see], I'm a dependable person [like that, so that was it, he depended on me… so he became my third child, I mean I found myself with three children]".* In the end she stopped seeing him as a husband or even a man, *"you stop seeing the person as a man and you are his wife".*

A loss of love can be depicted in Jasmine's story, as she describes her relationships with her ex-husbands, even though she does not explicitly use the term heartbroken. She describes how her second husband would belittle her, to the extent that he made fun of her when she told him that she is having a heart attack *"he came with me to the hospital just making fun of me…… my husband didn't believe me at all",* and again when she says, "*at the end you you you just destroy everything so easily and get drunk and get so bad with everybody around and me and shouting around".* She questions why she stayed in this marriage if all she got out of it was losing herself, *"even if I love him, and then why? I just lost myself".* She even blames him for her heart attack, *"I just had the second heart attack because of him".* Both marriages, though different in nature, left her with a longing to be loved. Even though she describes herself as a strong person, she acknowledges her weakness when it comes to love. This is captured when she says, *"I believe any guy who tells me I am beautiful, I love you, and then he's just after my pants or anything… ahhh stupid".* She describes her vulnerability at the time of her marriages, as she was lured into the relationship, as she says, *"it's the point that I was not strong at that time that he know how to suck my positive energy and let me down with him, he drained me you know, and its very very bad".* She uses the word '*drained*' a few times, for

example when she says, *"I was always drained, from marriages, from friends, from everything".* Jasmine's first husband cheated on her and took away her sense of womanhood, as she says, *"my first husband treated me like shit, he he know a lot of uhh he cheated on me a lot, so I didn't feel my womanhood, and he wanted me always kept at home".* He managed to break her in a way, where she craved being loved and needed to feel alive again. This is shown when she says, "*I wanted to have a boyfriend so soon coz I wanted to feel that I am alive again and I am nice again and somebody can love me and so on after cheating".* As she starts to take care of herself after the heart attack, Jasmine is looking for a man who accepts her as she is, "*it's the love I am searching for with a man, that he loves me just the way I am, I want him to see my soul".*

Farah mentions in passing how she was heartbroken by many people in her life, as she says, *"[I've had way too many] heartbreaks… heartbreaks from families from friends from uuuhhh uh husbands [no of course] heartbreak uuhh number one ahh ah ah… heartbreaks but that never broke me".* Even though she does not show a sense of heart break as she mentions her divorces and family losses throughout the interview, this sentence brings heart break into the equation. It is important to notice that Farah did not allow all these heart breaks to break her, which can be linked to her strong and resilient character described in the subtheme, *4.2.1 Strong & Independent Self.*

Nicky also talks about her heartbreak, but unlike the rest of the women she does not attribute it to her relationships. She believes it is her own doing. This is captured as she says, *"I felt that I broke my heart I I didn't do something that was right I didn't make the right decisions do you know what I mean?".* She believes that the wrong decisions she took led to her heartbreak. For example, she chose to marry a man that later on led to a broken family, as she says, *"my divorce wasn't a broken heart in a romantic way it was a broken heart because*

a family now is you know uhh being broken uhh but for me I would tell you that my 'broken heart' led me too a lack of tools to be able to deal with certain things".

The juxtaposition of these two experiences in the women's stories: the heart attack and the broken heart, have an interesting embodied relationship. Each woman experienced an emotional heart break as well as a physical heart attack. Though they do not happen at the same time, the women's narratives bring them together as part of their being-in-the-world.

4.4 Roles & Responsibilities

Each participant explores her roles and responsibilities during the interviews. These women held many responsibilities throughout their life which led them to take on specific roles. Five of the women related to what they considered to be a man's role, whether they represented the father in their family or had to embody a man's persona at work. All the women spoke about their role as a mother and their relationship with their children. There is a sense of living and providing for their children throughout all interviews. Six of the women spoke about the significance of work in their life, some linking the pressure and stress from work to their heart attack. The three subthemes discussed below are: *A Man's Role, Being-a-Mother, and Being-at-Work*.

4.4.1 A Man's Role

This subtheme is specific to how these women relate to a man's role. Egypt is a patriarchal society; five of the participants describe how it feels like to be a woman in what is considered to be a man's world. They describe aspects of masculinity in their lived story. Three of the women speak about their musicality at work, having high ranking jobs that are usually a man's position. Four of these women are the sole providers of the family, which in Egypt is

known to be a man's job. It is apparent that this theme is specific to the Egyptian culture, since what is expected to be a man versus a woman's role may not be the same worldwide.

Diana is a women of great power and a high position at work. She rules the field she works in, which will be discussed in the subtheme, *4.4.3 Being-at-Work*. She compares her position and responsibilities with that of a man's, as she says, *"all alternative responsibilities... whatever... so it's it's it's like a man... it wasn't a woman, it's a man"*. She stresses on the fact that woman in high positions, specifically *"women who have the same position as a man",* are more likely to get a heart attack. Not only is she carrying the same responsibilities as a man, but she also has her 'womanly' responsibilities as well. This is shown she says, *"so if if there are 4 women then they can get this heart attack if they don't take care of themselves".* Interestingly, Diana sees the heart attack as a kind man who gave her a second chance at life, as she says, "*it's a man... it's a hard man... but with me he was a very kind man".* There was no further elaboration, however this symbolism shows a masculine energy present in her story.

Nicky talks about how she embodies a man, in her physiology, the way she dresses, and her energy. During her medical check-up the doctor told her that the adrenaline in her body is similar to a man's, which is shown as she says, *"[the doctor was] like 'the amount of adrenaline that was in your body a man's heart might been able to handle, a woman's heart can't'".* She goes on to further explain her masculine appearance as she says, *"I I already I was already [I mean] this is the most feminine that I have ever been okay? I'm I I wore masculine clothes, I talked with men I, [I mean] I hold myself in a more of a masculine energy definitely at work uhumm and that was my comfort zone… right? umm which, I think led me to be able to work with these men for 20 years".* Her masculine energy was so strong that her doctor recommended that she stops working with these powerful men, *"[the doctor] was telling me that coaching men like that we need to close that chapter… because he feels that I've become in energy and nature, you cannot help but be like that".* In addition to that, Nicky is the sole

provider for her children; their father is not involved in their upbringing or even financial needs. This is shown when she says *"I am the one who completely takes care of my children uhhh umm their father is not in the picture at all".*

Jasmine compares her responsibilities to that of a man's. She describes how a man should work not the woman, but due to her circumstances she has always been 'the man'. From a very young age, with her mother, and today, being a single mother who is the sole provider for her family. This is highlighted as she says*, "look [I mean] I am a woman, in the Egyptian uhh society that uhh we are raised up that men should work and the women should have good time… I was the man all the time since even my mother, I was the one responsible, since 12 years old, till now, taking care of everybody and working and bringing money and everything".* Another masculine aspect in Jasmine's story is when she chooses to pamper herself because no man ever did, again showing how she reflects her assumptions on what a man is expected to do. This is captured when she says, *"I just went there to pamper myself, feel romantic alone because no man have ever give me that so okay I'm gonna give it to myself".*

To expand on Jane's experience mentioned in the subtheme, *4.3.3 Broken Heart*, Jane took on the role of the mother and father to her children, due to her marriage situation. By default, her husband became her third child. This is captured when she says, *"[like you see], I'm a dependable person [like that, so that was it, he depended on me… so he became my third child, I mean I found myself with three children, I mean I] I have to take care of both my kids and [my husband]".* Her husband's lack of existence in her life led her to live her life without his involvement, to the extent that she would take care of everything alone. The examples she gives, like taking care of her car or buying houses, are again specific to what can be considered a man's role in Egypt. This is shown as she says, *"[my husband] [is sitting on the couch… for example he doesn't tell me 'I'll come with you'… nothing, this sort of stuff never happens… the kids' doctor, I go on my own, all of that I do on my own, on my own, completely on my*

own… any errands relating to my car or to anything else… everything… I buy houses and I don't tell him… I bought [a summer] house and I didn't tell him until when I finally decided to furnish it… I mean I deal with everything, I'm living my life]". This kind of independence is an expression of her masculinity; she is fulfilling all of her husband's roles. Her aspirations in life are ones that are expected to be provided by the 'man' of the house, however she is the one who is responsible for them, as she says, *"[I want to get money, I want to make sure everything is in order, the kids, schools, colleges and so on, so on]"*, and again when she says, *"I need to be on top of everything, and I need to earn more money".*

Farah did not explicitly compare herself to a man in her story. However, like Nicky, Jane, and Jasmine, she is a single mother who also took on the role of the father. She had to work to provide a decent living for her daughter, with no support from her ex-husband, as she says, "*no money no nothing… [in a nutshell he was a nightmare for me]".* She fulfilled both roles, a mother and father, which is shown when she describes her ex-husband's lack of involvement, *"he never knew how I was bringing her up… and that's it but when he saw that she was brought up well and that she was successful and, but he was in our life, he wasn't in our life as a supportive person no".*

As these women embody a man's role, their responsibilities intensify, hence their pressure in life also increase. Taking on more roles than what is considered to be the norm in Egypt, has affected their roles as mothers, which will be discussed in the next subtheme.

4.4.2 Being-a-Mother

Motherhood is a vital concept in all the women's stories. Each participant explains her role as a mother and shows the importance and value of this relationship. Five of the participants' purpose in life is to provide for their children. Each women goes to describe their relationship with their children, which stands unique to the other. The remaining two women,

are not the sole providers for their children, however they discuss their role as mothers and its significance in their life. Being-a-mother who has experienced a heart attack presents a struggle for some of the women. Being the main source of support to their family, they could not afford to fall apart. In turn, the heart attack presents a slight change in their relationship with their children.

Jasmine describes herself as a young and playful mother who did everything in her power to provide the best for her children and raise them well. She stresses on the importance of being happy and light hearted. She uses comedy and freedom as expressions of how to live life, as she says, *"I just let them do what they want, and they go up the doors and go like this like a [swing] and they they destroyed my house [laughs], and I didn't care coz I just wanted them to have fun"*. She also says, *"I told [my son], I wanted you to be like my brother but you have to be a little bit more easier than him, since he is young, I and I I give him a life that made them, [I mean] I dedicated my whole life for them, so thank God they are very well risin, very good people"*. In her dialogue she seems to be a free spirited child more than her children actually are. They are worried about her as she says, "*my kids are always afraid that I go anywhere abroad without them or without work they always like somebody to be with me because they are afraid anything will happen to my heart"*. This happy and playful façade is also shown when she mentions how she needs to appear 'normal' for her children in her darkest hour. There is an importance to being happy and portraying the 'normal' mother, as she says, *"I want to let them feel mom is normal, but I wanted to heal myself from the outer world"*.

Farah had a very distant, if non-existent, relationship with her mother and chose to be nothing like her with her daughter. She believes that your only true love are your children, which is why she never related to her mother. This is shown when she says to her mother *"now that I am a mother, if I would have given you credit for this now there isn't any credit whatsoever"*. She believes that *"the only true love in life is your children… ahh the the [your*

husband yeah is nice and lovable and may God protect him and all of that] but it's it's it's it's being in love it's lust it's habit it's not real love… real love is only children… okay, [I mean, you will receive] real love from your child and you will give the real love to your child". The role of a mother for Farah is a very meaningful one, she lived her life working to provide the best possible life for her daughter. This is captured when she says, *"I had to work very very very very hard for [my daughter] so she doesn't feel less than anyone"*. Her dedication towards her daughter is shown when she says an Arabic saying that translates into "[*I married off my daughter as they say and I stayed home*]". Her hard work was not necessary after her daughter got married, so she stopped working to have time to spoil her grandchildren. This is captured when she says, *"I want to enjoy my grandkids, I want to enjoy my daughter which I never… I did but not as much as I should have because I was not very often around… I was around physically as a mother but and I saw her grow up but uuh I was all the time working",* and when she explicitly says, *"[of course] of course I am spoiling rotten my granddaughter"*. Farah lived her life working to provide for her daughter, which took away from the time she could have spent with her, so as soon as she was able to take a step back, she chose not to repeat this pattern with her grandchildren.

Nicky describes her relationship with her children as she says, *"we are a very tight knit family… umm I'm there mother and I'm also a friend uhm uuhmm we're very close we I take pride in they are both very bright they are both very talented… uhh that has nothing to do with me [they were born like this], umm I try as much as possible for them to have… to be independent of me [I mean] within reason… to give them the life skills not just education that they need"*. Nicky places importance on independence and communication with her children. She is the mother, but also the friend who helps them develop the skills to live through life. She expresses the significance of communication as she says, *"it's very important to me because it means that if those communication lines are open then what I wanna do to protect*

them will be done do you know what I mean?". As a mother, Nicky always wanted to protect her children and show her the best version of herself. This is captured when she says, *"I always wanted to them to see me in a perfect light"* and when she, *"always wanted to protect them"*. Since Nicky is the sole provider to her children, emotionally and financially, the heart attack affected her family a great deal. This is shown when she says, "*because I am a single mom… [I have two kids] [so so] it really affected our home life for a little bit you know"*. As a mother, her priority is her children, and after the heart attack she realizes that she has to also put herself as a priority in order to be there for her children the way she wants to be. This is captured when she says, *"my kids come first which means I come second which means I need I am their life line so I I when I take care of then then I will see"*, and when she says, "*nobody knows when there gonna go, and I I always don't want in my mind to have had something left that I wanted to tell them"*.

Diana's role as a mother is spoken about very briefly, however her minimal words were enough to paint a picture. She is a working mother, from a young age, *"I've been having very very big responsibility... at 23 or 24 years old I had my kid…my first kid, and I was trained [abroad] with the baby"*. For this reason, she did not have much time to spend with them, so she always valued quality time over quantity with her children. She is a mother who values independence. Her role as a mother is captured as she says, *"I care very much for my kids like any mother does but I believed when I was working in quality of time rather than quantity"*, and again when she says, "*I am not this type [I mean] I am not a mother who wants to control my kids"*. Diana shows the importance of her quality time as she says, *"you really give the proper wisdom and the proper decisions the proper discussions uhh with your kids"*.

Mary's life flipped upside down overnight when she lost her husband in a car accident. She went from depending completely on her husband and family, to needing to be the one who is depended on. She chose to put on a strong front for her children as she says, *"[you end up*

wanting to appear] strong [and that nothing is wrong]". As mentioned in the subtheme *4.2.2 Self-Care*, Mary would neglect herself so to not burden her children. This is shown when she says, *"[I feel very sorry when I have something, I mean, I feel that] their lives have to go on… [it's not possible for them to stop and to be considerate about what I have and what is happening and stuff like that I mean]"*. There is a sense of loneliness in her dialogue, which is shown when she says, "*the boys [are of course being] boys [they go off with their friends and I'm staying home completely alone and I know how the world is… everyone is busy]"*. She lost her loved ones and had to face life, alone, for her children, as she says, *"[my whole world was gone… and I started living for them]"*, and again when she says, *"[I started by putting in order the things relating to the kids first… because you have a lot of things… first of all there is no income, I don't work… he left things that I needed to run]"*.

Sarah's role as a mother is one who dedicates her life to her children. She sacrificed her life for them. She spoke about how she is always there for her children and helped them with school work, as she says, *"[as far as my kids are concerned I used to help them study… so praise be to Allah… but of course now due to my old age I'm not able to help the younger kids]"*. However, after the heart attack, she was not able to be fully present like before. The roles seemed to switch, where her children started to take care of her. This is captured when she says, *"[now my daughter may Allah bless her and bestow good things upon her… of course since the attack happened and she saw me almost dying in front of her eyes because of it… so God bless her she took all the housework off my hands completely]"*, and again when she says, *"[I mean I often feel that she is my therapist I swear, she's my beloved]"*. She refers to her children's advice a few times during the interview, which shows how she listens to them and allows them to take care of her. An example would be their take on her relationship with their father, *"[my kids love me very much and… but of course they keep, I mean, getting upset with me and they constantly tell me 'mom, forget about it, mom, enough thinking…']"*.

Jane's role as a mother was told using an emotional tone. Her love for them is captured when she says, *"now I am totally different, [I mean] very very very fragile [with the kids and I'm very affectionate and I give hugs and kisses, I mean as if they were babies, you understand? …so even they felt the difference…we became friends even more, but they were already grown up, so they were also, I mean, I missed quite a few cute things from when they were children]"*. She spoke about herself as a mother at the peak of her career in comparison to today, after she had filled her position at work. As a young working mother, Jane was not able to portray her love to her children the way she wanted to, as she says, *"[so I worry about them but I don't give them enough time…I work for their sake and they are my life, but I don't treat them like that, you understand]"*. Her priority is to ensure her children's security, and she works very hard to do so, *"the safety and security [of my kids, I want to secure a life for them]"*. Jane places importance on certain values that she wants to pass along to her children; she wishes them to be fair, balanced, and eager to be successful, as she says, *"[what matters to me is a balanced character], fair, objective, with values, [this is what I care about]… eager [to have] success stories"*. After she reached her desired position at work, Jane had the time to spend with her children to teach them these values and spend quality time with them. She also finds comfort and love from her children, which lately she realizes she has been missing. This is captured when she says, "*[I feel] emotional, [you need someone to give you a pat on the back, you understand] …I think I get this from my kids… [they are the ones who understand, they feel me], and they appreciate… [so my kids make up for it]"*. She repeatedly stresses on the regrets she has for not being present during their childhood as she says, *"[I really feel a lot of guilt, a lot of guilt, I mean I remember instances... I'm upset, I'm upset that I used to lose my temper at them, I'm upset that I didn't give them time, that I didn't have patience for them, I mean I came home completely drained and I wanted everything to be over and done with quickly... so there were none of the the tenderness I gave them later]"*.

At the time of their heart attack, each role was put on hold for the duration of the attack and recovery. In some cases, the women fought to stay strong in front of their children regardless of their pain and weakness. This quality is portrayed in Nicky, Jasmine, and Jane's stories. Mary and Farah experienced the heart attack after their children grew up and no longer depended on them, making it easier for them to accept care from them. Others, like Diana and Sarah, allowed their children and others to take care of them.

4.4.3 Being-at-Work

Four of the participants are working women who place great importance on their position at work and career path. Five of these women were put in a situation where they had to work to provide for their family, whether they are career oriented women or had no intention of building a career. Four of these working mothers related their work and pressure to having a heart attack.

Work to Diana is a big part of her identity. She rules the field she works in and is proud of it as she says, "*you must have googled me"*. She started working at a very young age and quickly started taking on more responsibilities at work. This is captured when she says, *"I had a very big post at the age of 26 with maybe over 100 persons reporting to me… and then I've been working very hard… waking up at 7 and till 11 until I really ruled the [field] and I ruled [that] community in Egypt"*. Her presence at work is also shown when she describes how she had her first child during her prime years at work, "*I've been having very very big responsibility... at 23 or 24 years old I had my kid…my first kid, and I was trained [abroad] with the baby"*. She goes on to explain the intensity and importance of her work as she says, *"you can't imagine responsibility for the largest [field of work] in the country, you can't imagine responsibility of 5 thousand employees, you can't responsibility of of being responsible of a [work place] that was number three or four and with me as a managing*

director it became number one in the country". Her success, as well as her reputation, is a key part of her identity, which is shown when she says, *"most of the industries and the factories that is there have passed through me... have passed... all these business men and all these names have passed through me... soo uh it is a big responsibility... my reputation"*. Her view of a working women changed after her heart attack. She attributes her heart attack to stress, and now believes that every woman with a high position at work should get regular medical check-ups, especially on their heart. This is highlighted when she says, *"women in institutions and with responsibilities must have a general check-up about their heart, not only about the blood pressure, heart heart uhh doctors must be there with women during their last years of their career... it's very important"*.

Like Diana, a big part of Nicky's identity is in relation to her work. As mentioned in the subtheme above*, 4.4.1 A Man's Role,* her job led her to embody a man in the way she dresses and even her physiology, "*I hold myself in a more of a masculine energy definitely at work uhumm and that was my comfort zone… right? Umm which I think led me to be able to work with these men for 20 years"*. This energy helped her succeed when working with men of great power, until it actually became her comfort zone. She has been working since the age of 12 as a way to gain independence from her living situation at home, *"I started working since I was 12… for money… I've always had a job since I was 12"*. Work has always been a need, whether to give her a sense of independence, or an actually financial need to support her family. She loves her job and her success, however the main reason for working this much is to provide for her family. This is captured as she says, *"I love the job itself but I don't love always doing it the way that I do it [I mean] to [I mean] to have an income [I mean] for me and the kids"*. Nicky also attributes her heart attack to pressure from work, which is captured a few times during the interview. She describes the nature of her work as she says, *"I had been traveling a lot uhh taking a lot of planes and I was exhausted and I came home after standing for a few*

days uhh in uhh stressful training". After she experienced a heart attack she quickly disregarded it, as she needed to get up the next day to finish her project at work. This is shown when she says, *"then I went to sleep [she laughs] and woke up and went to work the next day"*, and again when she says, *"I needed to get up and go to work the next day and I don't think that I wanted to… I never thought that it was a heart attack… I didn't not believe".* As discussed in the themes above, Nicky is used to pushing herself, and for this reason she chooses to dismiss her pain because work comes first.

Jasmine's passion and love for her work is shown in her descriptions as she says, "*I adore, I adore working, I adore my job, and I adore my office, I adore the people that work there with me".* She deals with all kinds of people at work, and has created a family-like atmosphere for her employees, "*we love each other as a family, I love my work, I was always the the first one at school, uhh in my class, and I was the best one in mathematics, I love mathematics, and my job is all about numbers, so I love it because numbers are the real uhhh letters, numbers never lie, number never lie".* Jasmine expresses a sense of security when working with numbers, since numbers never lie, which adds to her commitment and love for her job. She also discusses the empire she built at work and the success she has had as she says, *"I am the one who established it, I started with 2 person only, now I have I have more than 400 employees",* and again when she says, *"I can't leave work, not for any reason but uhh because of my success".* These expressions highlight Jasmine's importance within the institution she works in. Like Diana and Nicky, Jasmine attributes her heart attack to pressure and stress from work as she explicitly says, *"it was a big hit in my work you know because now I have to shift all my plans and all my financial plans to dollars so we got back again to the wheel and work like hell again so I got another heart attack".*

Jane is put in a situation where her work became the centre of her life. She has to work and make a living and provide for her family. Her husband's failure at work led to her taking

on this role. This is captured a few times during the interview when she says, *"I think [that circumstances have put me in] uhh a situation that work becomes the centre of my life"*, she needs to be on top of things as she says, *"I need to be success, and I need to be on top of everything, and I need to earn more money".* She goes on to explain how her work became of prime importance, by relating it to her husband's lack of work, *"that hiccup [which happened to [my husband] at work, gave importance to my work, because] to be able to cater and stand for the family, [that I spend and do things and so on… it gave it a different importance, I mean] suddenly, [instead of it being just important], it became very important".* Jane explicitly relates her heart attack to the stress and pressure she has from work. This is highlighted when she says, *"I was very stressed at that time [and] very concerned about being successful in that place... I was like [that] I am under testing… [so] I was completely uhhh overstressed [not normally] stressed, overstressed".* On a general note, her work effected all of her health issues as she says, *"I believe that my work impacted my life very big [in a] very very umm very harmful [way, on my health… all my health issues came from] work pressure… I totally believe that".* Regardless of the troubles caused by her work, Jane always put on a strong front in front of her colleagues. She did everything in her power to cover up her illness in attempts to cover up any weaknesses. She felt very strongly about this as she says, *"[I didn't tell anyone at work at all], again [because like I'm telling you, work was a problem… I didn't want them to know that I got sick], that I'm weak and [couldn't do the work they gave me]",* and again when she says, *"[because I was scared that they would find out 'oh she got sick! That's it! We can't depend on her at work again'… how can this happen to me?] No, I am bigger than this".* Her image and reputation are of great importance to her as she says, *"it's important to me, it's important to maintain [my] image, [and that I am capable of going everything] … I am capable of doing everything, so don't don't ever take me out of your [equation]".* She pushes herself to the maximum and wants her colleagues to always consider her and completely depend on her as

she says, *"so I wanted to be up to their uhh expectations all the time, [without saying no, without getting tired, without you understand?… without] excuses".*

Farah worked from a very young age and that set her pace in life. This is shown when she explicitly says, *"I worked very young, I started working when I was 17".* She describes her simplicity in her looks as a result of her work as she says, *"I don't put make up uhh because maaaa I don't put make up I never got used to it because I was always I working women… I used to wake up, [I just] take a shower and go down".* Work continued to be a vital part of Farah's life, especially after she became a mother as she says, *"I had to work very very very very hard for [my daughter] so she doesn't feel less than anyone".* Since work was a priority in Farah's life, it took her away from being fully present during her daughters childhood, *"I was around physically as a mother but and I saw her grow up but uuh I was all the time working".* For this reason, Farah decided to stop working once her daughter got married and was financially independent of her. This is captured when she says, *"I had to work… [so] now when I had the choice not to work financially then I stopped… I said enough is enough… I did enough I have worked for uhhh zillion years now I don't want to… even is my standard of living isn't the same [you know] because you don't have a steady income I didn't care I said no [that's it]… I'm going to enjoy life".* This quote also showed how work took her away from enjoying life, not only her daughter, and now that it is not of vital importance anymore, she decided to quit.

After Mary lost her husband she was put in a situation where she had to learn how to keep her husband's assets working in a way to maintain a regular source of income for her family. This is highlighted when she says, *"[first of all there is no income, I don't work… he left things that I needed to run… I needed to find tenants for two apartments and I had no idea about any of that]".* It was the first time she ever had to work as she describes, *"[I got married and I had kids and so on, so I didn't work]*". For Mary, work was never a part of her identity

like the rest of the women, it is something she had to do at some point in her life to keep the family afloat.

Work proved to be an essential, if not the most essential, aspect of these women's lives. Most of the women's identity is in relation to their work, namely Jasmin, Diana, Nicky, and Jane. Work provides them with a sense of purpose and also the financial security that helps them maintain a comfortable life for their family. In most cases, work results in more pressure, which has been directly associated with their heart attack.

4.5 Being-with-Anxiety

All Beings are inevitably with-anxiety. Moreover, as one is faced with their death, anxiety surfaces. Heidegger (2012) describes anxiety in relation to death as one that is the utmost potentiality-of-being:

> *"Thrownness into death reveals itself to Dasein in a more primordially and impressive manner in that state-of-mind which we have called 'anxiety'. Anxiety in the face of death is anxiety 'in the face of' that potentiality-of-Being which is one's ownmost, non-relational, and not to be outstripped" (p.295)*

Anxiety is the state that appears in response to one's fear of death. However, the women interviewed also express their anxiety before their 'throwness into death', that being their heart attack. All the women interviewed spoke about anxiety, some using other words such as 'pressure' and/or 'stress' to describe a state of unease. They go on to express their anxiety in different aspects of their life.

4.5.1 Confronting Anxiety

Anxiety is prevalent in all of the women's stories. Even though, they do not use the word anxiety itself, there is a sense of embodied anxiety in their being-in-the-world. In their

narratives they use words such as stress, pressure, emotional turmoil, to encompass their anxiety. As discussed in the subtheme, *4.1.2 Meaning: Anxiety & Heart Attack,* six of the women attribute their heart attack to anxiety caused by external factors. However, their experience of anxiety goes beyond just the heart attack. Anxiety is part of their life story with all the losses, heart breaks, and responsibilities. Three of the women experience anxiety in relation to their work; three of them experience it in relation to their marriages; and three women describe anxiety as part of their life challenges. Four out of the seven women, Nicky, Mary, Jasmine, and Sarah, describe an embodied anxiety, specifying their bodily sensations.

Nicky describes how she has always been anxious, and her automatic response is to just push it aside, get up and keep going. This is shown as she says, *"I'm used to being tired I am used to being in pain I am used to getting anxiety… I am used to feeling it in my chest"*. She describes how she always felt her anxiety in her chest, it is her weakest point in her body, "*I thought if there is a weak area it's my chest"*. She goes into more detail by saying, *"I would feel my chest always constrict when I feel bad or when things are stressed or uuhh [so] it's not a new feeling right I actually feel pain in my chest like physical pain in my chest"*. This chest pain was also experienced during her heart attack, though with a different intensity to it as mentioned in the subtheme, *4.1.1 Embodiment of Heart Attack*. Her familiarity with this embodied anxiety has always been met with a sense of dismissal as she says, "*I am used to just getting up and going"* and again when she says*, "this automatic default where I shut I just shut off and keep going"*.

Jasmine's experience of anxiety is mainly in relation to her marriages and work. She uses the words 'stress' and 'pressure' to denote her anxiety. She mentions how she can withstand a lot of pressure as she explicitly says, *"I can endure a lot of pressure"*, which is why it shook her to realize that her husband has managed to break this endurance. This is shown as she says, *"it was too hectic at work to, but working being too pressured at work it never*

never never got me down because I love work you know but to get pressure from your husband that you are really so good with for 7 years you never did anything bad […]so I started to feel the pain". As mentioned above, Jasmine associates her heart attack with the accumulated pressure caused by her marriage and work.

Jane's experience of anxiety is also related to work and family pressures, *"I was very stressed at that time [and] very concerned about being successful in that place... I was like [that] I am under testing… [so] I was completely uhhh overstressed [not] stressed [normally], overstressed"*. She has to work hard to maintain a certain standard of living for her children, and this is the source of her anxiety. Like Jasmine, she also attributes her heart attack and health concerns to her stress from work, "[*all my health issues came from) work pressure… I totally believe that"*. She describes her short temper with her children as a result of her work stress; there was no room for her to deal with anything at home because work took up all her energy. This is shown as she says, *"[I mean I came home completely drained and I wanted everything to be over and done with quickly]".*

Mary's anxiety is expressed throughout all her life story. She was hit by many losses as mentioned in the themes above, all of which left her alone to fend for her children and herself. Mary does not describe her anxiety explicitly, but rather describes an existential anxiety throughout her life as she says, *"(I've had enough!... too many hits… I mean, a very tough life)"*, and again when she says, *"(all the) pain (and the emotional suffering I went through)"*. Even the embodiment of her heart attack portrays her being-toward-death, *"I wanted to breathe... (you know when you feel that I want, that I want to live [took a deep breath] I want) oxygen"*. While this description is one of a physiological heart attack, the words she uses can be seen as a form of anxiety as well.

Farah vaguely speaks about her anxiety. Even though she describes a challenging life, one with losses and struggles, her tone does not correlate with the intensity of her life events.

She tends to just walk away from any stressor in her life, as she says, *"if somebody stresses me I walk, [I mean] I walk away [you know] I will see you another day [that's it]"*. However, unlike all others, Farah mentions her experience of being claustrophobic, which can be considered a form of anxiety. It is unclear to her what might have triggered such a fear, and she does not attempt to describe the experience in much detail, however she does mention its intensity. She could not ride elevators, or planes, and linked her experience in the ICU with being claustrophobic, as she says, "*it was my first time ever in a hospital let alone let alone intense care [and then] the place was [tight] and I am claustrophobic [you know]"*. The intensity of her experience is also portrayed as she says, "*I couldn't take elevators… [I mean] I have a friend she lives on the 9th floor I used to go once a week and climb 9 floors"*. Can her tendency to walk away from stress be reallocated and expressed through in her claustrophobia?

Sarah's anxiety is translated into emotional pain and stress. Like Mary, there is a sadness to her story which is caused by her husband's indiscretions and their dynamic thereafter. This sadness has put a big strain on her emotional wellbeing, *"[I was very very deeply hurt]", "[everything in my life causes me pain]"*. As mentioned above, Sarah attributes her experience of anxiety to her heart attack as she says, *"[it's quite possible that to begin with I fell ill due to my emotional state]"*. She describes her emotional state by saying, *"[I swear I started hating even the air that I breathe… I didn't want to breathe, I saw nothing but darkness darkness extreme darkness in my life]".* There is also an expression of anxiety in her description of her heart attack as she says, *"[I would feel terrible pain… as if I were suffocating]"*. Her emotional pain can be considered an expression of existential anxiety. Her being-in-the-world seems to be governed by her emotional pain.

Anxiety, being inevitable, is shown in all the women's stories in different forms, and proves to be the centre point of all their troubles. It sets a direction and pace to their life, from the working and/or single mother who has to attain certain targets to support her family, to the

one who is hit hard by many life events. Though the word anxiety was not used by all the women, their description of their stress, pressure, and emotional pain are all reflections of their experience of anxiety.

The following section will bring all these themes together with the literature review, and discuss how it adds to this phenomenon.

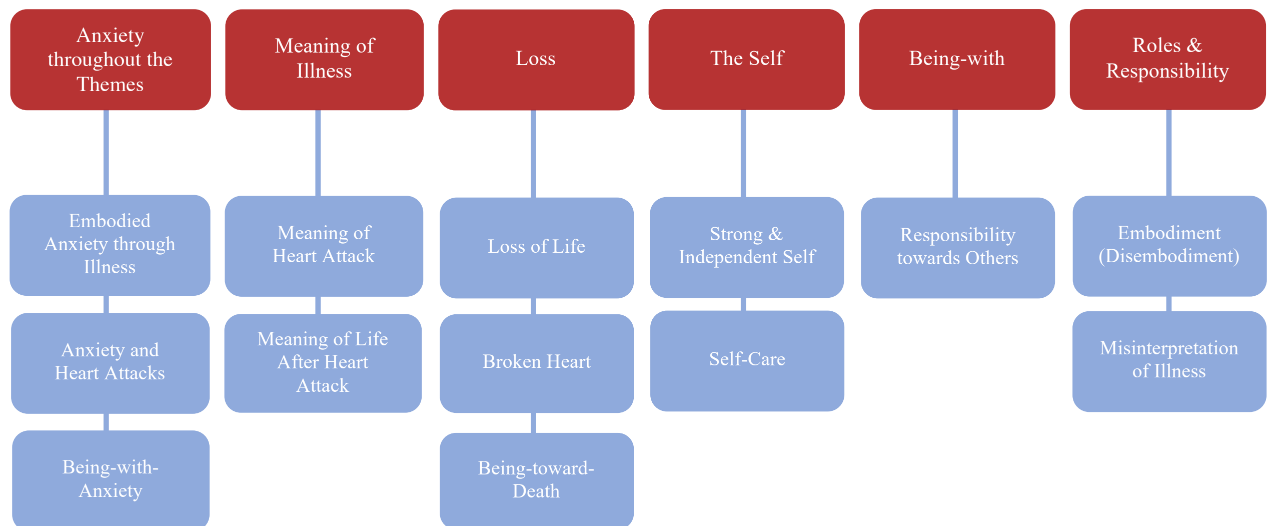
5. Discussion

This chapter will discuss the findings of this research in relation to the literature reviewed above. The aim of this research to is to explore the lived experience of women who suffered from a heart attack. The findings show that the experience of a heart attack is not limited to a medical concern, but is also one that reflects the women's lived experience. Five main themes were put forth, most of which overlap with aspects of the existing literature, while also adding an existential perspective.

The pre-existing literature presents a variety of themes relating to the experience of women who have suffered a heart attack. The literature reviewed covers a wider scope exploring the experience of all cardiovascular diseases, as studies specific to heart attacks and women are limited. Physical illness, in general, is being explored from a more holistic perspective rather than a purely scientific one. Understanding the meaning behind illness, is an ongoing quest with a growing curiosity in many research fields. More specifically to this research, heart attacks and women are of prime interest as it presents itself in a different picture to what is more commonly known and understood, the man's heart attack (BHF Press Office, 2016).

The literature shows how this phenomenon has many avenues that are yet to be explored, not only from a medical and biological perspective, but also from a psychological, more holistic and experiential one. From a holistic view, the experience of women draws on many existential considerations. How the women relate to themselves, their world, life events, and health concerns were reflected throughout the interviews and the analysis. The research findings gave importance to the women's embodiment of their heart attack while also reflecting on their life story.

The findings and literature come together below and are discussed in relation to each other. When looked at together, six themes come up: Anxiety Throughout the Themes, Meaning of Illness, Loss, The Self, Being-with, and Relationship to the Body. The diagram below maps out the outcomes of the discussion.



5.1 Anxiety Throughout the Themes

"Anxiety strikes us at the very 'core' of ourselves: it is what we feel when our existence as selves is threatened."

(May, 2009, p.23)

Anxiety presents itself throughout all the themes. Some women use the words stress or pressure interchangeably to encompass their experience of anxiety. However, regardless of the word used, anxiety proves to be a vital phenomenon in all of the women's lived experience. Anxiety was also a key notion in most of the literature reviewed, whether specific to heart attacks or on a more general note, cardiovascular diseases (Affleck et al., 1987; Allison and Campbell, 2009; Andersson et al., 2013; Sjostrom-Strand et al., 2011; Hasankhani et al., 2014;

Alhurani et al., 2015; Simony et al., 2015; Seah et al., 2016; Vongmany et al., 2016; Aggelopoulou et al, 2017; Greenman et al., 2018; Hanna et al., 2019; Jones et al, 2019; Musey Jr. et al., 2019; Rechenberg et al., 2020). The following sections will take a closer look at the phenomenon of anxiety within the findings in comparison to the reviewed literature.

5.1.1 Embodied Anxiety through Illness

May (2015) relates a physical symptom to anxiety as he says, a "symptom is bound anxiety, or, in other words, anxiety which has been crystallized into an ulcer or heart palpitations or some other symptom" (p.85). Anxiety takes many forms as it is the human being's basic reaction to any threat. In May's description, the form anxiety takes is that of a physical symptom such as heart palpitations.

This coincides with the research findings as many of the women directly relate their heart attack to their anxiety and stress. As mentioned in section *4.1.1 Embodiment of Heart Attack*, most of the women describe their embodiment of the heart attack through the symptoms experienced. With some being more descriptive than others, most of them experienced a tightness in their chest, difficulty to breath, and pain in their chest shooting up to their back, arm or neck. Chest pain and shortness of breath are the most common experiences among the women. Some expressed how the slightest movement or effort caused pain and the inability to continue what they were doing. All the women, with the exception of one, describes the intensity of their experience. There was a shared need of survival; they struggled to survive this threat they were facing, the heart attack. Both Jasmine and Mary use strong and descriptive words to describe their embodiment of every symptom experienced.

> *"It was such a pain in my chest and in my shoulder, and the worst thing is like you feel a rope is around your neck, somebody as if he is pulling out the rope from your neck and [that's it]*

your gonna die, it's like something getting tighter and tighter around your neck you can't even breathe" – Jasmine

"I wanted to breathe... [you know when you feel that I want, that I want to live [took a deep breath] I want] oxygen... [it's like I don't want surgery, nor do I feel pain on my heart, nor do I think about the] pain, I want to, [you know it's like you are underwater [she takes a deep breath] I want air] ... I need to breathe!" – Mary

Though none explicitly use the term anxiety in relation to their symptoms or their embodied experience of the heart attack as they did with the reason that lead to it, their descriptions portray and manifest a sense of anxiety.

From a medical stance, the symptoms reported by these women are supported by the WHO (World Health Organization, 2017), which goes to show that the medical field has begun to fill the gap they intended to in regards to diagnosing heart attacks in women successfully (BHF Press Office, 2016).

Anxiety can be seen as "a potential prognostic predictor" (Vongmany et al., 2016, p.478), and it can be argued that symptoms as well can be seen as such. Some of the literature highlighted the symptoms experienced by the participants, leading up to the heart attack or during the attack itself. The participants reported experiencing chest pains, shortness of breath, fatigue, back pain, indigestion (Sjöström-Stranda and Fridlund, 2008; Allison and Campbell, 2009; Sjostrom-Strand et al., 2011; Roncella et al., 2013; Madsen and Birkelund, 2016; Smeijers et al., 2016; Bowles et al., 2018; Gyberg et al., 2019; Jones et al., 2019). The symptoms mentioned were similar to those described in the findings above, and like Jasmine and Mary, some participants used metaphors in attempts to encapsulate the strength of their symptoms. In Madsen and Birkelund (2016), one of the participants expressed their pain by saying "I felt like I had 10 elephants jumping on my chest and my arms, pains down both of them" (p.602), others compared their experience to a coiled spring that became tighter with

time until it broke or exploded into a heart attack (Allison and Campbell, 2009). In Bowles et al.'s (2018) research, participants used the phrase "a drowning sensation" (p.65) to describe their experience, which is similar to Mary's experience.

The literature also shows how their symptoms caused anxiety, feeling of uncertainty and fear (Sjöström-Stranda and Fridlund, 2008; Gyberg et al., 2019). It was mentioned that "the anxiety provoked the pain, and the pain was perceived as severe when it was linked to anxiety" (Sjöström-Stranda and Fridlund, 2008, p.1006). Though pain and anxiety are spoken about separately, the experience of their symptoms seemed to denote embodied anxiety.

Although the women did not explicitly link their symptoms to anxiety, they did attribute their heart attack on a whole directly to stress, pressure, and/or anxiety. Considering May (2015) and Shapiro's (2012) explanation of the relational aspect of a symptom to anxiety, it can be suggested that these women's symptoms may be related to, or an expression of, their embodied anxiety. The following section will delve into the heart attack as a result of stress and anxiety.

5.1.2 Anxiety and Heart Attacks

> *"People get sick because they are down, people get sick because they are depressed they are stressed" – Jasmine*

Section *4.1.2 Meaning: Anxiety & Heart Attacks* in the findings expresses the women's idea of what their heart attack meant and its relationship to their life. There is a consensus that their personal stress, pressure from work, and responsibilities led to a build-up, that expressed itself as a heart attack. Most of the women discuss the responsibilities that come with their positions at work and roles in the family, all of which add on to their anxiety, or what they refer to as stress and pressure. Others generalize their anxiety as a result of the life they have lived. Below are examples of women attributing their heart attack to anxiety:

"I believe that my work impacted my life very big [in a] very very umm very harmful [way, on my health… all my health issues came from] work pressure… I totally believe that" – Jane

"[An accumulation… the] heart attack [was an accumulation, I mean, that's it, I've had enough!... too many hits… I mean, a very tough life]" – Mary

If we were to relate these women's perception of their heart attack to the section above, this build up can be considered an accumulation of embodied anxiety. Embodied anxiety that can be associated with their heart attack. There is a sense of ownership in these women's attributions; it is their responsibilities and pressures that led to this. Even though it can also be seen as an outward blame to external circumstances, throughout the interviews they own their roles at work and within their family. It is interesting to note that only one participant mentioned a family history of heart illness, while none of the rest mention genetics as a reason.

This explanation goes hand in hand with Charon (2006) and Frank's (2013) approach to physical illness. They propose that our body is our blueprint. Therefore, illness being expressed through the body, can be considered an expression of our life. This can be confirmed through Mary and Diana's perception. Furthermore, more specifically to these women, their life story is accompanied by anxiety and pressure.

Three studies indicated that anxiety and stress led to their heart attack (Affleck et al., 1987; Allison and Campbell, 2009; Jones et al, 2019), in specificspecifically stress from work. Allison and Campbell (2009) found that stress was rarely expressed by their participants before their heart attack. Nonetheless it was amplified, eventually manifesting itself into symptoms. Jones et al.'s (2019) research was specific to women, and added their family responsibilities to their stressors. This research paper specifically mentioned that genetic factors, along with stress and responsibilities, led to the women's heart attack. It is interesting to realize that only one

woman in this current research spoke about her family's cardiac history, and none of the rest mentioned genetics.

Lowen (2013) and Neill (1987) describe a person who would experience a heart attack as one who is extremely tense, striving, with a sense of responsibility and hurriedness. Even though, they take on a very categorical stance, and seem to put these 'kind' of people in a box labelled Type A, the findings relate to their descriptions on some level. These women mentioned responsibility, tension, as well as an aspect of striving, as part of their lived experience.

Another three studies bring together anxiety and cardiovascular diseases (Alhurani et al., 2015; Vongmany et al.,2016; Rechenberg et al., 2020). Rechenberg et al. (2020) concludes that anxiety is related to our "pathophysiologic mechanisms" that can facilitate illness (p.358). Without going into much detail, Alhurani et al. (2015) and Vongmany et al. (2016) both showed a correlation between anxiety and rehospitalisation or mortality rates. It can be elicited from these results that anxiety can led to disease, as portrayed in the findings.

5.1.3 Being-with-anxiety

> *"I'm used to being tired I am used to being in pain I am used to getting anxiety […] this automatic default where I shut I just shut off and keep going" – Nicky*

Some of the women describe the tendency to push through, or push aside their anxiety in order to keep going. There is a sense of urgency and a fast paced life, with no time to sit with or deal with their anxiety. This is captured in different situations, with a consensus that anxiety is not dealt with.

> *"[I'm upset that I used to lose my temper at them, I'm upset that I didn't give them time, that I didn't have patience for them, I mean I came home completely drained and I wanted everything to be over and done with quickly]" – Jane*

Here Jane describes how she deals, or does not deal, with the anxiety and pressure she gets from work. Farah also summarizes her tendency to just walk away from stress.

> *"If somebody stresses me I walk, (I mean) I walk away (you know) I will see you another day (that's it)" – Farah*

Can this be considered a form of suppression? This phenomenon was not reflected across all women in this research, however in the reviewed literature, anxiety as a constant companion surfaced in a few studies (Allison and Campbell, 2009; Andersson et al., 2013; Sjostrom-Strand et al., 2011; Simony et al., 2017; Hanna et al., 2019). The anxiety described in these studies were ones that magnified their fear of a reoccurrence after the heart attack. Though both the literature and findings bring up anxiety as a constant, the findings portray anxiety before the heart attack, whereas the literature was focused on after. In fact, the findings did not bring up the same intensity of anxiety after their heart attack; however, the findings portray a shift in the essence of their anxiety, as women's start to take care of themselves. Only one study highlighted anxiety before their heart attack (Allison and Campbell, 2009), also expressing disappointment and anger towards their lives beforehand, mainly in relation to work.

The literature added another dimension to the experience of anxiety in heart attack survivors, namely how therapy helps the participants deal with their anxiety (Gruen, 1975; Roncella et al., 2013; Hasankhani et at., 2014). The research is in consensus that therapy helps participants move forward with their lives, improve their quality of life, and understand their anxieties and challenges. The research goes further by suggesting that when anxiety is 'dealt' with, their quality of life improves and in turn their treatment and health is enhanced (Joekes et al., 2007; Rechenberg et al., 2020). This conclusion was also shown in studies related to other cardiovascular diseases (Simony et al., 2015; Aggelopoulou et al, 2017; Greenman et al., 2018; Musey Jr. et al., 2019).

Even though this phenomenon was briefly touched on by a few women in the findings, it could have been interesting to explore such an experience in all the women's story to see its relevance. How do these women relate to and process their anxiety? What rhythm has anxiety taken in their life?

5.2 Meaning of Illness

A shift in the understanding of illness, from a purely medical stance to a more holistic view, was shown in the reviewed literature. "Illness cannot be grasped in separation from the lived experience of the person who suffers it" (Aho, 2018, p.198). It is to be understood in the context of one's lived experience, as Leder (1998) argues that the body's physiology is always intertwined with the body's intentionality. Shapiro (2012) supports this idea, however without linking it to existential thought. She writes how symptoms are considered messages from the body, telling us what is 'wrong' in our way of living. She explores how each syndrome is symbolic to a certain phenomenon in our lives.

The women in this current research express the meaning of the heart attack in their life, and the meaning of their life after the heart attack. The following section will discuss both phenomena in relation to the review literature.

5.2.1 Meaning of Heart Attack

Shapiro (2012) writes, "a heart attack implies that the heart is being 'attacked' by a build-up of unexpressed hurt, loss, grief, or resistance to love" (p.225). Even though her writing may imply a causational effect, she opens a space for exploring the experiential aspect of a physical ailment or illness.

The findings show a strong association between the build-up of anxiety, or pressure, in the participant's lives, and their experience of a heart attack. The women link their anxiety,

that is a result of their life pressures and responsibilities, to their heart attack. In four of the women's stories, the heart attack left a mark and actually meant something in their lives. It was described as a wakeup call, or a second chance at life, where it is time to finally take care of themselves. Both Jasmine and Diana describe the meaning of their heart attack as they say:

> *"I was so pressured that I felt the heart attack was the saver from God, God saved me with the heart attack, it was a wake-up call" – Jasmine*

> "*It's a man... it's a hard man... but with me he was a very kind man... he just shook me up but he stood beside me and uhhh I was there, the next morning I was there" – Diana*

Only one of the studies reviewed showed the meaning of a heart attack. Similar to the findings it was also seen as a wakeup call or more specifically a "warning that made them aware of the very thin line between life and death" (Andersson et al., 2013, p.767). This description adds to the realization of one's death, which was not touched on by the participants in the current research. This description touches on the notion of being-toward-death, a concept which seems fit to be considered in the phenomenon of the heart attack. From a philosophical stand point, Nietzsche and Heidegger both wrote about the meaning of illness. Nietzsche saw illness as a possibility for one to connect with themselves (Nietzsche, 2006; Sedgwick, 2013). Contradictory to Nietzsche, Heidegger thought of illness as something foreign that penetrates Dasein, hinders any possibility, and enables inauthentic living (Heidegger, 2012; Svenaeus, 2011).

The anxiety discussed earlier can be seen as either (1) Nietzsche's idea of a possibility, or (2) Heidegger's view of a foreign 'object', that ruins authenticity. In relation to the findings, the women who saw this experience as a wakeup call have taken this 'possibility' to better their life in a way or the other, which will be discussed below in *5.4.2 Self-Care*. However, even

though this would be a very forceful argument, the notion of inauthentic living can be explored in terms of these women's lives before the heart attack. All these women struggle with living for the other and not taking care of themselves, which could indicate an inauthentic way of living.

When the meaning of the heart attack is explored a step further, the findings, in fact, show themes of loss and struggles with love, namely broken heart, as mentioned in Shapiro's (2012) description of what a heart attack might symbolize. However, these themes will be explored in later sections, as their strength and intensity in the women's stories needed to be acknowledged separately, not as part of another theme.

5.2.2 Meaning of Life After Heart Attack

Theoretically after an event such as a heart attack, one's view of life is likely to change. In the subtheme *4.1.3 Reaction to Heart Attack,* the findings explore the women's meaning of life after the heart attack through their reaction thereafter. Some of the women showed a shift in their priorities. There is a general attempt from most women, though with different intensities, to push all their burdens aside and look at their wellbeing after their heart attack. They understood the importance of their self-care; in order to continue living and caring for others, they must first care for themselves. Some showed more success than others, however they all voiced this understanding. Life became more valuable, mainly because if they fall ill again, they will not be able to take care of their children. The position of the children in their lives awoke the importance of their own lives after their attack.

> *"Now I am second on the list… I wasn't even on the list to be honest yeah… [so] now I I'm aware that I'll give but not [to the detriment of] either my children or myself now…. But there was no myself before" – Nicky*

The reviewed literature depicted the theme 'life will never be the same again' throughout a few studies (Sjostrom-Strand et al., 2011; Andersson et al., 2013; Simony et al., 2017; Jones et al., 2019). Andersson et al. (2013) showed how participants started to value quality time with their family, instead of investing in materialistic things in life. Like the findings, this article stresses on the importance of family. Sjostrom-Strand et al. (2011) and Simony et al. (2017) both depicted the experiences of being weak after the heart attack and with that came social challenges and limitations. Life became challenging and it was difficult for the participants to move forward. Janssen-Niemeijer et al. (2017) explored lifestyle change in cardiovascular patients, and found an importance in the notion of connectedness with others. Participants expressed the importance of support in order to help them get better, and with that they had the space to find meaning and purpose in their illness.

The findings and the literature both add a different perspective to the meaning of life after the heart attack. The literature was more focused on the effect of their limitations and weakness that made life challenging. One article brings the notion of connectedness into play, suggesting the importance of family support when trying to 'getting better' (Janssen-Niemeijer et al., 2017). This overlaps with the findings to a small degree, seeing that the findings focused on the self-care, in other words 'getting better'. However, the findings show the importance of getting better for their family, not due to family support. The value of the family and their support will be discussed further in the section *5.5 Being-with* below.

5.3 Loss

The first visible sign of loss in relation to this phenomenon is that it is, in fact, the most common cause of death globally (World Health Organization, 2018). Ironically, those who die from it do not experience the effect of loss, like those around them. However, they have lost

life. Those who survive it, are awakened by this sudden possibility of loss of life. This theme presented itself in different ways in the findings, as well as the reviewed literature.

5.3.1 Loss of Life

The notion of loss is prevalent throughout all of the women's stories. They speak about the loss of their loved ones, other family members, and even the loss of their sense of self, all of which created a toll on their life story. This was shown in Diana's quote:

> "*I forgot about myself and that's very important you have to really [I mean], I in business trips in business trips... I didn't put a day extra where I can enjoy a movie or something" – Diana*

Their losses shifted their being-in-the-world, and left them with the need to 'fend' for themselves in a way. Those who lost love, seeked care and tenderness elsewhere, those who lost marriages, needed to work hard to fulfil a certain living, and so on. For example, when Mary said:

> *"[I mean] already I was heartbroken with my brother [and every time I keep trying to find a replacement for this tenderness]" – Mary*

The literature reviewed also showed the notion of loss with those who experienced a heart attack, as well as other cardiovascular diseases (Sjostrom-Strand et al., 2011; Hasankhani et at., 2014; Seah et al., 2016; Simony et al., 2017; Walsh et al., 2018). Sjostrom-Strand et al. (2011) and Simony et al. (2017) reported loss in relation to the participant's physical abilities. The heart attack caused physical limitations that resulted in the inability to carry out their usual routines. Hasankhani et at. (2014) depicted a physical loss in their themes, as well as an emotional loss. These new physical limitations effected the participant's self confidence, which they experienced as an emotional loss. A loss of control over their lives was expressed in Walsh et al. (2018), where participants mourned the loss of their independence and confidence.

Differently to the findings, the literature spoke about losses as a result of the heart attack. They identified physical and emotional losses that were considered ramifications of the heart attack. Whereas the findings show the phenomena of loss before the heart attack, who and what they lost throughout their life and how it impacted them. Losses specifically related to love will be discussed in the following section.

5.3.2 Broken Heart

"The heart attack, and I believe in it very much… [when he says] heartbroken, really the heart [becomes] broken… [it becomes] broken for real" – Mary

The findings highlight a specific kind of loss that was experienced by almost all the women, that of love. It was metaphorically spoken about in relation to the heart attack; that the heart was physically broken after they were 'emotional' heart broken. While split in their description, the women attempt to bring both aspects together into an embodied experience. Their heart break created a strain on their embodied self, and since it was never catered to or dealt with, it caused a void. This void is attributed to the physical 'breaking' of the heart, the heart attack. Jane describes this experience vividly as she says:

"[It's causing me] emotional voidness [in a certain area… sometimes… I feel] emotional, [you need someone to give you a pat on the back, you understand]" – Jane

The findings show a glimpse of Lowen (2013) and Shapiro's (2012) ideas, that a heart attack is most likely an expression of loss, grief, and love. Though none of the reviewed literature explicitly talks about heart break, Chandan et al. (2020) explores cardiovascular diseases in relation to domestically abused women and their psychological stressors. The correlation suggested by the study gives room for exploring the relationship between domestically abused women and heart break. Can domestic abuse be an experience of loss of love?

5.3.3 Being-toward-Death

As mentioned above, the findings reflect how a few women took this experience as a wake-up call or second chance at life. They were faced with the possibility of death, and each woman reacted in a different way. The theme death is not prevalent in the findings, like the literature might have suggested. Only three of the women describe their heart attack as a near death experience. An example would be:

"*Somebody as if he is pulling out the rope from your neck and [that's it] your gonna die" – Jasmine*

The other two women don't explicitly use the word 'die' or 'death' in their descriptions, but use other words that prompt their being-towards-death are used, as mentioned in the subtheme *4.1.1 Experience of Heart Attack*. The other times death comes up for these women is in relation to their loved ones, as discussed above. However, two of the women briefly mention an element of being-toward-death in their stories. Jasmine, when she declares how she now chooses to live her life happily without all the burdens she used to carry, making death a welcomed phenomenon. Jane highlights the importance of her children in her being-toward-death, without their presence she does not 'mind' death; she is living solely for them.

"Without them I can easily die, [I mean, if I don't have my children, maybe tomorrow morning, I wouldn't want to go on, I mean]" – Jane

Yalom (1980) writes that "death is a primordial source of anxiety and, as such, is the primary fount of psychopathology" (p. 29). He goes on to explain how life and death are interdependent and that being alive means death is inevitable. He writes that death "whirs continuously beneath the membrane of life" (p.29), bringing about death anxiety. In the case

of a heart attack, death no longer whirs but is directly confronted, making the idea of death ironically more alive.

The literature reviewed portrayed this phenomenon in two articles. Participants in both studies expressed the fragility of life, that at any sudden point, life can hit them again with a heart attack, or even death (Andersson et al., 2013; Simony et al., 2017). Andersson et al. (2013) depicted the theme 'an unreliable body and mind' that was triggered by their heart attack. This theme describes the participant's lack of trust in their body, experiencing it as weak and unfamiliar, which was also expressed by one of the women in the findings, Jasmine. The theme 'understanding that life has become frail' was portrayed in Simony et al. (2017); the participants "realised that they were also suffering from a chronic and potentially fatal condition" (p.235). They were faced with their death at the time of the heart attack, and were left with this experience thereafter. These findings can be considered an expression on their being-toward-death in relation to their heart attack. They are suddenly faced with the reality of their mortality, which brings forward death anxiety.

5.4 The Self

This section discusses the participant's definition of themselves as well as their understanding and meaning of self-care. The findings and literature add a certain importance to how these participants view themselves. There is a general strength shown in their character, that is also reflected in other sections; their being-with-others, their presence at work, their experience of anxiety, all portray a strength and resilience. With this persona comes a challenge with self-care, that is confronted by the heart attack.

5.4.1 Strong & Independent Self

Most of the findings portray strong, resilient, and independent women. They all work hard for their family and believe they can endure anything that comes their way. There is a general description of independence. These women do not need anyone to take care of them or provide for them, in fact they are the providers. There was only one woman in the findings, who can be seen as resilient, but does not identify herself as strong and independent. Both Nicky and Diana sum up most of the other findings as they say:

"*I was more able to handle sticky situations emotional situations desperate situations than most of the others around me… umm I felt I was stronger" – Nicky*

"*I am a success freak, I love success, I love to be there in in all the [big stories] in the country, and I was everywhere" – Diana*

The literature proposes a personality profile, Type A personality, describing those who are susceptible to having a heart attack (Neill, 1987; Lowen, 2013). Neill (1987) describes this person to be competitiveness, assertive, striving, and has a sense of responsibility. Lowen (2013) goes on to analyse how this 'type' of person will probably have low self-esteem, which is compensated by overachieving. Even though their description is one that is very categorical, they describe some of the women in the findings. The element of achieving, striving, and sense of responsibility are all similar qualities to the women. Allison and Campbell (2009) explore the lived experience of men who experienced a heart attack and found two themes relevant to the self: keeping up appearances and invincibility (p.119). The men portrayed a need to appear strong in front of others, and not show any hint of weakness, which is similar to Jane's experience mentioned in the section below, *5.5 Being-with*. This strength is a characteristic but also a desire and need, which brings invincibility into play. These men believed that nothing could hit them, they are strong and resilient.

Even though only one study showed the participants strength directly, this quality can be seen through the literature in other themes. For example, the research that portrays the tendency to self-medicate can insinuate a sense of independence (Arslanian-Engoren and Scott, 2017; Jones et al., 2019). The research together with the findings show a vast opening in exploring the personal dimension of a woman who suffered from a heart attack.

5.4.2 Self-Care

The phenomenon of self-care is more apparent in the findings than in the literature reviewed. The women describe a lack of self-care that was challenged by their heart attack. Even though, not all of the women abided by this 'wake-up' call, they all admitted to its importance. There is an element of sacrifice and putting other's needs before their own, as shown in Sarah's quote:

> *"[I have really scarified a lot for their sake… I mean I have deprived myself from everything that I loved, in order to make them happy]" - Sarah*

They all understood that it is important to take care of themselves, however the meaning of self-care differed from one woman to the other. Some women understood that taking care of themselves will allow them to be able to take care of their family, others realized that it is time to prioritize themselves over others. Self-care took different forms, from giving themselves the time to indulge in movies or religious practices, to making an entire lifestyle change that caters to their health situation.

Again these qualities resemble that of the Type A personality (Lowen 2013; Neill, 1987), one who is always striving and prioritizing others needs before their own. The lack of self-esteem that leads to overachieving, as suggested by the literature, can be seen in relation to the sense of self-sacrifice portrayed in the findings. The literature reviewed also showed the notion of self-care in participants who experienced a heart attack (Isaksson at al., 2013;

Arslanian-Engoren and Scott, 2017; Hanna et al., 2019). Women interviewed by Isaksson at al. (2013) and Arslanian-Engoren and Scott (2017) portrayed their lack of self-care through not wanting to burden their family members. Hanna et al. (2019) explored the motivators that would allow the participants to take care of themselves and found that, like some of the findings, their family was considered a motivator for them to adhere to their treatment. Two of the three articles reviewed were specific to women (Isaksson at al., 2013; Arslanian-Engoren and Scott, 2017), which warrants us to question this phenomenon specifically in relation to women.

5.5 Being-with

The notion of being-with presents itself in a few themes, especially in *4.4.2 Being-a-mother* and *4.4.3 Being-at-work*. The women mainly discuss their roles within their family and at work throughout the interviews. Work proved to be a vital part of their life, most of them strived to achieve high positions at work. They portrayed strength and resilience towards their colleagues and bosses:

> *"[I was scared that they would find out 'oh she got sick! That's it! We can't depend on her at work again'… how can this happen to me?] No, I am bigger than this" – Jane*

With this resilience comes their Being-a-mother. Most of them are single mothers or are the sole financial providers for their family. That strength at work can be considered a reflection of their life at home. Not only do they want to build their career, but now they need to. As mothers they all discuss how they would do anything for their children, as they are their only real love. They live for their children, love and are loved by them. It can be considered that their sense of purpose revolves around their motherhood. This was captured as Farah says:

> *"Real love is only children… okay, [I mean, you will receive] real love from your child and you will give the real love to your child" – Farah*

According to van Deurzen (2011) “our map of the world of other people is drawn up from the sort of relationships we establish” (p.155) and this becomes a blueprint. Therefore, for these women, their losses and family dynamics have created their blueprint, which reinforces a being-strong, independent, and resilient nature.

The literature reviewed showed their connectedness with their family from a different light. The findings highlighted the importance of the women’s support towards their family, whereas the literature explored the importance of family support towards the participants (Janssen-Niemeijer et al., 2017; Bowles et al., 2018; Hanna et al., 2019; Jones et al., 2019). Family support gave the participants direction and purpose. Jones et al. (2019) and Bowles et al. (2018) focused on women, and both studies implied that women attempted to withstand their pains, on their own, until it was too much for them to handle. This shows their tendency to be independent and strong, like the findings suggested. Some literature also showed the participants prioritizing their family’s needs over their own (Isaksson at al., 2013; Arslanian-Engoren and Scott, 2017). These studies were specific to women, which is important to point out as it can be a gender-related concern.

5.5.1 Responsibility towards others

> *“I am a woman, in the Egyptian uhh society that uhh we are raised up that men should work and the women should have good time…I was the man all the time since even my mother, I was the one responsible, since 12 years old, till now, taking care of everybody and working and bringing money and everything” - Jasmine*

The findings show that being a strong woman, in what is considered to be a man’s world, has been an ongoing challenge. In some cases, they found themselves embodying the father’s role in the family as well as the mother. At work, they are faced with challenges that come with possessing power and responsibilities. They speak about their responsibilities in

relation to their roles in life, as discussed in section *5.5 Being-with*. However, for some women, this sense of responsibility and care for others is extended to the entire family not just their children, and has been part of their being-in-the-world since a very young age. Whether the women work or not, they are responsible in keeping the family afloat. This can be considered a cultural quality of a women's role in the family, and along with that they have the added role of a man to fulfil as well. As mentioned above, work and family responsibilities cause anxiety which, in most cases in the findings, is associated with the heart attack. The findings show an embodying of a man's persona in the family and at work:

> *"I wore masculine clothes, I talked with men I, [I mean] I hold myself in a more of a masculine energy definitely at work uhumm and that was my comfort zone" - Nicky*

The sense of responsibility that Neill (1987) writes in her description of a person susceptible to a heart attack, is supported in the findings, as well as the literature review. The literature reviewed portrayed participants juggling between their personal and professional responsibilities, and in the meantime delaying any treatment needed for themselves (Neill, 1987; Arslanian-Engoren and Scott, 2017; Jones et al., 2019). The participant's responsibilities have blinded them from their own wellbeing, and when it came time to take on responsibility for themselves after their heart attack, it proved to be very difficult (Sjostrom-Strand et al., 2011).

Glimpses of the notion of responsibility can be seen constantly throughout the findings and literature. Participants tend to take on too much responsibilities towards the other, which in most cases backfires at some point in their life. Moreover, as mentioned in the section above *4.1.2 Meaning: Anxiety & Heart Attack,* this responsibility brings about anxiety, which is attributed to their heart attack.

5.6 Relationship to the Body

When exploring the heart attack, it is inevitable to discuss the body, specifically that the heart attack is, in fact, a physiological event. The women's relationship to their body is reflected in the findings, and each prove to be unique to the other. They range from a very embodied and embracing experience, to one that is disembodied and detached.

The reviewed literature adds a different angle to the notion of the body, the misinterpretation of their physical symptoms, one that was only mentioned by two women in the findings (Brink et al., 2002; Gundersen et al., 2007; Sjöström-Stranda and Fridlund, 2008; Isaksson et al., 2013; Madsen and Birkelund, 2016; Arslanian-Engoren and Scott, 2017; Bowles et al., 2018; Gyberg et al., 2019). This can be seen as being out of sync with one's body.

5.6.1 Embodiment (Disembodiment)

The findings show an awakening after the heart attack, one that recognizes the body, and realizes the importance of attending to it. The women have lived their lives disregarding their needs, whether their emotional needs, as portrayed in section *4.2.2 Self-Care,* or their physiological needs. Most of the women had gained weight over the years and are heavy smokers. There is an attempt to lead a healthy lifestyle, but each lady embodies a different lifestyle. Their experience of their body is rather dismissive, which is captured when Jane says:

> *"I hate my body, I hate my looks! [I know that how I look, maybe my face is okay… but I hate… my body… totally] […] [I mean these days I don't look in the mirror, I get dressed and I don't even know what I put on, I can't look in the mirror]" - Jane*

Others described an aged body but a young soul, and some did not even consider their physical body in their story until asked. However, throughout their dialogue there seemed to be a 'distance' sense of embodiment; most of them were well aware of the effects of their

being-in-the-world on their lives, but chose not to attend to it. This is also portrayed in section *4.2.2 Self-Care*.

> *"I have to care about my psychology and then my my my physical will be fine" - Jasmine*

Two of the women in the findings explicitly discuss being detached from their body, which insinuates a sense of disembodiment.

> *"I don't uhh value my physical body…I don't take care for it like I should…I don't give myself time to rest I don't… [I am detached from it]"- Nicky*

This disembodiment relieves their pains, whether pains caused by trauma or the shock of having a heart attack.

> *"[You feel that you, what I felt was that I] I detached from my body… okay [my body was one thing], okay, [walking alongside] my soul*"*- Farah*

According to Lowen (2013), our physiology is affected by our way of living, at times of stress blood pressure levels increase, and prostacyclin levels decrease, causing platelets to stick together to form a clot that might eventually close down an artery and trigger a heart attack. Though none have boldly linked our psychology with the actual physiological processes that happens within our body like Lowen (2013) does, many other authors support the idea (Charon, 2006; Aho and Aho, 2009; Shapiro, 2012; Aho, 2018). They all suggest that our physical symptoms are more than just physiological changes as understood by science, in fact, that are a representation of our lived story.

The reviewed literature depicted the participants sense of embodiment after the heart attack, most of which were studies focused on women (Sjostrom-Strand et al., 2011; Madsen and Birkelund, 2016). Women reported a general exhaustion and lack of energy due to bodily limitations, after the heart attack. Sjostrom-Strand et al. (2011) depicts how, after the heart attack, the women were more aware of their physical heart, and this awareness made them conscious of the risks of having a reoccurrence (p.463). This indicates a very strong sense of

embodiment, as they centre in on themselves and ‘listen to their body’. Only one article discussed their sense of embodiment before the heart attack like the findings (Gyberg et al., 2019). The women push their bodily needs and signals aside, in order to fulfil their daily responsibilities. None of the literature reviewed discussed detachment, however the phenomenon of disembodiment can be depicted through their misinterpretation of illness, discussed below.

Merleau-Ponty (2014) writes: “I engage myself with my body among things, they coexist with me insofar as I am an embodied subject” (p.191). Embodiment means to be present and engaged with the world (Csordas, 2001). Before the heart attack, the women in the findings and the literature, seem to be disengaged. They do not coexist, but exist solely for the other, losing themselves along the way. The stories show a glimpse of embodiment, for example their experiences of embodied anxiety mentioned above. Moreover, after being faced with their mortality, they question life, bringing them closer to an embodied self.

5.6.2 Misinterpretation of Illness

> *“I started feeling pain in my arm [so] I thought it was my neck because usually we are sitting long hours [like that] … [so my father] gave me medication for my neck” - Jane*

Misinterpreting their symptoms may be a sign of unfamiliarity with the illness or a sense of disembodiment, a lack of synchronization with the body (Shapiro, 2012). In the findings, only two women describe a misinterpretation of their physical symptoms. One of the women simplified her experience to neck pain from staying long hours on a computer, and the other woman described an extremely painful experience, yet thought it was as simple as Anaemia.

“[I felt that something has hit me like that… a fracture … horrible pain from my throat to my stomach… in the beginning I thought that, I mean, that I had Anaemia for example not that… I never expected at all that it was something related to the heart]” – Sarah

Since most of the participants describe a bodily experience, it may be controversial to assume that misinterpreting your illness may insinuate disembodiment. Is it considered disembodied if you are describing bodily experiences? Disembodiment is a complex phenomenon, and for the purpose of this theme, it is meant to describe a lack of synchronization between the participant and what is physiologically happening to the body.

This phenomenon is shown in the literature more than in the findings participants were amazed at the fact that they were actually having a heart attack, since they have been minimizing the effect that the symptoms had on their life (Brink et al., 2002; Arslanian-Engoren and Scott, 2017; Bowles et al., 2018). They reported feeling symptoms of indigestion or aging, which can be considered ‘milder’ than a heart attack (Madsen and Birkelund, 2016). The literature also suggests a general lack of knowledge in diagnosing a heart attack in women, since it has mostly been seen as a male illness (Gundersen et al., 2007; Madsen and Birkelund, 2016). Gyberg et al. (2019) explored the interpretation of illness from a different angle, that which identifies the participants experience of a heart attack in relation to the intensity of the symptoms. Most participants pushed their symptoms aside to go by their daily activities, until their symptoms intensify and crippled their ability. This warrants the question of women’s attention to their body; how attentive are they to themselves? The lack of self-care can also assume this lack of attention. There is a general sense of living for others, and losing their embodied self in the process.

In conclusion, the literature and the findings both complement each other. None of the research negates the other, on the contrary, they either support each other and strengthen a

theme or add a new perspective. In most of the literature, anxiety presents itself as an underlying phenomenon. Whether the participants describe their anxious nature before the heart attack or describe the anxieties of living with the ramifications of said illness. On accession, anxiety presents itself through the participants embodied experience, as they describe the intensity of their experience and how they embody it. Both the literature and the findings suggest that their heart attack may be an accumulation of their anxieties. Along with this description is the notion of being-with-anxiety, which describes the position of anxiety in the participant's lives. As participants explore their anxiety in their own way, the meaning of their heart attack is portrayed, as well as the meaning of the life after the heart attack. As shown above, it was apparent that throughout their life's journey participants are faced with losses; loss of life, love, and the possibility of their own death. These themes are of great depth, and can be explored further if focused on. Moreover, both the literature reviewed and the findings describe strong and independent people, which can be considered a gateway to explore the participants personal dimension further. In addition, the notion of self-care appears to be of importance in most of the participant's story. Another prevalent notion in the research above, is quality of the participants with others. Their description of themselves in relation to others, specially their family and work colleagues, provides an understanding of what might be their main motivation in life. There is a general sense of responsibility towards the other that keeps them moving in life. With these responsibilities, comes the lack of self-care, which is also reflected in their relationship to their body. The heart attack being a physiological event, hits their body directly, and through the literature and findings, we see the importance and relation to their body.

All of the themes above have an existential basis to them, opening up possibilities for existential work with heart attacks. These women have been faced with a threat to their existence and each women makes sense of this experience in her own way. The general attitude

of taking up too much responsibilities or putting others before themselves, can be seen as the focal point that shapes their embodied experience in this specific way. Their being-in-the-world is for the other.

6. Conclusion

The purpose of this study is to explore the embodied experience of women who suffered from heart attacks. There has been a shift in the medical research expanding the perspective of looking at it from a purely scientific standpoint to one that values phenomenological input. A heart attack is no longer solely considered a physiological illness, but one that can be related to our 'psychology', as it affects our lived experience. The findings explore the women's experience throughout their lives and attempts to understand how the heart attack fits in, focusing in on their embodiment throughout. The findings and reviewed literature together depict many existential concerns throughout the themes portrayed, giving room for existential therapists to work with such a phenomenon.

As suggested by the findings and the literature, physical illness is not just physiological or biological but also a lived and embodied experience that most likely has an impact on one's life. According to the findings, in order to understand the function of this illness, it is important to understand the participant's life story pre-heart attack, not just after it. Their life story puts their illness in perspective, which may help with their therapy and treatment. The heart attack itself is an experience that threatens a person's existence. It is apparent that this existence is one that has been rushing through life, striving to achieve and cater to the family with increasing pressure and stress. A lack of self-care was apparent among most research along with the findings, as all subjects give priority and more importance to their family and work. This heart attack, or this threat to one's existence, brings up all hidden or 'unthought-of' concerns to the surface. It acts as a wakeup call for most participants, as they realize the impact of their being-in-the-world on their body, whether they then act upon it or not. Findings of this research support the lived experience of the women, with several themes

arising through the analysis of the data. The findings together with the literature bring out existential concerns such as the self, being-with, loss, anxiety, and meaning.

Most participants portray a strong and independent character that is embedded in the way they work and take care of others. It can be said that this strength is what keeps them going. This brings about the notion of being-with, which is an existential concern that appears to be a focal point in the findings, and also in the literature reviewed. Being-with-others is the main motivation in life of these subjects. It is what gives their life purpose while also adding to their responsibilities and limitations. They live for others, which takes away from living for themselves, in other words living authentically. Even though the notion of authenticity did not explicitly come into the themes, the question of authenticity emerges at times, especially when exploring their being-with-others. All of these notions are vital phenomena in the findings that make up the women's stories. This suggests the relevance of taking on an existential framework when working with heart attack experiences.

Loss and death were also main themes that emerged in the findings and literature. Both notions are known to be existential givens; we are born (thrown) into this world and it is inevitable that we eventually leave the world through death as we are essentially being-toward-death. Throughout life, until we reach our death, we are faced with loss. It can be seen as an inevitable experience we got through in life if we consider that every day we lose the day before, losing loved ones, or losing an ability due to illness. Like death, loss is inevitable. The findings and the literature together bring out this notion in relation to this phenomenon. They experienced immense loses before and after their heart attack, and were faced with death when they had the heart attack.

As experienced by the women in the findings, anxiety can thus be understood as the underlying emotion here stemming from the fact that from the moment we are thrown into this world, we are being-toward-death. It may also explain the subjects' rush in life to achieve at

work and at home, before it is 'lost'. Anxiety is a constant, therefore an existential concern yielding its right to be considered in the experience of a heart attack (Yalom, 1980). From this anxiety, meaning of life and the illness emerged.

The heart attack, this threat to one's existence, is seen to be one that is trigged by all the anxieties, losses, and life circumstances. It is not only a blockage in the heart, but also a blockage in life. It poses as a point in one's life where one question's their existence or quality of life. The meanings portrayed in the findings and the literature all suggest the above, that these strong and independent people have lived their life for the other, and now they stop and look at themselves. When they do so, the concepts mentioned above emerge in a different light. Their being-with shifts, their losses are of a different nature, and their life takes on new meaning. It can be seen that both the findings and literature review complete one another, as the findings focus more on the lived experience of these women before the heart attack, while the literature is more focused on the experience after the heart attack.

This research highlights how having a heart attack shifts one's lived experience. They are thrown into a near-death experience and come out of it alive, despite the statistical odds (World Health Organization, 2017). In theory, it can be said that those who experience a heart attack are directly faced with their being-toward-death. Even though the findings have not highlighted this notion in specific, other existential concerns surface through the analysis of the data, thus bringing this theory closer to practice and experience. This research shows the individuality in each woman's story, though all grouped together in themes, the detail of their experience is unique. Moreover, this research adds a new perspective to the existing literature regarding this phenomena, by looking at the life of the participants before the heart attack, not just after it. The participants are invited to explore their embodied experience leading up to the heart attack. According to their experiences, it is undeniable that their life before the heart attack has played a significant role on their embodied experience of the heart attack, as much

as it did after. A relationship between their way of living, or their being-in-the-world, and the heart attack was acknowledged by all participants. What life meant to them, their anxieties, the losses they experienced, their roles in life are all factors that contributed to their susceptibility of having this heart attack. The women brought up the losses and anxieties experienced before the heart attack and how they shaped who they are, their being-in-the-world. The findings all add to the understanding of this phenomenon in that is more than just a medical criterion, but a complex and unique embodied experience. Their heart attack is part of their lived story; in fact, it is a turning point in their life.

6.1 Implications for Counselling Psychology

When you think of the psychology of physical illness, one might think of health psychologists, as they aim to "use their knowledge of psychology and health to promote general well-being and understand physical illness" (BPS, 2020). They are trained to help people deal with the emotional challenges that they face during their illness, and reinforce a change in lifestyle to suit their situation. Health psychologists provide patients with the space to explore their emotional processes and learn how to cope with what life has thrown their way. It can be seen as a compliment to medical practice; while doctors deal with the physiological aspects of illness and provide medical treatments, the health psychologists are there to support the process.

Counselling psychologists also have a role in working with physical illness, even if it is not the main presenting complaint. As the phenomenon of illness never ceases to grow, therapists are bound to have clients with physical illness. Therefore, instead of maybe considering the illness as secondary to the main complaint, it is important to embed it as part of their lived experience. Following this rationale, this research adds an additional dimension to the understanding of heart attacks in women. It attempts to look beyond the emotional

processes and understand their embodied experience. Phenomenological research has been moving in this direction (Smith, 1996). Most research reviewed looks at the effect of the heart attack on their life thereafter, however this research looks at the women throughout their life in attempts to understand their movement in the world and where the heart attack fits. Looking at the women's entire life story gives a different perspective to the heart attack and to the women; it is not only about how it affected them today, it is also about how it has come to happen in relation to their existence.

6.1.1 Implications for Existential Therapy

If we take a closer look at the literature, an evident gap appears in the research on existential therapy and physical illness. The current literature shows a link between existential philosophy and the experience of physical illness. Many themes surfaced in various articles, such as death, anxiety, responsibility, limitations, choice, and so on, whether specific to heart problems or to other physical illnesses (Allen et al., 2009; Allison and Campbell, 2009; Gebler and Maercker, 2014; Jeon et al., 2010; Schulz, 2015; Strömberg and Jaarsma, 2008; Thornhill et al., 2008; Westman et al., 2006). Even though these themes were found, there lacks an in-depth phenomenological exploration of the lived experience of having a heart attack. Moreover, none of the research found considered illness in relation to van Deurzen's four existential dimensions, namely the personal, physical, social, and spiritual world (Van Deurzen, 2011). The existential approach allows the therapist to work very closely with the client's predicaments, as it follows a framework aimed to explore these dimensions of existence (Van Deurzen, 2012).

Our existence is "always anchored in an actual physical presence in a material world" (Van Deurzen, 2012, pg.76), we are physical bodies in material world. We are thrown into a physical environment, and exploring the physical dimension entails looking at how participants

relate to, or act towards, their physical boundaries and limitations. The heart attack being a physiological event is bound to affect this dimension. Moreover, the findings and literature both support this point. Other than the obvious exploration of the experience of the heart itself, it would be of value to also explore how do these participants balance the idea of life and death, health and illness, security and insecurity, and how are these tensions embodied (Van Deurzen and Arnold-Baker, 2005)?

The social dimension is people's relationship with others, as "we are always thrown together with other people in a with-world" (Van Deurzen and Arnold-Baker, 2005, pg.89). Again the notion Being-with is present and gives room for more exploration in therapy. The findings and the literature both highlight the importance of the other in a heart attack survivor's life, however there is still much room to explore this dimension. How do people deal with the existence of the other in their lives? Specifically to this research, how are these women relating to others in their lives, in relation to their experience of the heart attack?

The personal dimension is the world of intimacy with the self and others. It is the world that represents our inner most potentiality and how we relate to that. Authenticity comes to play here: do we allow the world to decide for us and live in an inauthentic manner, or are we authentic and affirm our own way of being? (Van Deurzen and Arnold-Baker, 2005). There might not be an obvious relationship between the experience of a heart attack and one's personal world, especially if the participant holds the assumption that the mind and body are separate. However, the findings and literature portray glimpses of one's self image that is a starting point into exploring this dimension.

The last dimension, the spiritual world, is one that explores the relationship with one's beliefs and values on an ideological level, the "abstract and metaphysical aspects of living" (Van Deurzen, 2012, pg.102). Does one's relationship to their spiritual world affect their embodied experience of their physical illness? In this case, their heart attack?

The four dimensions together with the findings open up a space for women who suffered from heart attacks to explore their existence and reflect on their embodied experience. This space, held by existential therapist, can allow the women to work towards becoming more authentic to themselves; in other words "to become more aware of their actual existence, and to live more in accordance with their true values, beliefs and experiences" (Cooper, 2003, p.138).

6.2 Limitations of Study

Throughout the research process, there have been a few challenges and limitations that might have affected the findings. Each challenge was faced with a limitation, from language, to subcultures, to the interview process itself. In addition to all these points, my assumptions as the researcher throughout posed as a limitation since this research is a double hermeneutic, my assumptions might have influenced my interpretation.

In section *3.5.2 Challenges of IPA*, the question of langue was proposed. Can langue capture experience? Initially, English speaking was part of the criteria, which proved to be difficult to find, and even with the fluent English speakers, Arabic was used at times, since it is their native language. English speaking women would resort to Arabic in attempts to capture an experience more descriptively or accurately. It was important for the women to express in Arabic, as their description might be considered or felt to be more precise, even if they speak English fluently. On some occasion, translating may not have captured the power or intensity of the quote. This challenge was only met when there was a powerful metaphor or saying being used, which may have been played down when translated.

Another limitation is related to the interview questions. The perks of having an open ended interview, allows for the space to follow the participant's unique story before moving onto the next question. This also gives room for many other questions to surface along the way,

which at times I felt I did not have the time to get into. It was also very challenging to capture the participant's embodied experience, since most women spoke about themselves in a Cartesian manner, which in itself says something about the participants. There was a definite mind/body split in the way they spoke about their lives, as they explicitly separated them to describe their health and healing attempts. Moreover, since this is considered a 'new' phenomenon, most of the themes portrayed can be further explored separately.

Egypt has many subcultures, some adopt a more Westernised life, while others are still more accustomed to more conservative traditions. This made is challenging to find a homogenous group of women. In this sample, most of the women were private practice patients, with the exception of one woman who was funded by the government. This in itself adds to the lack of homogeneity of the sample. Would have the themes been different if all women were either private practice patients or vice versa?

Since I myself am an Egyptian woman, I have a few assumptions that I thought would have come up more prevalently in the themes. As mentioned above in section *3.10 Reflexivity*, I believed that the theme death would be more apparent, since a heart attack is commonly known as a near death experience. I assumed that the women would talk about it more, but it proved to be more apparent in the literature than in the findings. In addition to that, I believed from the start that spirituality would be a major theme in all the women, and again I was proven wrong. In my experience, spirituality, or religion is a major factor in Egyptian culture and identity. However, in this research, not all the women placed importance on spirituality, again proving the vast variety of subcultures in Egypt.

These limitations most likely played a role in the direction of the results. However, this also indicates a vast avenue for further research in this field that can attempt to tackle these challenges.

6.3 Recommendations for Future Research

. Exploring the experience of illness from a phenomenological stance has been a growing interest. The richness of the findings in this current research and the literature suggests the possibility of future research in the embodied experience of any physical illness. Moreover, each theme portrayed in the findings can be a gateway to further research

Medical research has already differentiated between a man and a women's experience of a heart attack (World Health Organization, 2017), and this research takes that into consideration and focuses on women, specifically Egyptian women. This phenomenon can also be considered and explored specifically in other cultures to see the different findings. As seen in the literature, Bowles et al. (2018) focused on Mexican American women, Jones et al. (2019) on African American women, and this current research on Egyptian women. Each study presented different findings, which allows room for more exploration in said cultures or even the opportunity to look into others.

Each theme portrayed represents an aspect of the women's lived experience. Further research can attempt to zoomed in on each theme and explore them separately for an even deeper understanding. For example, loss or being-with-anxiety are both themes of great merit, and if focused on, the research can bring more insight on these notions in relation to this phenomenon.

Moreover, further research can branch out into exploring the embodied experience of any physical illness. Researchers should take this opportunity to explore illnesses that were previously seen as purely physiological, and bring in the participant's experience, as the world starts to move away from the Cartesian dualism view, to one that acknowledges the holistic unity of the mind and body.

6.4 Reflexivity

This research has had a major impact on my own embodied experience. I have become a lot more connected to myself (my body). I have come to allow my body to respond to my process and adopted a 'let it be, let it flow' attitude. Instead of questioning 'why?' anything is happening to me. I believe that I am also a lot more in touch with my anxiety, which proves to be a double edge sword. I experience it more frequently because I allow it to happen, however, I also believe I have embodied it.

My embodied experience of going on this research journey has been one big rollercoaster. My anxiety skyrocketed on many occasions, and I remember experiencing shortness of breath, pain in my chest, and a choking sensation, during the interviewing and analysis stage, which was pointed out to be similar to the women I interviewed. I am not sure what to make of this, but this is how my body expresses anxiety.

In the midst of my research journey, I became a mother. Being-a-mother has shifted how I value the body, whether my own when I was pregnant or my son's body. Children have the rawest ways of expressing themselves, without the 'baggage' of our lived experience. It makes me wonder if we are born embodied, and then life splits our paths to cater to our everyday pressures and responsibilities.

Moreover, the theme Being-a-mother in the findings has affected my own relationship with my son. I can relate to the 'living for them' aspect that is apparent in all the women's stories, but I also questioning if I am not present with him as I should be. I notice myself drifting in and out of presence with him, according to the pressures I have, and with this comes a sense of guilt and anxiety. I noticed my embodied presence with him, effects the way he is as well.

My understanding of illness has shifted throughout the span of this research. The world today has become a dis-eased world, the most recent and symbolic example would be Covid-19. I started with the belief that every symptom meant something, which I still believe is true. However, it is not as simple as that. I see your body as a canvas and your story is painted and

expressed through it. Illness is an aspect of the story, and my challenge today is to push modern medicine from over-involving itself, and bringing in 'alternative' ways of healing in the mix, without overstepping the role of medicine either. Throughout the past few years, I noticed the word 'stress' being used frequently by medical doctors; each person in my nuclear and extended family has been told by different doctors that their symptoms are stress related. This ongoing comment has strengthened my belief that your body does speak your mind. I believe the word stress is over-used, and that this 'stress' might in fact be many things. However, this gives more reason for us to explore what exactly do these doctors mean by 'stress', or what is this 'stress' that triggers symptoms?

A few months ago my husband had to take out half of his thyroid gland and shortly after he experienced a constant headache, which he is being treated from until today. All I can see is what these ailments represent and express. In Shapiro's (2012) work, the thyroid represents your voice, while the headache represents "too much time spent in the head" or avoidance (p.159). I believe that this is a bit too directive, but somehow it fits his lived experience. For the past few years, my husband was faced with a few challenges where he was unable to speak up, I have observed him sit and stare into nothingness, constantly thinking. He has also been more evasive at times of stress. All of these assumptions come from my experience of him. However, it is hard to for me to not make the link between his medical diagnosis and his embodied experience. His physiotherapist has explicitly told him that his headache is stress related. And in my opinion, his thyroid issues are not solved solely by the operation, but he has to work with it towards authenticity and explore what this stress is?

In practice, I do not shy away from illness, in fact at times I seek it. I believe that I am slowly shifting my attention away from daily activities and 'gossip', which I used to get stuck in, to the client's lived experience. I am more confident in moving passed the gossip, and mundane talk, in attempts to delve deeper. However, this research has also altered my

homeopathic practice, to the extent that at times I complicate the presented case. Sometimes I just need too simply reportize the symptoms mentioned to find the remedy, while now I get lost in exploring the meaning and experience. It does not defy the purpose of the session, but it takes me longer to get a remedy. The homeopathic workshops and seminars I have been attending all reinforce the idea that most physical symptoms mean something 'psychological'. Therefore, there is an ongoing challenge for me to take this approach while also looking beyond their suggested meanings.

Today, I value what the body has to say and express. It is the focal point of my understanding and relating to the other.

References

Affleck, G., Tennen, H., Croog, S. and Levine, S., 1987. Causal attribution, perceived benefits, and morbidity after a heart attack: an 8-year study. *Journal of Consulting and Clinical Psychology*, 55(1), pp.29-35.

Aggelopoulou, Z., Fotos, N., Chatziefstratiou, A., Giakoumidakis, K., Elefsiniotis, I. and Brokalaki, H., 2017. The level of anxiety, depression and quality of life among patients with heart failure in Greece. *Applied Nursing Research*, 34, pp.52–56.

Aho, J. and Aho, K., 2009. *Body Matters: A Phenomenology Of Sickness, Disease, And Illness*. Lanham: Lexington Books.

Aho, K., 2018. *Existential Medicine: Essays On Health And Illness*. London: Rowman & Littlefield International Ltd.

Alberti, F., 2009. Bodies, Hearts and Minds: Why Emotions Matter to Historians of Science and Medicine. *Isis*, 100(4), pp.798–810.

Al-Busaidi, Z., 2008. Qualitative Research and its Uses in Health Care. *Sultan Qaboos University Medical Journal*, 8(1), pp.11-19.

Alhurani, A., Dekker, R., Abed, M., Khalil, A., Al Zaghal, M., Lee, K., Mudd-Martin, G., Biddle, M. and Lennie, T., 2015. The Association of Co-morbid Symptoms of Depression and Anxiety with All-Cause Mortality and Cardiac Rehospitalization in Patients with Heart failure. *Psychosomatics*, 56(4), pp.371–380.

Allen, J., Arslanian-Engoren, C. and Lynch-Sauer, J., 2009. The lived experience of middle-aged women with New York Heart Association class III heart failure: A pilot study. *Progress in Cardiovascular Nursing*, 24(3), pp.96-101.

Allison, M. and Campbell, C., 2009. "Maybe it could be a heart attack… but I'm only 31": Young men's lived experience of myocardial infarction: an exploratory study. *American Journal of Men's Health*, 3(2), pp.116-125.

American Heart Association. 2015. *Heart Attack Symptoms In Women*. [online] Available at: <https://www.heart.org/en/health-topics/heart-attack/warning-signs-of-a-heart-attack/heart-attack-symptoms-in-women> [Accessed 25 November 2020].

American Heart Association. 2015. *Heart Disease And Stroke Statistics: At A Glance*. [online] Available at: <https://www.heart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_470704.pdf> [Accessed 25 November 2020].

American Heart Association. 2019. *Cardiovascular Diseases Affect Nearly Half Of American Adults, Statistics Show*. [online] Available at: <https://www.heart.org/en/news/2019/01/31/cardiovascular-diseases-affect-nearly-half-of-american-adults-statistics-show> [Accessed 25 November 2020].

Andersson, E., Borglin, G. and Willman, A., 2013. The Experience of Younger Adults Following Myocardial Infarction. *Qualitative Health Research*, 23(6), pp.762-772.

Angel, S., 2018. Movement perceived as chores or a source of joy: a phenomenological-hermeneutic study of physical activity and health. *Journal of Qualitative Studies on Health and Well-being*, 13(1), pp.1-10.

Arslanian-Engoren, C. and Scott, L., 2017. Delays in Treatment-Seeking Decisions Among Women With Myocardial Infarction. *Dimensions of Critical Care Nursing*, 36(5), pp.298-303.

Askay, R., 1999. Heidegger, the body, and the French philosophers. *Continental Philosophy Review*, 32, pp.29-35.

Bakker, J., 2019. *Heart Attack Gender Gap Is Costing Women's Lives*. [online] British Heart Foundation. Available at: <https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2019/september/heart-attack-gender-gap-is-costing-womens-lives> [Accessed 25 November 2020].

Bårdsgjerde, E., Kvangarsnes, M., Landstad, B., Nylenna, M. and Hole, T., 2019. Patients' narratives of their patient participation in the myocardial infarction pathway. *Journal of Advanced Nursing*, 75(5), pp.1063-1073.

BHF Press Office, 2016. *Women Are 50% More Likely Than Men To Be Given Incorrect Diagnosis Following A Heart Attack*. [online] British Heart Foundation. Available at: <https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2016/august/women-are-50-per-cent-more-likely-than-men-to-be-given-incorrect-diagnosis-following-a-heart-attack> [Accessed 25 November 2020].

Biggerstaff, D. and Thompson, A., 2008. Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research. *Qualitative Research in Psychology*, 5(3), pp.214-224.

Bowles, J., McEwen, M. and Rosenfeld, A., 2018. Hispanic Health Care International. *Hispanic Health Care International*, 16(2), pp.62-69.

BPS. 2020. *Health Psychology*. [online] Available at: <https://careers.bps.org.uk/area/health> [Accessed 18 December 2020].

Brink, E., Karlson, B. and Hallberg, L., 2002. To Be Stricken with Acute Myocardial Infarction: A Grounded Theory Study of Symptom Perception and Care-seeking Behaviour. *Journal of Health Psychology*, 7(5), pp.533-543.

Brink, E., Karlson, B. and Hallberg, L., 2002. To Be Stricken with Acute Myocardial Infarction: A Grounded Theory Study of Symptom Perception and Care-seeking Behaviour. *Journal of Health Psychology*, 7(5), pp.533-543.

British Heart Foundation. 2020. *UK Fact Sheet*. [online] Available at: <https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwjS-PiZ0p_tAhXsQRUIHdgVCAsQFjALegQIHBAC&url=https%3A%2F%2Fwww.bhf.org.uk%2F-%2Fmedia%2Ffiles%2Fresearch%2Fheart-statistics%2Fbhf-cvd-statistics-uk-factsheet.pdf&usg=AOvVaw3cL0StMVuLgIemlJ7AwHTV> [Accessed 26 November 2020].

British Psychological Society. n.d. *Anxiety | BPS*. [online] Available at: <https://www.bps.org.uk/public/a-z-of-psychology> [Accessed 25 November 2020].

Buber, M., 1970. *I And Thou*. New York: Charles Scribner's Sons.

Carel, H., 2016. *Phenomenology Of Illness*. Oxford: Oxford University Press.

Carman, T., 1999. The Body in Husserl and Merleau-Ponty. *PHILOSOPHICAL TOPICS*, 27(2), pp.205-226.

Chandan, J., Thomas, T., Bradbury-Jones, C., Taylor, J., Bandyopadhyay, S. and Nirantharakumar, K., 2020. Risk of Cardiometabolic Disease and All-Cause Mortality in Female Survivors of Domestic Abuse. *Journal of the American Heart Association*, 9(4).

Charon, R., 2006. *Narrative Medicine: Honoring The Stories Of Illness*. New York: Oxford University Press.

Cohn, H., 2002. *Heidegger And The Roots Of Existential Therapy*. London: Continuum.

Cohn, H., 2008. *Existential Thought And Therapeutic Practice: An Introduction To Existential Psychotherapy*. London: Sage Publications Ltd.

Cole, C., McSweeney, J. and Pettey, C., 2012. Sleep disturbance in women before myocardial infarction. *Heart & Lung*, 41(5), pp.438-445.

Collins, B., Singh, A., Qamar, A., Divakaran, S., Baez, J., Klein, J., Hainer, J., Jarolim, P., Shah, R., Plutzky, J., Polk, D., Nasir, K., Di Carli, M., Bhatt, D. and Blankstein, R., 2017. Women Who Experience a Myocardial Infarction at a Young Age Have Worse Outcomes Compared With Men. *Journal of American College of Cardiology*, 69(11).

Cooper, M., 2003. *Existential Therapies*. London: Sage Publications Ltd.

Cousins, N., 1979. *Anatomy Of An Illness As Perceived By The Patient*. New York: W.W Norton & Company, Inc.

Csordas, T., 2001. *Embodiment And Experience: The Existential Ground Of Culture And Self*. Cambridge: Cambridge University Press.

Davis, L., Mishel, M., Moser, D., Esposito, N., Lynn, M. and Schwartz, T., 2013. Thoughts and behaviors of women with symptoms of acute coronary syndrome. *Heart & Lung*, 42(6), pp.428-435.

Dempsey, S., Dracup, K. and Moser, D., 1995. Women's decision to seek care for symptoms of acute myocardial infarction. *Heart & Lung*, 24(6), pp.444-456.

Dreyfus, H., 1991. *Being-In-The-World: A Commentary On Heidegger's Being And Time*. Massachusetts: The MIT Press.

Eatough, V. and Smith, J., 2017. Interpretative Phenomenological Analysis. In: C. Willig and W. Stainton-Rogers, ed., *The SAGE handbook of qualitative research in psychology*, 2nd ed. London: Sage Publications Ltd., pp.193-211.

Escudero, J., 2015. Heidegger and the Hermeneutics of the Body. *International Journal of Gender and Women’s Studies*, 3(1), pp.16-25.

Finlay, L., 2006. The body's disclosure in phenomenological research. *Qualitative Research in Psychology*, 3(1), pp.19-30.

Finlay, L., 2011. *Phenomenology For Therapists: Researching The Lived World*. West Sussex: Wiley-Blackwell.

Frank, A., 2013. *The Wounded Storyteller*. Chicago: The University of Chicago Press.

Freud, S., 2005. *The Unconscious*. London: Penguin Books.

Gallagher, R., Marshall, A. and Fisher, M., 2010. Symptoms and treatment-seeking responses in women experiencing acute coronary syndrome for the first time. *Heart & Lung*, 35(6), pp.477-484.

Gebler, F. and Maercker, A., 2014. Effects of including an existential perspective in a cognitive-behavioral group program for chronic pain: A clinical trial with 6 months follow-up. *The Humanistic Psychologist*, 42(2), pp.155-171.

Geiser, F., Urbach, A., Harbrecht, U., Conrad, R., Pötzsch, B., Amann, N., Kiesewetter, K., Sieke, A., Wolffs, K. and Skowasch, D., 2017. Anxiety and depression in patients three months after myocardial infarction: Association with markers of coagulation and the relevance of age. *Journal of Psychosomatic Research*, 99, pp.162-168.

Gendlin, E., 1982. Two phenomenologists do not disagree. In: R. Bruzina and B. Wilshire, ed., *Phenomenology: Dialogues and Bridges*. Albany: State University of New York Press, pp.321-335.

Giorgi, A., 1997. The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology*, 28(2), pp.235–260.

Goldstein, K., 1959. Health as Value. In: A. Maslow, ed., *New knowledge in human values*. New York: Harper & Brothers, Publishers, pp.178-188.

Green, J. and Thorogood, N., 2004. *Qualitative Methods For Health Research*. London: Sage Publications.

Greenman, P., Viau, P., Morin, F., Lapointe-Campagna, M., Grenier, J., Chomienne, M. and Jbilou, J., 2018. Of sound heart and mind: A Scoping Review of Risk and Protective

Factors for Symptoms of Depression, Anxiety, and Posttraumatic Stress in People With Heart Disease. *Journal of Cardiovascular Nursing*, 33(5), pp.16-28.

Gruen, W., 1975. Effects of brief psychotherapy during hospitalization periods on the recovery process in heart attacks. *Journal of Consulting and Clinical Psychology*, 43(2), pp.223–232.

Gundersen, A., Sørlie, T. and Bergvik, S., 2017. Women with coronary heart disease – making sense of their symptoms and their experiences from interacting with their general practitioners. *Health Psychology and Behavioral Medicine*, 5(1), pp.29-40.

Gyberg, A., Bjorck, L., Nielsen, S., Maatta, S. and Falk, K., 2016. Women's help-seeking behaviour during a first acute myocardial infarction. *Scandinavian Journal of Caring Sciences*, 30(4), pp.670–677.

Hanna, A., Yael, E., Hadassa, L., Iris, E., Eugenia, N., Lior, G., Carmit, S. and Liora, O., 2020. "It's up to me with a little support": Adherence after myocardial infarction: A qualitative study. *International Journal of Nursing Studies*, 101, pp.1-9.

Hansen, T., Berg, S., Sibilitz, K., Zwisler, A., Norekvål, T., Lee, A. and Buus, N., 2018. Patient perceptions of experience with cardiac rehabilitation after isolated heart valve surgery. *European Journal of Cardiovascular Nursing*, 17(1), pp.45-53.

Hasankhani, H., Gholizadeh, L., Mohammadi, E., Zamanzadeh, V., Allahbakhshian, A., Ghaffari, S. and Allahbakhshian, M., 2014. The lived experiences of patients post coronary angioplasty: A qualitative study. *Journal of Vascular Nursing*, 32(4), pp.144-150.

Heidegger, M., 2001. *Zollikon Seminars: Protocols, Conversations, Letters*. Illinois: Northwestern University Press.

Heidegger, M., 2012. *Being And Time*. Oxford: Blackwell Publishing Ltd.

Higginson, R., 2008. Women's help-seeking behavior at the onset of myocardial infarction. *British Journal of Nursing*, 17(1), pp.10-14.

Husserl, E., 1970. *The Crisis Of European Sciences And Transcendental Phenomenology*. Evanston: Northwestern University Press.

Husserl, E., 1999. *The Idea Of Phenomenology*. Dordrecht: Kluwer Academic Publishers.

Huston, P. and Rowan, M., 1998. Qualitative studies: Their role in medical research. *Canadian Family Physician*, 44, pp.2453–2458.

Illich, I., 2010. *Limits To Medicine: Medical Nemesis - The Exploration Of Health*. London: Marion Boyars Publishers Ltd.

Isaksson, R., Brulin, C., Eliasson, M., Näslund, U. and Zingmark, K., 2013. Older women's prehospital experiences of their first myocardial infarction. *Journal of Cardiovascular Nursing*, 28(4), pp.360-369.

Janssen-Niemeijer, A., Visse, M., Van Leeuwen, R., Leget, C. and Cusveller, B., 2017. The Role of Spirituality in Lifestyle Changing Among Patients with Chronic Cardiovascular Diseases: A Literature Review of Qualitative Studies. *Journal of Religion and Health*, 56(4), pp.1460-1477.

Jeon, Y., Kraus, S., Jowsey, T. and Glasgow, N., 2010. The experience of living with chronic heart failure: a narrative review of qualitative studies. *BMC Health Services Research*, 10(1), pp.1-9.

Joekes, K., Van Elderen, T. and Schreurs, K., 2007. Self-efficacy and Overprotection Are Related to Quality of Life, Psychological Well-being and Self-management in Cardiac Patients. *Journal of Health Psychology*, 12(1), pp.4-16.

Jones, L., Williams, S., Bydalek, K., Elkins, C. and Fruh, S., 2019. African American Women's Perceptions of Cardiovascular Disease After Myocardial Infarction: A Phenomenological Inquiry. *Journal of Cardiovascular Nursing*, 34(6), pp.503–510.

Kierkegaard, S., 1980. *The Concept Of Anxiety*. New Jersey: Princeton University Press.

Kleinman, A., 2020. *The Illness Narratives: Suffering, Healing, And The Human Condition*. New York: Basic Books.

Langdridge, D. and Hagger-Johnson, G., 2013. *Introduction To Research Methods And Data Analysis In Psychology*. 3rd ed. Harlow: Pearson Education Limited.

Langdridge, D., 2007. *Phenomenological Psychology: Theory, Research And Method*. Harlow: Pearson Education Limited.

Leder, D., 1998. Lived Body. In: D. Welton, ed., *Body and flesh : a philosophical reader*. Oxford: Blackwell Publications Ltd, pp.117-129.

Løvlien, M., Mundal, L. and Hall-Lord, M., 2016. Health-related quality of life, sense of coherence and leisure-time physical activity n women after an acute myocardial infarction. *Journal of Clinical Nursing*, 26(7-8), pp.975-982.

Lowen, A., 2013. *Love, Sex, And Your Heart*. Texas: The Alexander Lowen Foundation.

Madison, G., 2015. Daring to listen to the truth of the body: Existential-phenomenology needs the body's response. *Existential Analysis*, 26(2), pp.237-242.

Madsen, R. and Birkelund, R., 2016. Women's experiences during myocardial infarction: systematic review and meta-ethnography. *Journal of Clinical Nursing*, 25(5-6), pp.599-609.

May, R., 2009. *Man's Search For Himself*. New York: W.W Norton & Company, Inc.

May, R., 2015. *The Meaning Of Anxiety*. New York: W.W Norton & Company, Inc.

Merleau-Ponty, M., 1983. *The Structure Of Behavior*. Pittsburgh: Duquesne University Press.

Merleau-Ponty, M., 2014. *Phenomenology Of Perception*. London: Routledge.

Mitchell, J., 2019. *No Difference In Key Heart Attack Symptoms Between Men And Women*. [online] British Heart Foundation. Available at: <https://www.bhf.org.uk/what-we-do/news-from-the-bhf/news-archive/2019/august/no-difference-in-key-heart-attack-symptoms-between-men-and-women> [Accessed 25 November 2020].

Moustakas, C., 1994. *Phenomenological Research Methods*. Thousand Oaks: Sage Publications Ltd.

Moya, P., 2014. Habit and embodiment in Merleau-Ponty. *Frontiers in Human Neuroscience*, 8, pp.1-3.

Musey Jr., P., Schultebraucks, K. and Chang, B., 2019. Stressing Out About the Heart: A Narrative Review of the Role of Psychological Stress in Acute Cardiovascular Events. *Official Journal of the Society for Academic Emergency Medicine*, 27(1), pp.71-79.

Neill, K., 1987. A review of atypical clinical manifestations of acute myocardial infarction. *Journal of Intensive Care Medicine*, 2(1), pp.25-32.

Nietzsche, F., 2006. *Thus Spoke Zarathustra*. New York: Cambridge University Press.

Novak, D., 1985. Buber's Critique of Heidegger. *Modern Judaism - A Journal of Jewish Ideas and Experience*, 5(2), pp.125–140.

Pelliccia, F., Rosano, G. and Mehran, R., 2020. Gender-related differences after acute myocardial infarction: A major global health challenge. *International Journal of Cardiology*, 311, pp.18-19.

Rechenberg, K., Cousin, L. and Redwine, L., 2020. Mindfulness, Anxiety Symptoms, and Quality of Life in Heart Failure. *The Journal of Cardiovascular Nursing*, 35(4), pp.358-363.

Ricoeur, P., 1976. *Interpretation Theory: Discourse And The Surplus Of Meaning*. 5th ed. Fort Worth: Texas Christian University Press.

Rodriguez, F., Foody, J., Wang, Y. and Lopez, L., 2015. Young Hispanic Women Experience Higher In-Hospital Mortality Following an Acute Myocardial Infarction. *Journal of the American Heart Association*, 4(9), pp.1-8.

Roncella, A., Pristipino, C., Cianfrocca, C., Scorza, S., Pasceri, V., Pelliccia, F., Denollet, J., Pedersen, S. and Speciale, G., 2013. One-year results of the randomized, controlled, short-term psychotherapy in acute myocardial infarction (STEP-IN-AMI) trial. *International Journal of Cardiology*, 170(2), pp.132-139.

Rosenfeld, A., Lindauer, A. and Darney, B., 2005. Understanding treatment-seeking delay in women with acute myocardial infarction: Descriptions and decision-making patterns. *American Journal of Critical Care*, 14(4), pp.285-293.

Sampaio, C., Renaud, I. and Leao, P., 2018. "When illness dictates who I am": A hermeneutic approach to older adults with heart disease. *Nursing Forum*, 53(3), pp.324-332.

Sartre, J., 2003. *Being And Nothingness*. Oxford: Routledge Classics.

Sartre, J., 2007. *Essays In Existentialism*. New Haven: Yale Unversity Press.

Schulz, C., 2015. Existential Psychotherapy With a Person Who Lives With a Left Ventricular Assist Device and Awaits Heart Transplantation: A Case Report. *Journal of Humanistic Psychology*, 55(4), pp.429-473.

Seah, A., Tan, K., Huang Gan, J. and Wang, W., 2016. Experiences of patients living with heart failure: A Descriptive Qualitative Study. *Journal of Transcultural Nursing*, 27(4), pp.392-399.

Sedgwick, P., 2013. Nietzsche, Illness and the Body's Quest for Narrative. *Health Care Analysis*, 21(4), pp.306-322.

Shapiro, D., 2012. *Your Body Speaks Your Mind*. London: Piatkus Books Ltd.

Shaw, R., Holland, C., Pattison, H. and Cooke, R., 2016. Patients' perceptions and experiences of cardiovascular disease and diabetes prevention programmes: A systematic review and framework synthesis using the Theoretical Domains Framework. *Social Science & Medicine*, 156, pp.192-203.

Simeone, S., Savini, S., Cohen, M., Alvaro, R. and Vellone, E., 2020. The experience of stroke survivors three months after being discharged home: A phenomenological investigation. *European Journal of Cardiovascular Nursing*, 14(2), pp.162– 169.

Simony, C., Dreyer, P., Pedersen, B. and Birkelund, R., 2017. It is not just a Minor Thing – A Phenomenological- Hermeneutic Study of Patients' Experiences when afflicted by a Minor Heart Attack and Participating in Cardiac Rehabilitation. *Scandinavian Journal of Caring Sciences*, 31(2), pp.232–240.

Simony, C., Pedersen, B., Dreyer, P. and Birkelund, R., 2015. Dealing with existential anxiety in exercise-based cardiac rehabilitation: a phenomenological-hermeneutic study of patients' lived experiences. *Journal of Clinical Nursing*, 24, pp.2581–2590.

Sjöström-Strand, A. and Fridlund, B., 2008. Women's descriptions of symptoms and delay reasons in seeking medical care at the time of a first myocardial infarction: A qualitative study. *International Journal of Nursing Studies*, 45(7), pp.1003-1010.

Sjostrom-Strand, A., Ivarsson, B. and Sjoberg, T., 2011. Women's experience of a myocardial infarction: 5 years later. *Scandinavian Journal of Caring Sciences*, 25(3), pp.459-466.

Smeijers, L., Mostofsky, E., Tofler, G., Muller, J., Kop, W. and Mittleman, M., 2017. Anxiety and anger immediately prior to myocardial infarction and long-term mortality: Characteristics of high-risk patients. *Journal of Psychosomatic Research*, 93, pp.19-27.

Smith, J., 1996. Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health*, 11(2), pp.261-271.

Smith, J., 2004. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, pp.39-54.

Smith, J., 2008. *Qualitative Psychology: A Practical Guide To Research Methods*. 2nd ed. London: Sage Publications Ltd.

Smith, J., 2011. Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review*, 5(1), pp.9-27.

Smith, J., Larkin, M. and Flowers, P., 2009. *Interpretative Phenomenological Analysis: Theory, Method And Research*. London: SAGE Publications Ltd.

Strömberg, A. and Jaarsma, T., 2008. Thoughts about death and perceived health status in elderly patients with heart failure. *European Journal of Heart Failure*, 10(6), pp.1003-1010.

Svenaeus, F., 2011. Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Medicine, Health Care and Philosophy*, 14(3), pp.333-343.

Swanoski, M., Lutfiyya, M., Amaro, M., Akers, M. and Huot, K., 2012. Knowledge of heart attack and stroke symptomology: a cross-sectional comparison of rural and non-rural US adults. *BMC Public Health*, 12(1).

Taipale, J., 2014. *Phenomenology And Embodiment: Husserl And The Constitution Of Subjectivity*. Illinois: Northwestern University Press.

The British Psychological Society. 2014. *Code Of Human Research Ethics*. [online] Available at: <https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf> [Accessed 29 November 2020].

The British Psychological Society. 2018. *Code Of Ethics And Conduct*. [online] Available at: <https://www.bps.org.uk/sites/www.bps.org.uk/files/Policy/Policy%20-

%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf> [Accessed 29 November 2020].

Thoibisana, A., 2008. Heidegger on the Notion of Dasein as Habited Body. *Indo-Pacific Journal of Phenomenology*, 8(2), pp.1-5.

Thornhill, K., Lyons, A., Nouwen, A. and Lip, G., 2008. Experiences of living with congestive heart failure: A qualitative study. *British Journal of Health Psychology*, 13(1), pp.155–175.

Tillich, P., 2000. *The Courage To Be*. 2nd ed. New Haven: Yale University Press.

Tuffour, I., 2017. A Critical Overview of Interpretative Phenomenological Analysis: A Contemporary Qualitative Research Approach. *Journal of Healthcare Communications*, 2(4), pp.1-5.

van Deurzen, E. and Arnold-Baker, C., 2005. *Existential Perspectives On Human Issues: A Handbook For Therapeutic Practice*. London: Palgrave Macmillan.

van Deurzen, E., 2011. *Everyday Mysteries*. London: Routledge.

van Deurzen, E., 2012. *Existential Counselling & Psychotherapy In Practice*. 3rd ed. London: Sage Publications Ltd.

Vilchinsky, N., Horowitz, Y., Bar-Kalifa, E., Hasson-Ohayon, I., Berlin, T. and Mosseri, M., 2019. Existentially Oriented Group Intervention for Patients With Heart Failure: Intervention Development and Preliminary Assessment. *The Journal of Cardiovascular Nursing*, 34(2), pp.141-146.

Vongmany, J., Hickman, L., Lewis, J., Newton, P. and Phillips, J., 2016. Anxiety in chronic heart failure and the risk of increased hospitalisations and mortality: A systematic review. *European Journal of Cardiovascular Nursing*, 15(7), pp.478-485.

Walsh, A., Kitko, L. and Hupcey, J., 2018. The Experiences of Younger Individuals Living With Heart Failure. *Journal of Cardiovascular Nursing*, 33(6), pp.9-16.

Waugh, A. and Grant, A., 2010. *Ross And Wilson Anatomy & Physiology In Health And Illness*. 11th ed. London: Churchill Livingstone Elsevier.

Westman, B., Bergenmar, M. and Andersson, L., 2006. Life, illness and death: Existential reflections of a Swedish sample of patients who have undergone curative treatment for breast or prostatic cancer. *European Journal of Oncology Nursing*, 10(3), pp.169-176.

Wilberg, P., 2011. From existential psychotherapy to existential medicine. *Existential Analysis*, 22(2), pp.303-317.

Willig, C., 2013. *Introducing Qualitative Research In Psychology*. 3rd ed. Berkshire: Open University Press.

World Health Organization. 2017. *Cardiovascular Diseases (Cvds)*. [online] Available at: <https://www.who.int/en/news-room/fact-sheets/detail/cardiovascular-diseases-(cvds)> [Accessed 25 November 2020].

World Health Organization. 2018. *Causes Of Death*. [online] Available at: <https://www.who.int/data/gho/data/themes/topics/causes-of-death> [Accessed 25 November 2020].

Yalom, I., 1980. *Existential Psychotherapy*. New York: Basic Books.

Appendix I – Interview Question

Age:

Marital status:

Occupation:

How many Heart Attacks:

Date of last Heart Attack

1) Describe the experience of your heart attack.
   a) How did you experience your Heart Attack?
   b) Where they all the same/different?
2) How has it affected your life?
   a) Tell me more.
   b) How has the heart attack changed the way you see your life?
   c) Self? Work? Others? Spirituality? Different choices? Body?
3) Looking back... Tell me about yourself before the attack.
   a) Self? Work? Relationships? Spirituality? Body?
4) How were you generally feeling before the heart attack?
   a) Describe the emotions your felt?
   b) Bodily sensations?
   c) Describe.
5) Was your body giving you any hints/signs before the attack?
   a) How? What? Where? Describe.
   b) How did you experience your body throughout?
6) If your Heart Attack was a person can you describe it?
   a) Tell me more.
7) From everything we just said, what does having a Heart Attack mean to you?
   a) Think of the word heart attack… what comes to mind?

Appendix II – Informed Consent

Informed Consent

NSPC Ltd

Existential Academy

61-63 Fortune Green Road

London NW6 1DR

Psychology Department

Middlesex University

Hendon

London NW4 4BT

Middlesex University School of Health and Education
Psychology Department
Written Informed Consent

Title of Research: The embodied experience of women who suffered from a Heart Attack in Egypt: An
Existential View

Academic Year: (2017-2018)

Name of Researcher: Rana Heiba **Email:** RH667@live.mdx.ac.uk

Name of Supervisor: Dr. Simon Cassar **Email:** simon.cassar@yahoo.co.uk

- I have read and understood the details of the research as explained in the Participant Information Sheet which I have been given to keep and have had the opportunity to ask questions.
- I understand that my participation will involve an in depth interview that is digitally recorded and I give my consent for this to happen.
- I have been informed that the data will be anonymised, coded and stored either on an encrypted memory stick or in a locked drawer in the researcher's home

- I understand that my participation is voluntary and I have the right to withdraw from the study at anytime without needing to explain.

- I have been informed that the confidentiality of the information I provide will be safeguarded subject to any legal requirements.

- I understand this interview is for the purposes of research and I agree to take part.

Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Health and Education Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: ___________

_____________________________ _________________________________

Print Name Signature

Date: ______________________

Appendix III – Participant Information Sheet

Information Sheet

NSPC Ltd

Existential Academy

61-63 Fortune Green Road

London NW6 1DR

Psychology Department
Middlesex University
Hendon
London NW4 4BT

Name of Researcher: Rana Heiba **Email:** RH667@live.mdx.ac.uk

Title of Research: The embodied experience of women who suffered from a Heart Attack in Egypt: An
Existential View

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research? This study is being carried out as part of a doctoral degree in Counseling Psychology at NSCP Ltd and Middlesex University. The main purpose of this research is to gain a phenomenological understanding of the lived experience of women who have suffered a heart attack. Instead of conceptualizing heart attacks from a bio-medical stance, I hope to take a closer look at the embodied dimensions of this phenomenon and its impact on your personal, physical, social, and spiritual worlds.

What will happen to me if I take part? I, the interviewer, will contact you to arrange an interview which will take place at a time which is convenient to you. The interview will last up to 60 minutes and will explore your experience of having a heart attack and touch on life events prior to the attack as well. Your participation is entirely voluntary and you are free to withdraw at any time without giving a reason. The information from the interview will be combined with other information from other interviews during the analysis stage of the research.

What are the possible disadvantages to taking part? By taking part in this research, you will be asked to talk about your heart attack experience, which might bring about the feelings you had at the time and cause distress. If this happens and you feel uncomfortable, please tell me during the interview and we can stop or pause according to your desire.

What are the possible advantages of taking part? Research about the embodied experience of heart attacks is yet to be explored from an existential point of view, let alone focusing on women. Whilst there are no specific benefits of taking part in this research, some people find talking about their experiences beneficial and even therapeutic.

Consent You will be given a copy of this information sheet for your personal record and asked to sign a written Consent Form prior to taking part in the research, if you agree. Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part, you may withdraw at any time without giving a reason

Who is organising and funding the research? This research is completely self-funded as part of my Doctorate in Counselling Psychology.

What will happen to the data? Your interview will be recorded, transcribed by me, the researcher. The transcription will be anonymised, all identifying features will be removed and you will be given a pseudonym. Your data will be stored in strict confidentiality on an encrypted memory stick and paper copies will be held in a locked cabinet in the researcher's own home office. The data will be stored by NSPC in accordance with NSPC's Data Retention Policy. Abstracts from your interview might be used anonymously in the thesis. In addition, if my research is published, I will make sure that neither your name nor other identifying details are used.

There is no official regulation regarding data protection in Egypt. Therefore, data will be stored according to the GDPR.

What if I change my mind? Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part, you may withdraw at any time without giving a reason.

Who has reviewed the study? All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC Research Ethics Sub Committee and Middlesex Psychology Department's Ethics Committee have reviewed this proposal.

Thank you for taking the time to read this sheet. Should you have any further questions you can contact me at:

Rana Heiba
NSPC Ltd
Existential Academy
61-63 Fortune Green Road
London NW6 1DR, UK
RH667@live.mdx.ac.uk
01001538756 (This is a dedicated number and is available Sundays through Thursdays from 10:00 am to 7:00 pm)

If you have any concerns about the conduct of the study you can contact my supervisor:

Dr. Simon Cassar
NSPC Ltd
Existential Academy
61-63 Fortune Green Road
London NW6 1DR, UK
simon.cassar@yahoo.co.uk

Appendix IV – Debriefing Sheet

Debriefing

NSPC Ltd

Existential Academy

61-63 Fortune Green Road

London NW6 1DR

Psychology Department
Middlesex University
Hendon
London NW4 4BT

Name of Researcher: Rana Heiba **Email:** RH667@live.mdx.ac.uk

Name of Supervisor: Dr. Simon Cassar **Email:** simon.cassar@yahoo.co.uk

Title of Research: The embodied experience of women who suffered from a Heart Attack in Egypt: An Existential View

Thank you for your time and effort in participating in this research. Your contribution will add to our understanding of the embodied experience of women who have suffered from a heart attack. With your contribution we hope to take a closer look at the embodied dimensions of this phenomenon.

Your digital recording will now be transcribed by the researcher, Rana Heiba. During the transcribing process any identifying information will be removed and you will be given a pseudonym. The anonymised data will be coded and then analysed and written up as part of the findings of this research. The findings may also be published in peer-reviewed journals.

Your data is strictly confidential and will be stored either on an encrypted memory stick or in a locked cabinet in the researcher's own home. Following completion of the project, the data will be stored by NSPC in accordance to NPSC's Data Retention Policy.

Your participation in this research study is entirely voluntary and you are free to withdraw at any time.

I hope you have understood the overall aim of this study and enjoyed your participation in it. Should you be left with any questions about the research and your participation in it, or would like to discuss your experience please feel free to contact me on the above email. Should you have any concerns or complaints, you can contact my supervisor, Dr. Simon Cassar, by email at simon.cassar@yahoo.co.uk.

For further support you might find the following resource helpful. This center provides one-to-one counselling services:

Exist Counselling Education Network
Address: 13 Al Israa St. off Lebanon St.,
Floor 2, Flat 5
Mohandeseen, Giza, Egypt
Tel: (+202) 3346 9992
Fax: (+202) 3346 9993
Mob: (+2) 0106 277 1515
Email: contact@exist-counselling.com

Appendix V – Transcript Example

I	Okay… I'll start off with basically describe the experience of your heart attack
P	Uummm… just the experience not what led up to it right?
I	Whatever comes to mind like we will get to what led to it so if you want to start with that
P	Okay the experience itself… I was on a business trip [abroad]… I had been traveling a lot uhh taking a lot of planes and I was exhausted and I came home after standing for a few days uhh in uhh stressful training uhh and what happened was I was standing and all of a sudden uhh I felt my heart, my chest constrict very very much and then pain shoot up my neck and then pain shoot down my arm and I couldn't breathe it took [she pauses] about 10 minutes to calm down I didn't know I was having a heart attack… uumm and then I went to sleep [she laughs] and woke up and went to work the next day
I	Okay
P	Okay… and then I woke up the day after that and fainted passed out in my hotel room and then I went to the hospital and they told me that I was at risk for another heart attack right now [she laughs] and that I should have come in when that happened
I	What made you not go in?
P	Ummm [she pause] I know this is gonna sound a bit silly [she laughs] but ummm I'm I'm used to being tired I am used to being in pain I am used to getting anxiety
I	Okay…
P	I am used to feeling it in my chest... nana I have never felt that because that was that was pain and the lack of breath [I mean, that's it] eehhh I needed to get up and go to work the next day and I don't think that I wanted to… I never thought that it was a heart attack… I didn't not believe…I didn't know what it was… looking back [of course] I should have been more scared than that I wasn't [I mean] I am used to just getting up and going
I	And going… okay… alright… uhh and tell me you were saying things that led up to the heart attack… was there something in mind that you had or…
P	I I I had had a lot of stress and pressure and travel uhh my dad got very sick for 7 months I am one who takes care of my parents and I am the one who completely takes care of my children uhhh umm their father is not in the picture at all [so] it was a very very stressful time for a while for a good year a year and some before it where I had uhh that that constriction in in my even even when I went to the hospital and I was like 'no it's not pain it's constriction' they were like 'no you need to call it pain because that's what it is you need to acknowledge that its pain' but I call it constriction [I mean] ehhh [but] I had ehh [I mean, its normal] I used to have shooting pains but I wasn't having a heart attack [I mean so] this one [of course] was very different than anything that I ever had [but] ehhh I feel like it was accumulated stress that's all
I	Okay so you do you do attribute it to accumulated stress
P	Oh yeah they told me yeah
I	And it makes sense to you?
P	They said it was a stress heart attack there was nothing wrong with my arteries they said this was a stress heart attack
I	Okay…
P	Yes and they said there was too much adrenaline in my body
I	okay
P	Uuhhmm and it took them a while to calm that down they gave my medicines and stuff
I	But you didn't do you didn't have a stent?

P	No no no I was going in to see if they needed to put a stent and I told them no because I didn't want to do that [abroad] and then I had to stay in ehh [abroad] for a few days because they took my papers… one of the people… one of the organizations that I have done executive coaching for on and off is [work place] okay? [So] I sent all of the papers from the hospital to a friend of mine there because they have good doctors and they are quick and you know [so] he sent it to the head of cardiology in [hospital and doctors name] he looks like Einstein [like that]
I	[We both laugh]
P	[So] ehhhhmmm and they said 'don't get on a plane' and I had to go back ehh and get tests done every day until they told me like two and a half days later 'you can get on a plane come back'
I	okay
P	When I got on a plane and came back they said 'you don't need a stent there is nothing wrong with your arteries' this was a stress heart attack
I	A stress okay… you were saying after that the aftermath of it like how was it medically or how was it?
P	It was awful…I've never it took me very long to recover… I I .. it took me at least 6 months I I get dizzy going downstairs I get very out of breath
I	Was it from the medication or the heart attack?
P	I don't know…it wasn't from medication… [I mean] after that it took it took my body a a while to get back to where I was… but I don't think it was from the medication
I	Okay
P	Yeah… because I was… I was having the same symptoms before the heart attack [but] no so…
I	Not as intense?
P	Yes yes
I	Okay
P	Yes before any medication… and they put me on antidepressants that were awful…[but] I didn't like it [so] I stopped after a couple of months ah… they were like 'you need this to calm down'
I	Okay…
P	They told me it was protocol
I	Yeah I think that they do this as protocol…. Uhhmm there are 2 things that came to mind uhhmm the after math it took you around 6 months for you of get back and kind of [as if] your body is getting back to where it was… umm what other sorts of healing… I don't know if you want to call it healing or treatments therapies whatever… have you been in any of that after
P	Yes uuhmmm [homeopaths name] gave me a whole bunch of homeopathy
I	Okay
P	Uhhmm which I took uhh I can't tell you [I mean] it was a time where I was taking regular medicine traditional [I mean, you understand] medical medicine and I was also taking homeopathy… I did feel a difference in my mood with the homeopathy because for some reason I was very depressed after the heart attack uhhmm I don't know if that was my mental state because I I felt like I did something wrong or I got myself to a bad space you know what I mean or if I was just depressed because of the heart [I mean, I don't know which one it was] but I was I was a bit depressed [I mean]
I	Can you tell me a bit more about that depression?
P	Uhhm I felt very very down
I	mmhum

P	Uumm my body was very weak… I wasn't able to get up and do all of the things that I regularly do without getting a little dizzy or out of breath
I	Mmhhm
P	Ummm that made meee uuuhhh down and I felt guilty as well fooorr not being able to handle things well enough or it doesn't [affect me and] my house like this you know what I mean… because I am a single mom… [I have two kids] [soo soo] it really affected our home life for a little bit you know
I	okay
P	[Yeah]… [that's it, so] it made me down… I am not sure if I down if that's a natural effect of…
I	But that was your experience
P	Yes yes
I	Okay… and you were saying also ummm… you said the word constricted a lot at the beginning uhh [even] if if it's the heart but… can you tell me a bit more about what this constriction was? Even like before during like that constriction in your life?
P	I ummm ehhhh [she paused] I always joked that I am gonna go with a heart attack
I	Okay?
P	Not because I thought I was actually gonna have a heart attack but in my life I thought if there is a weak area it's my chest
I	Okay…
P	Okay? Uuhh in a symbolic my heart is broken kind of way not a physical way
I	Okay
P	Right? Uuuhhmmm I had uh quiet a bit of trauma when I was a child and since [she paused] then like maybe at the age of 9… I would feel my chest always constrict when I feel bad or when things are stressed or uuhh [so] it's not a new feeling right I actually feel pain in my chest like physical pain in my chest for a very long time
I	Okay…
P	But not heart attack pain [she laughs]
I	Yeah… but that's what led to the joke?
P	Yeah
I	Okay… and uhh your saying heartbroken… I don't want to jump to conclusions and say your divorce but can you tell me a bit about that or if there was anything else that was that heartbroken experience
P	I I wasn't heartbroken…. My divorce wasn't a broken heart in a romantic way it was a broken heart because a family now is you know uhh being broken uhh but for me I would tell you that my 'broken heart' led me too a lack of tools to be able to deal with certain things
I	Mmhmm..
P	Led me too some bad decisions that led me to that marriage that led me you know what I mean
I	Okay
P	[So] I had aa… he didn't break my heart I broke my heart
I	Okay
P	Is that… [I mean] I felt that I broke my heart I I didn't do something that was right I didn't make the right decisions do you know what I mean?
I	Okay
P	Like in that term… but in a romantic heart break no
I	And how have your decisions or the way the path or the way you are moving in life change after the heart attack? Or [it doesn't need to be] after the heart attack but changed in general?

P	I'm still because it's still new… and I've been the way that I am for a long time… uhh of course my emotional psychological issues I very much focused on healing over the past 20 something years
I	Mhhmm
P	I've come to a place where I'm comfortable I am happy… it doesn't mean that I still don't have stuff to learn… but uuhhh because of physical and sexual abuse for many years I used to detach from my body
I	Okay
P	Okay? And since then I don't uhh value my physical body… I don't take care of it like I should… I don't give myself time to rest I don't… [I am detached from it]
I	Okay
P	[So] and I just keep going… I've always had something or other physically… it doesn't matter what… I've had many things physically throughout the years and my way of dealing with it is putting on the side… which [of course] for me I very much believe that it was psychosomatic because I wasn't able to deal with certain traumas throughout the years… it's gotten much better now but I'm not good with my body
I	Okay
P	You know I don't I don't treat it well because I'm used to just separating from that
I	And detaching
P	Yeah I focused very much on psychological and emotional healing and I didn't focus on my physical body
I	Okay… But that very like… [I mean] you are very well aware of it
P	Yes yes but its its been very very difficult for me to connect
I	To connect?
P	Yeah I I it's like [she paused] this automatic default where I shut I just shut off and keep going... I'm I've been tired since I had my first kid do you know what I mean? And I work and I take care of my parents and I'd like to also have friends and a life you know what I mean? [so so] I don't ummm
I	You keep going…
P	Ahh I don't stop [I mean so] I keep going and I know that I tired [but] for me the way to deal with that is mind over matter
I	Okay…
P	Yeah… until it caught up with me last year [she laughs] and then my body went 'no we are not gonna do that anymore' yeah
I	[Laughs with her] alright
P	[That's it, so] I'm still working out the process to change that yes
I	Okay…. Uhh tell me a bit about who you are… you did a little bit you don't stop… you keep going… the detachment but tell me who else are you?
P	Uhh I'm a mom uh I'm a friend I'm a coach uhh what else would you like to know? Uhh
I	Describe a bit of whatever comes to mind… it doesn't need to be
P	Uhhmmm I dont know for me I like to help
I	Okay
P	Uhh I guess I am a helper uhhm I've managed that along the way to be able to focus my help in directions that will impact better you know what I mean? Than just giving my energy to everything and everyone
I	Okay…
P	Uhhmm I very much enjoy being a mom and hanging out with my kids… I very much enjoy uuuuh socializing uhh I love research I love reading I like my job… even though okay… I

	love being a trainer I love being an executive coach I don't care much anymore for the psychometric assessment
I	Mmhmmm
P	Uhhmm [but] doing it corporate is is not I love the job itself but I don't love always doing it the way that I do it [I mean] to [I mean] to have an income [I mean] for me and the kids
I	Mmm
P	Uhhmm but the job itself I love
I	The corporate world [is what's hard]?
P	Yeah and actually [doctor's name] he sat with me for a good hour asking me a lot about my life… and he had instructed me that number one the amount of airplanes that I was taking was not allowed anymore
I	Okay
P	Forever… not just for a little bit uhh umm he also told me that umm I should not the chapter with coaching men like I do in the [work place] because he he is like [there has been a lot of requests to give you the best possible care] how do you know these people? [she laughs]
I	[Laugh with her]
P	[I mean] how do you know these people? [so so] I told him how I knew these people and he knows these people because obviously he is one of the doctors [I mean] that they called and that's one of the hospitals that they use [soo so] he was telling me that coaching men like that we need to close that chapter
I	Okay
P	Because he feels that I've become in energy and nature, you cannot help but be like that
I	Mmmmm
P	20 years is enough umm
I	It's a lot
P	Yeah and he is like 'the amount of adrenaline that was in your body a man's heart might been able to handle, a woman's heart can't'
I	Wow
P	He said
I	So it's like you embodied these men
P	Yes he he was telling me that a man's heart can take more adrenaline than a woman's heart and the amount of adrenaline that was in me was too much for a woman
I	Okay
P	[I mean, I'm telling you what he said]
I	Ahh but does that it make sense to you?
P	Eehhh I I never knew that men's heart can take more adrenaline than I woman's heart that was completely new to me… I I'm very aware that I am pumped with adrenaline that's what keeps me going I have an automatic like you know go go go… umm and I never cared to stop that because I felt like if I sat down I might not get back up
I	Okay
P	Right? [so so] I just kept going [so] no I didn't I didn't know that you know?
I	Mmm but did you feel that you actually… like thee energy has affected you or the people not necessarily them but [I mean, anyone] at work?
P	Yeah of course…. Look I don't believe that the people that I worked with affected this I think that I affected myself which made me match those people… I I already I was already [I mean] this is the most feminine that I have ever been okay? I'm I I wore masculine clothes, I talked with men I, [I mean] I hold myself in a more of a masculine energy definitely at work uhumm and that was my comfort zone… right? Umm which, I think led me to be able to work with these men for 20 years

I	Okay… yeah
P	You know what I mean? Or else you wouldn't… I I was already that way does that make?
I	Yeah yeah no it makes a lot of sense?
P	[So] I can't blame them but yes I put myself in that in that ummm circle of my comfort zone yes