Sufferers’ Perspectives of Non-Cardiac Chest Pain

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Dedicated to:

Lily and Geoff, two wonderful parents who are greatly loved.
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Addendum

Transcripts from the five interviews.
Sufferer's perspectives of Non-Cardiac Chest Pain

by Lindsey Hume

Background: Both in primary care and emergency departments, chest pain has been a common presentation. However, it has frequently been identified having a non-cardiac pathology. This non-cardiac chest pain (NCCP) has been diagnosed for as much as 50 percent of referrals to cardiologists (Mayou, 1997). Nevertheless, the pain often persists after heart related diseases and other aetiologies have been ruled out. Psychological treatment studies have shown some positive results, but recruitment was low. Often, the sufferers who did not engage in the research believed that the NCCP had no psychological components. The aim was to gain a better understanding of the experience of NCCP from the sufferer’s perspective.

Method: Five NCCP sufferers were recruited from a rapid access chest pain clinic. They were interviewed by a psychologist for up to one hour. The semi-structured interviews were transcribed and the data analysed using Interpretative Phenomenological Analysis (Smith, 1996).

Analysis: Three main themes emerged from the data. (1) Understanding: which included sub-themes; cause, not knowing, comparison and context. (2) Impact: which included sub-themes; daily activity, emotion, symptoms, control, image and chest pain results. (3) Support: which included sub-themes; self-support, availability of support and support from others.

Implications: The main clinical implication related to: communication with health care professionals; interventions; and information dissemination.
INTRODUCTION

Many psychological approaches to health research have attempted to find labels to place on people in order to predict their behaviour. However, this seemed like another way of using, what Atschuler (1997) called, the outsider’s account and did not fully investigate the individual’s perspective. There had been an increase in the use of research methods that took into account the individual’s perspective and associated variables, such as the relationship with social and cultural influences, and self-identity (Atschuler, 1997). More recently, the critical health psychology approach questioned why we are trying to change people’s behaviour, and suggested more focus on meaning and understanding (Crossley, 2000). For instance, Crossley (2000) talked of there being many health problems that were reduced to an individualistic level rather than appreciating, for instance, the social context of modern life. This current research aimed to investigate the perceptions of non-cardiac chest pain (NCCP) from the sufferer’s viewpoint, taking into account contextual factors.

This introduction first explores the existing literature to identify current thinking on the definition, distinguishing features, and prevalence of non-cardiac chest pain (see Figure 1). The aetiology of the complaint will be discussed, followed by conceptualisations and researched interventions. Second, the introduction will consider the perception of health, illness and symptom attribution in general. Two broad and complementary approaches will be used to highlight important aspects when attempting to understand health and illness.
Non-cardiac Chest Pain

Definition

Across both primary care and emergency departments chest pain has been a common presentation (Kroenke et al., 1989 cited in Mayou, 1997). However, despite its suggested cardiac pathology it was often found to be a non-cardiac problem (Mayou et al., 1997). This atypical chest pain ailment has been difficult to define and it was generally considered in terms of presenting symptoms rather than aetiology (Mayou, 1997). This may have been due to the uncertainty surrounding the cause of NCCP (see Aetiology section below).

Distinguishing features of NCCP have been difficult to identify. Nevertheless, the literature suggested that there were symptoms associated with NCCP such as: fear of organic or heart disease plus being pre-occupied with their heart; limited daily life,
breathlessness, nausea, dizziness, weakness, palpitations and numbness (Klimes et al., 1990; Eifert, 1992). Also, sufferers may have experienced symptoms of anxiety and panic disorder such as: avoidance and compulsive checking behaviour, hyperventilation, chest muscle tension and sweating (Eifert, 1992). These symptoms appeared to be based on the assumption that NCCP was caused by anxiety and fear of illness, and yet there seemed to be no evidence to back up this assumption. The confusion may have arisen from the possible co-morbidity of anxiety related factors (Van Peski-Oosterbaan et al., 1999). It could have been that the panic, hyperventilation and sweating symptoms, for example, were related to anxiety and not the NCCP, or that NCCP was an intrinsic part of anxiety. However, studies have shown that not all those with NCCP suffered from panic disorder (PD). One estimate ranged from 31 percent to 63 percent (Carter et al., 1997).

In summary, NCCP was generally defined by its presentation. The psychological symptoms appeared to overlap with those of anxiety/panic disorder; however these may have been as a consequence of the problem and not intrinsic. Also, if assumptions had been made that anxiety was strongly linked to NCCP, it might have been that the focus was drawn towards the anxiety-related symptoms, and other symptoms were overlooked. The primary problem may have been one of pain and the secondary symptoms may have varied due to contextual factors, but this was yet to be established.

**Distinguishing Features**

As mentioned above, it appeared to be difficult to untangle the features of NCCP and anxiety/panic disorder. Many clinicians also had difficulty in distinguishing between
non-cardiac and cardiac chest pain (Cormier et al., 1988). At present, the main methods of differentiating between the two rely upon cardiac tests such as elevated cardiac enzymes, positive exercise, electrocardiography, or >50 percent occlusion on coronary angiography (Carter et al., 1992).

Misdiagnosis can be costly, for instance the uncertainty and intrusive investigations suffered by patients, as well as the clinician’s wasted time (Bass & Wade, 1984 cited in Cormier et al., 1988). Also, a lengthy involvement with health services when the patient thought they might have heart disease may have made it more difficult for them to accept different diagnoses (Mayou, 1997).

Papers comparing NCCP with cardiac chest pain, and panic disorder with chest pain were reviewed. The majority of the studies used small samples (n<50) and the sampled populations had often been taken from a stressful setting, such as an intensive care unit (ICU). Taking into account the problems of generalisation and confounding variables, the following was worth noting, even though it may have been considered as tentative evidence.

**Cardiac and Non Cardiac Chest Pain**

*Cormier et al. (1988)* compared 98 subjects undergoing cardiac testing after reporting chest pain. They identified some divergence among participant characteristics, indicating that those who were younger and female were more likely to report NCCP, although there was no significant difference between social class or marital status. They investigated psychiatric symptoms and found that NCCP patients were
significantly more likely to suffer from panic disorder, major depression or multiple phobias and that cardiac disease patients were significantly more likely to have no psychiatric diagnosis. From self-rating measures they found that only NCCP sufferers showed a significant difference in anxiety and negative life events as compared to cardiac patients. This may imply that NCCP patients are more likely to be suffering from anxiety prior to the chest pain, or as a consequence of the chest pain, and/or the investigation.

Marusic and Gudjonsson (1999) compared biological factors and psychosocial risk factors of ischaemic heart disease (IHD) in three groups of men: those suffering from NCCP (n=19), those with confirmed IHD (n=76) and controls (n=76). The biological factors included family history of IHD, presence of hypertension, measurement of blood clotting factors, and history of smoking. The two psychosocial factors were neuroticism and sensitisation of emotion. This study matched for age and location of data collection. Their exclusion criteria omitted those with terminal illness, a history of head injury or mental illness. The results showed significant differences for five out of eight biological factors between the three groups, where the NCCP group tended to score mid-way between the cardiac and control group. However, family history of IHD showed the NCCP group to be much closer to the IHD group. The psychosocial factors showed no significant variation among the three groups, but it was noted that the neuroticism scores for the NCCP group were higher than the others.
The results suggest that those with a family history of IHD are more likely to suffer from NCCP, which may be linked to fear of a heart attack. Also, levels of neuroticism may warrant further investigation, as this may be a distinguishing factor.

The sample showed an average age of 51 years (standard deviation, 8.9), and the participants were all male. This group could be criticised for not being a representative sample, especially as previous studies have indicated that age and gender may be significant factors in distinguishing NCCP sufferers (Cormier et al., 1988).

Bennett et al., (1996) looked at the difference between cardiac chest pain sufferers’ (n=15) and NCCP patients’ (n=15) levels of vital exhaustion, neuroticism and symptom reporting. However, the results showed no distinction among the three groups on any of the three factors, independently or in combination. The samples were matched for age and gender. However, the sample sizes were small, which emphasises caution in generalising results (Bennett et al., 1996). Also, subjects were interviewed within three days of hospital admissions, so this could also limit the interpretation of results, as responses may have been heavily influenced by that experience (Bennett et al., 1996). For instance, the admission to hospital in itself may have provoked high levels of symptoms not related to illness, and therefore could mask any distinguishing factors.

**Chest Pain and Panic Disorder**

It has already been mentioned that NCCP has a strong link with anxiety symptoms including panic disorder, implying that it may be primarily a psychological disorder.
However, studies have attempted to differentiate between panic disorder and cardiac problems or chest pain in general. The next reviews will look at such studies.

*Jolley et al. (1992)* investigated cardiac status and compared two groups of panic disorder sufferers. Ten of the subjects had sought medical help for cardiac symptoms while the other 10 had not. Recruitment methods were not mentioned in the study. Various cardiac measures were used but none showed a significant difference between the two groups. The results suggested that there was no difference in incidence of cardiac pathology between those who report cardiac symptoms and those that do not. The inference is limited, however, due to the size of the sample (*Jolley et al.*, 1992). Jolley and colleagues also recognised that some members of the sample were being treated for panic disorder and were on antidepressants, which may have confounded the data.

*Carter et al. (1992)* tried to determine whether a significant proportion of those entering a cardiac unit for chest pain were suffering from panic disorder. Carter and colleagues also studied whether those with panic disorder were less likely to be suffering from coronary artery disease (CAD). The investigation aimed to differentiate between panic disorder and non-panic disorder by psychiatric factors, such as anxiety, agoraphobia and depression, and demographic factors such as age and gender. Finally they considered whether there was a sub-type of panic disorder which did not include fear as a component.
Clinicians, who were blind to the participants' cardiac status, interviewed the 62 people for panic disorder, depression, agoraphobia and substance abuse. The interviews were conducted in an intensive care setting when participants were considered medically stable. Cardiac status was determined by any objective measures (e.g. ECG, elevated cardiac enzymes, positive exercise electrocardiography, or >50% occlusion on coronary angiography), whereas, in clinical diagnosis, a collection of such measures would be used (Carter et al., 1992).

The results showed there was no significant difference in cardiac outcome between those with or without panic disorder. Also, those suffering from myocardial infarction (MI) could suffer from panic disorder as well. However, there was a significant difference between those diagnosed with CAD and panic disorder; those with panic disorder are less likely to have CAD.

With regard to demographic and co-morbidity factors, age, presence of agoraphobia and depression scores distinguished those with or without panic disorder. Factors such as gender, major depression, a history of major depression, history of substance abuse or trait anxiety were not shown to distinguish between those with or without panic disorder. The results also found no significant difference between panic disorder sufferers with fear or without fear. These results imply that with chest pain sufferers it is difficult to differentiate by non-cardiac measures between those having and not having a panic disorder.
Carter and colleagues (1992) stressed the possibility that some participants may have panic disorder symptoms secondary to the MI. They suggest that the non-standardised method used for cardiac evaluation could have introduced confounding variables. They imply that less thorough cardiac evaluations may result in biased associations between cardiac symptoms and panic disorder. They also imply that the association between negative cardiac symptoms and panic disorder may be partly due to the amount of cardiac investigations held in the intensive care unit.

Carter and colleagues (1992) did not exclude from their sample those who had a previous history of heart problems, which could also have confounded the data. However, they did re-analyse the data, excluding those subjects, and found similar results, but the sample size was only 23, five of which suffered from panic disorder. Due to the small sample size and the possible confounding variables, caution should be used when interpreting results.

Serlie, et al. (1996) sampled 67 patients with NCCP and 47 patients with heart disease, who were attending an outpatient cardiology clinic for chest pain over a 20 month period. The aim of the study was to investigate the distinguishing factors between the two groups. The researchers excluded participants on the grounds of psychiatric history and further medical complications since referral to the clinic.

A battery of questionnaires was used to measure: socio-demographic variables, anxiety, depression, psychopathology, symptomatology, hyperventilation, health anxiety, displeasure & disability, fear, state & trait anxiety, mood states and vital exhaustion.
The socio-demographic variables showed a significant distinction between the two groups, where NCCP participants were younger, more likely to be female, more often single, and generally non-smokers.

The results also showed that those with NCCP have higher levels of anxiety, somatization, obsessive-compulsive behaviour, neuroticism and hyperventilation. Once the data was adjusted for age and gender, hyperventilation and anxiety still showed significant differences. Using logistic regression the data highlighted six factors that were predictive of NCCP: anxiety symptoms, hyperventilation, medical information seeking, health anxiety, disability and state anxiety. However, this study does not specify whether the inclusion criteria established whether the participants were still suffering from chest pain and at what level. This distinction could make a difference in care and treatment provision.

**Summary**

To summarise, there have been few studies that have established factors that could easily distinguish, with near certainty, between those suffering from NCCP and those with cardiac disease. Although panic disorder has often been associated with chest pain, clarification is still necessary to identify whether NCCP is part of this symptom group or separate. Research does suggest that one can have NCCP without panic disorder.

In the papers reviewed there has been conflicting evidence as to whether symptoms themselves or fear cognitions distinguish NCCP from cardiac disease. For example,
neuroticism and symptom reporting differed between the two conditions by Serlie et al. (1996), but Bennett et al. (1998) presented contrasting results.

There had been some supportive evidence that psychiatric symptoms may have been higher in the non-cardiac population, as compared to those with heart disease (Cormier et al., 1988). In addition, those with panic disorder and chest pain were more likely to have NCCP than a cardiac pathology (Carter et al., 1992). However, Carter et al. (1992) acknowledged that this association may have been partly due to the amount of cardiac investigations held in the research setting; an intensive care unit.

Research showed some demographic evidence to distinguish cardiac from non-cardiac chest pain (Serlie et al., 1996). Those with NCCP were more likely to be younger, female, single and non-smokers (Serlie et al., 1996). In addition, from an all male sample, it was shown that NCCP sufferers were likely to have a family history of heart disease compared to a control group (Marusic & Gudjonsson, 1999). Therefore, although demographic evidence was infrequent, initial indications showed a tendency for discriminating by factors, such as gender and age.

The majority of the studies used small samples (n<50) and the sampling could be criticised for not being representative, for instance in terms of age and gender. Also, the sampled subjects have often been taken from one setting which has frequently been a stressful one, for instance in an intensive care unit (ICU). This raises the issue of confounding variables, for instance anxiety due to being in an ICU in hospital. It also
raises the issue of how representative the sample is if data is only gathered from stressful hospital settings and not from other hospital or community locations.

It appears that in some studies inclusion and exclusion criteria have not been given enough consideration when reflecting on the research aims. This raises ethical questions about the necessity of certain people participating in the investigation. For instance, when researching symptoms to distinguish cardiac from panic disorder, one study included participants who were on medication (Jolley et al., 1992), which may have suppressed the symptoms being targeted.

In conclusion, the specific symptoms associated with NCCP have been hard to identify and this is understandable when studies investigating distinguishing features have not highlighted many consistent factors. Further large-scale controlled studies may be helpful.

Also, these studies implied that detailed consideration had not been given to the individual's understanding and context. Emphasis was generally placed on diagnostic features such as anxiety disorders. It was understandable that if professionals could not easily distinguish between NCCP and a cardiac pathology, then sufferers may also have had difficulty.

Prevalence

Research had shown that NCCP often persisted after the heart-related diseases or other somatic aetiologies have been ruled out and despite medical reassurance (Mayou,
It was especially concerning as people have reported suffering from NCCP for more than 10 years after receiving negative results from cardiology services (Potts & Bass, 1995).

There has been an inconsistency in how this health problem was labelled; for example Da Costa syndrome, irritable heart, cardiac phobia, cardiac neurosis and non-cardiac chest pain (Serlie et al., 1995). These difficulties may have been part of the reason why prevalence rates were difficult to establish directly.

The current estimates of the occurrence of NCCP were as a consequence of investigating a different ailment, such as heart disease. Therefore, the prevalence figures were likely to underestimate the true extent of NCCP. Nevertheless, as an indication of the size of the problem, studies have shown that up to 50 percent of those entering cardiac clinics complaining of chest pains have been identified as non-cardiac (Van Peski-Oosterbaan et al., 1999; Mayou et al., 1997).

In the UK, 12,000 people each year have undergone cardiac catheterization to find no heart difficulties (Sanders et al., 1997). Although this was an indication of prevalence, it was recognised as only a sub-group of the NCCP population. Finally, in America up to 100,000 people a year, presenting with chest pain, were investigated for heart disease and found to have no cardiac cause (Beitman et al., 1989 cited in Eifert, 1992).

So, although not directly measured, NCCP could be considered as a sizable problem both for the sufferer and the health service.
Aetiology

Many suggestions have been made as to the cause of this unexplained chest pain; both physical and psychological. Possible physical causes have included oesophageal spasm and mitral valve prolapse, but these and many others lacked strong causal links (Mayou, 1997). Although many anxiety-related psychological disorders have been associated with NCCP, the distinction between what is causal and what is secondary has yet to be established (Mayou, 1997). It has been argued that a physical cause has in the past been over emphasised and that the aetiology was likely to be a combination of physical and psychological factors (Mayou, 1997). This opened up the possibility of meaning and context being relevant. Three of the recent hypotheses for NCCP will now be considered.

Models

The conceptualisations for NCCP briefly described here will include a physiological explanation which argued that the non-cardiac chest pain has its cause rooted in the central nervous system. The second hypothesis was identified as a psycho-biological model which had been adapted from an anxiety theory. The third model was rooted in psychology and concerned the misinterpretation of symptoms.

Central Nervous System Model

Carter et al., (1997) proposed a model to explain NCCP. They suggested that there was no evidence that panic disorder sufferers with chest pain had a cardiac disease and
therefore proposed that NCCP was associated with the central nervous system (CNS). They supported this association by giving the example of CNS Disease and its relationship with perceptual and somatosensory symptoms. They argued that research suggested a link between abnormal metabolic activity in the limbic system and panic disorder (Reiman et al., 1984, cited in Carter et al., 1997). In an experiment where healthy subjects were given a limbic system excitant, results showed panic and cardiac symptoms such as palpitations and chest discomfort, but at the time did not induce changes in blood pressure or heart rate (Carter et al., 1997). They concluded that NCCP was not related to cardiac disease but to a CNS dysfunction.

Although the model appeared plausible it required a number of robust studies to lend credence to the explanation. However, even if the model was confirmed, it would not explain why some NCCP sufferers' experienced panic attacks and some did not. This was because studies focused on panic disorder and chest pain with normal coronary arteries rather than NCCP, which may or may not have included panic disorder. In addition, the model did not explain how the information might have helped in the treatment of NCCP or indicated whether treatment was possible. Neither did the model indicate whether it would be easy to distinguish between NCCP and cardiac disease.

Finally, the model described a malfunction in the CNS and considered the physical aspects of the problem. If the cause was physical it would not eliminate the possibility of a psychological impact of such an ailment. The whole NCCP experience was not contemplated.
Psycho-Biological Model

Eifert (1992) suggested an integrative psycho-biological model to explain NCCP and heart-focused anxiety. He attempted to integrate research findings with psychological and biological variables, plus life stressors. The model was an adaptation from a general theory of anxiety disorders (Staats & Eifert, 1992 cited in Eifert, 1992).

The model suggested that previous learning experiences associated with separation, abandonment, cardiac death and illness behaviour could have influenced the development of psychological vulnerabilities. The vulnerabilities included deficient and inappropriate basic behavioural repertoires: emotional-motivational e.g. hypersensitivity to separation; language-cognitive e.g. hypervigilance to somatic cues; and sensory-motor e.g. obsessive-compulsive habits. It was suggested that the vulnerabilities were associated with the development and persistence of the NCCP. In addition to previous learning, the contextual factors may have impacted on the individual's interpretation or reaction to the symptoms. For instance, current negative life events and stressors could have triggered and contributed to the symptoms. Similarly, biological and genetic predispositions may also have had a role to play in emotional, behavioural and cognitive symptoms. Eifert (1992) argued that it was the interaction of previous learning, current life situation and the psychological plus biological vulnerabilities that produced the negative affect, cognitions, and behaviours associated with NCCP.

Although the model appeared to have considered many possible influences affecting an individual’s experience of NCCP, there was little supportive evidence. The main body
of evidence used was anecdotal or came from research connected with panic disorder. Eifert (1992) mentioned briefly a comment made by Beck and colleagues (Beck et al., 1989 cited in Eifert, 1992) that chronic pain may explain psychological characteristics and not anxiety specifically. However, this was not discussed in any depth. Eifert’s (1992) assumption was that the key to those suffering from NCCP was the interpretation of chest pain to mean cardiac problems.

Eifert (1992) suggested that his model could be used as a framework for analysis and treatment, although not all variables were necessarily relevant. Suggestions for treatment included relaxation techniques and exposure therapy. Where there were separation/abandonment issues, these would be a focus for therapy. The treatment suggestions were only ideas, and no structured interventions were put forward. Eifert (1992) stressed the importance of giving an alternative explanation to the individual for the symptoms rather than leaving them with the knowledge that there was no organic cause.

**A Psychological Model**

Mayou (1997) promoted a model which he argued covered all functional somatic symptoms. The underlying assumption was that NCCP sufferers were interpreting emotional symptoms and were pre-occupied with catastrophic thoughts related to their heart. Mayou (1997) suggested that the framework of understanding centred on cognitive appraisal and attribution of symptoms was evidence of cardiac pathology. There were parallels made between NCCP, health anxiety and other psychiatric disorders.
The predisposing factors included: psychiatric disorder, previous encounters with heart disease and experience with medical care. Both acute and chronic life stresses were considered as precipitating factors alongside physical complaints. Finally, maintaining variables incorporated underlying physical cause, lack of explanation, attitude of others and medical care. The suggested approach to treatment included reassurance and explanation as to possible cause of the chest pain. In addition, other anxiety management techniques were suggested, such as breathing retraining and graded increase in activity.

However, the model was only supported by descriptive evidence and was reliant on panic and health anxiety sources (Mayou, 1997). Therefore this explanation required further investigation, highlighting the relevant components, to aid understanding and treatment efficacy.

Summary

In summary, these three different approaches had attempted to explain NCCP. The CNS model focused on the origin of the pain and other physiological symptoms and gave no consideration to the individual in life context. The psycho-biological model emphasised how previous learning could have influenced the interpretation of symptoms. In particular, Eifert (1992) focused on for instance, separation issues and fear of a cardiac death. Finally, the psychological model emphasised the influence of causal attribution and the misinterpretation of symptoms. However, none were strongly supported by research; generally the models were underpinned by anecdotal evidence.
All appeared to be associated with symptoms of anxiety, either as a direct consequence of a physiological malfunction or indirectly from the misinterpretation of symptoms. There was some interest in the individual’s perspective and the part that might play in the whole experience of NCCP. However, as mentioned earlier, research had yet to prove that NCCP was intrinsically linked to anxiety. Now, consideration will be given to research on current interventions and their efficacy.

**Interventions**

Although there have been pharmacological treatment studies, many appear to focus on reducing panic attack symptoms and not NCCP, due to this and the limits of the review, they were not considered here. There have been some studies showing treatment success from the use of a cognitive behavioural approach, these formed the main focus of the literature review.

Klimes et al. (1990) sampled 31 subjects who were still suffering from NCCP after being given negative results from cardiac investigations. The treatment was based on that used for general anxiety disorder and included relaxation techniques, breathing exercises, distraction techniques and the review and management of maintaining factors. Participants were referred by general practitioners and cardiologists and excluded if they were depressed, had multiple somatic symptoms or were currently being investigated for other physical explanations for their pain. Subjects were randomly assigned to treatment or control groups.
Treatment was carried out by a clinical psychologist over a three month period and for up to 11 sessions. Subjects were assessed pre and post treatment, then again at a four to six month follow-up. The control group was given an opportunity to discuss their symptoms and offered a behavioural explanation; a graded increase in daily activity was encouraged. Outcome measures included frequency of chest pain, limitations of daily life, mood and mental state.

The results showed significant differences in all factors between pre and post measures for the treatment group, except anxiety. Similarly, comparing after treatment results with controls, all factors except anxiety showed a significant difference. The number of pain episodes were reduced to zero for nearly a third of all participants (31 percent) and, by the three month follow-up, the number had increased to 38 percent.

Klimes and colleagues (1990) suggest that further systematic research was necessary and that the essential components of this treatment approach needed to be determined. They also emphasised how clinical reports, although not objectively measured, indicated that being given an explanation to symptoms resulted in a positive reaction from participants.

Many of the measures were self report. It might have been helpful to have objective measures to substantiate results and reduce the influence of demand characteristics. There was no explanation or hypothesis given as to why anxiety levels did not significantly alter after treatment. This could have helped explain why only 31 percent were pain free. Also, the control and treatment group were combined when reporting
the clinical improvement. This analysis did not allow identification of improvement due
to the intervention; therefore the treatment could not be credited. Nevertheless, it was
interesting that there appeared to be a possible distinction between the effects on NCCP
and anxiety.

The sampling methodology was not explicit and may have biased results. For instance,
the clinicians may have approached people who they felt would most suit a cognitive
behaviour therapy (CBT) style intervention. Also, the time-lapse between being given
negative results and being offered treatment appeared not to have been standardised.
Other studies have suggested that immediate intervention may be less successful
(Sanders et al., 1997). Finally, the sample size was small and therefore caution should
be used in generalising results.

Sanders et al. (1997) investigated treatment efficacy on 57 people with chest pain and
negative angiogram results. They were invited to take part in a randomised control trial
where the treatment was a brief psychological intervention. The intervention was given
by a specially trained cardiac nurse and included a psychological explanation for
symptoms, teaching of coping strategies and an opportunity for discussion.

They used self-report questionnaires to measure anxiety, depression, physical
symptoms, level of limitation to daily routine and their beliefs about the causes. The
intervention began as soon as possible after the patient received the negative results.
Each participant was followed up by telephone over the following month at two-week
intervals to gauge progress, reinforce advice and discuss any associated issues. After
three months each participant was interviewed again and the questionnaires were repeated.

The treatment group showed no significant improvements. This might have been due to the treatment itself or the way it was communicated. Sanders and colleagues (1997) suggest that the timing of the intervention, as well as the acceptability of the psychological approach, may have hampered results. They also suggested that the intervention itself may not have contained all the appropriate aspects of therapeutic treatment.

There was a difficulty in recruitment. There were 142 subjects that met the inclusion criteria but, for various reasons, 57 entered the study and only 41 completed the follow-up assessment. The reasons were mainly refusal to take part and disinterest in a psychological approach, as many felt that it was irrelevant. Again this was a study with a small sample size, and caution should be taken if generalising results. Also issues regarding whether the sample was representative of the NCCP population should be considered when interpreting the outcome.

The studies so far have not shown the effectiveness of psychological treatment and both raised doubts as to the acceptability of this style of intervention. Recruitment difficulties also arose for Mayou et al. (1997). These researchers carried out a randomised control study, where the treatment offered was up to 12 individual psychological therapy sessions. The focus for the therapy group (n=20) was alternative non-cardiac explanation of symptoms, teaching coping strategies and examining
maintaining factors. The control group (n=17) were offered what Mayou and colleagues only described as “standard clinical management and advice” (Mayou et al., 1997, p.1022).

Prospective participants were sent a letter after discharge from a cardiology department, asking them to take part in a research study in six weeks time. Measures of frequency and severity of chest pain symptoms, limitation of activities, mood, mental state and beliefs about symptoms were used to assess treatment efficacy.

The results showed a significant difference at three months in the treatment group for all measures, which were largely maintained at six months. The control group showed no improvement at three months, but at six months the distress and frequency of symptoms reduced and their mental state improved. Severity of symptoms and activity limitations had not improved. When the two groups were compared at six months, there was only a significant difference in severity of chest pain symptoms and activity limitations. The implications were that the CBT treatment was effective to some extent, having a lasting effect on dimensions and impact of the NCCP. However, some factors appeared to improve in both groups over time. It was hard to identify what may have been instrumental in these improvements when a full explanation of the “standard clinical management and advice”, given to the control group, was needed.

Again, there were difficulties in recruitment; over 40 percent of the original sample refused to take part, and some felt that psychological intervention was inappropriate. From the original 20 participants, who were allocated to the treatment group, only 16
participants completed the study. The remaining four dropped out prior to treatment. Again, there was a problem with sample size and generalisability. The problems with recruitment appeared to mirror those of the previous study. More time may have been needed between patients receiving negative results and being asked to participate in psychological treatment. Also, there was no description of "clinical management and advice". This may have had a therapeutic element which was not considered.

There did appear to be some tentative evidence that aspects of psychological intervention could be effective, but clarity was needed. In addition, the acceptability or general appropriateness of psychological interventions for NCCP was yet to be established. Van Peski-Oosterbaan et al. (1997) looked at the suitability of cognitive behavioural therapy for those with NCCP. People were approached two years after being diagnosed with NCCP. From 35 individuals who experienced weekly NCCP, 27 were willing to take part in the study. The inclusion criteria focused on weekly episodes of pain and a normal cardiovascular system. The exclusion criteria were no psychiatric disorder, or currently receiving psychiatric/psychotherapeutic treatment.

From the original 27, only 17 were invited to take part in the treatment, two of those did not meet inclusion criteria, and five dropped out. The reasons given by three were related to time commitment to do the homework. The other two did not turn up. This left 10 to go forward for treatment. The outcome measures included a chest pain diary, recording frequency and duration of pain, levels of anxiety and depression, functional limitations, fear of bodily sensations, interpretation of bodily sensations and beliefs about chest pain symptoms.
The treatment consisted of between eight and twelve weekly sessions offered by a physician with brief CBT training and a psychologist trained in behaviour therapy. The therapy was based on the principles used in treating panic, health anxiety and unexplained physical symptoms.

The results showed that from baseline to a 12 month follow-up there was a significant difference in all measures except interpretation of bodily sensations, which had a significance level of $p=0.06$, and level of depressive symptoms, where neither pre or post treatment scores were near caseness levels. Frequency of pain episodes reduced to zero for 60 percent of the group; 10 percent reduced slightly and 30 percent remained the same.

Van Peski-Oosterbaan and colleagues (1997) noted that, due to the uncontrolled nature of the study, no firm conclusions could be drawn. However, they argued that the results gained were unlikely to be related to spontaneous remission. They suggested that the results supported the hypothesis that the reduction in NCCP was related to changes in cognitions about physical symptoms. However, they also recognised that the assessments used could have been influenced by demand characteristics. Again the small sample size caused problems with ability to generalise results. Also, a possible confounding variable was that of therapeutic style, since two different therapists were used.
More recently, Van Peski-Oosterbaan et al. (1999) carried out a randomised control trial with those suffering from weekly NCCP, where the treatment offered was four to twelve weekly sessions of CBT. The therapists plus inclusion and exclusion criteria were the same as the previous study. They hypothesised that changes in cognitions might be associated with a reduction in NCCP.

The therapy was based on a detailed manual to standardise treatment for each participant. From a possible sample of 227, 65 took part in the study (32 in treatment group); the reduction in participants was due mainly to non-response. Therefore, an indication of acceptability by the sufferer was not established. The outcome measures were the same as the previous study, plus likert-type scales to measure the extent to which individuals attributed their chest pain to heart, stress or other physical problems. Six and twelve month follow-up assessments were carried out.

The results showed that with the treatment group there was a significant difference in frequency of pain, levels of anxiety and fear of bodily sensations over the period of the study. There was also a significant difference in attribution pertaining to the heart and to stress but not to other physical problems. Subjects were more likely to attribute symptoms to stress and less likely to attribute it to the heart itself. These results supported their hypothesis that changes in cognitions were associated with reduction in NCCP.

The 12 month follow-up results comparing treatment and control groups showed significant variations in all measures, except for the interpretation of bodily sensations
and attribution to other physical causes. Van Peski-Oosterbaan and colleagues (1999) suggest that the results supported the hypothesis that CBT had a positive effect on heart-related cognitions and levels of pain. They also argued that the reduction in pain appeared independent of levels of anxiety. They suggested that measures may not be specific enough to capture all the pertinent cognitions, and argued that this required further investigation.

The proportion of participants with panic disorder was 21.5 percent, and comparisons were made with non-panic subjects. The results showed that all baseline measures were significantly different between the groups, except for the frequency of pain. At the 12 month follow-up there was no significant link with being pain free and the presence or absence of panic. Van Peski-Oosterbaan and colleagues (1999) suggested this implies that those with panic disorder would benefit to the same degree as those without panic symptoms.

In summary, the study showed positive effects of CBT for NCCP sufferers. However, the sample sizes were small and interest in participation was low, which raises questions of generalisability and how representative the participants were of the NCCP population. Van Peski-Oosterbaan et al. (1999) recognised that they had assumed that changes in heart related cognitions affected levels of pain, but admitted that there could have been a mediating factor.

In conclusion, many of the treatment studies varied with respect to treatment regimes, timing of interventions, length of time to follow-up and research design. Therefore,
although many showed positive results they do not allow pooling of salient treatment factors and, due to sample sizes, could not be easily generalised. Nevertheless, the themes that had arisen indicated that cognitions related to heart attribution of chest pain appeared to justify further investigation.

Also, the lack of interest in participating in psychological treatment could warrant future research. It might have been helpful to have more insight into the individual’s perspective of experiencing NCCP to allow more appropriate care and advice to be offered. Van Peski-Oosterbaan et al. (1998) carried out one such study, using a large sample of 1053. There were 778 people who responded to an initial questionnaire, and of those 63.7 percent were interested in psychological treatment. These tended to be younger and male, and the most important predictor was limitations in activities. However, this did not explain why people were not interested in psychological intervention, and therefore further investigations may have been helpful. Although beyond the scope of this current study, comparisons could have been made between levels of interest in psychological interventions in other physical or psychological conditions. However, it may, have been related to communication issues, for instance how the interventions were described, who was giving the information and what were the associated implications.

Another theme that has emerged in many studies was the importance of giving the patient an alternative explanation to their symptoms. This factor, although not objectively measured, was supported by other researchers who suggested that not having a reliable diagnosis could leave people in an ambiguous and stressful state.
(Radley, 1994). Future research could investigate whether giving individuals an explanation of NCCP and giving their condition a label made any difference to levels, duration or impact of the pain.

Conclusions

Non-cardiac chest pain was a common occurrence. However, there has been difficulty in distinguishing it from cardiac disease and from panic disorder. There appeared to be little consistency in the causal research reviewed. Studies have shown that many suffering from NCCP also suffered from psychological or psychiatric problems. However, treatment studies often exclude those individuals. Assumptions have been made that NCCP was anxiety related, yet CBT treatment based on anxiety disorders had not always reduced anxiety symptoms. Alternative suggestions such as a chronic pain diagnosis have largely been ignored. However, themes associated with chronic pain and cognition, such as interpreting pain in a catastrophic way, were linked to depression, avoidant behaviour and higher levels of disability (Sharp, 2001). This association was very similar to NCCP. Sharp (2001) was quick to emphasise that he was not suggesting that cognitions cause pain. He argued that cognitions may be associated with the impact on individuals’ coping strategies and the degree to which pain impacts generally on their lives.

The majority of the treatment studies reviewed here could be methodologically criticised. However, they have highlighted areas for future research. It appeared important to understand the thoughts and attributions associated with illness, as they could affect the way individuals cope (Leventhal et al., 1992). To gain an
understanding of the subjective meanings attributed to the experience of NCCP, further
research was necessary. Additional information would help to support and shape
interventions, which had shown possible potentional, and assist in understanding why
individuals were not interested in psychological approaches. The following section will
consider general health and illness perceptions in more detail.

**Health and Illness Perceptions**

Initially, a brief outline will be given of two complementary views of illness
perceptions. First, originated with Leventhal and colleagues (e.g. Leventhal *et al.*, 1992) whose main focus was the individual’s common sense approach to illness. The
second was from Radley (e.g. 1994), it emphasised contextual factors and was from a
social psychology perspective. Finally, three relevant pieces of research in the field of
pain and illness perceptions were used to illustrate the importance of the individual’s
understanding health and illness.

**Self-regulation model**

Leventhal and colleagues (Leventhal *et al.*, 1992) argued that to understand how
individuals manage illness, there was a need to consider the respondent’s perspective.
One of the most dominant models in health psychology was Leventhal’s self-regulation
model (see Leventhal *et al.*, 1992). This was a parallel processing model which
suggested there were cognitive and emotional reactions to the threat of disease. The
cognitive and emotional representations worked relatively independently, although they
did have some influence on each other. It was the internal and external stimuli that
generated the cognitive and emotive reactions, which in turn provoked both coping
procedures and appraisals of outcome to the health threat. The representations were considered to have at least five attributes: *identity* or label given to the disease/symptoms; *time-line*, where the threat was considered acute, chronic or cyclic; *consequences* in terms of physical, social or economic factors; *causes*, such as infection or injury; and potential *cure* and/or *control* (Leventhal et al., 1992).

Leventhal and colleagues (1992) also highlight how there were underlying processes related to the person’s memories, for instance schematic and conceptual memory. Schematic memory considers previous illnesses experienced, and conceptual memory relates to reflections about possible causes and outcomes. All of the processes were affected by the individual’s psychological and biological systems, as well as the social context (Leventhal et al., 1992). More recently, Leventhal et al. (1997) identified the need to consider the self-regulation model in a more social context.

**Contextual Approach**

Radley (1993) also emphasised the need to consider illness in terms of an individual’s interpretation. His view promoted the exploration of the way people understood the onset, progress and treatment, within their own life context. The social context could be influential on how people made sense and reacted to illness threat. In turn, society could affect the individual with an illness, influencing their social identity (Gerhardt, 1989 cited in Radley, 1993). For instance, people suffering from chronic pain may not be believed and others may have suggested they were malingering.
Radley (1993) also argued that health and illness can be influenced by social class and religion. Social class may impact on the way illness was morally viewed, and the degree to which one was considered responsible. Religious beliefs could influence the perception of control one had over the illness. Also, to express one's opinions and beliefs about health and illness served several purposes. One such purpose could have been to search for meaning, with the aim of legitimising suffering and uncertainty. Another could have been to be believed and valued in society.

Radley (1994) suggested that prior to a cardiac diagnosis, chest pain symptoms could have been interpreted by: normalising; by explaining it away as, for instance indigestion; or seeing it as a more significant sign of illness. The latter interpretation was likely to be made by those who had prior knowledge of heart conditions. Radley (1994) also highlighted that those suffering from symptoms which have not been given a reliable diagnosis left the individual in an ambiguous position. They saw themselves as being ill but the medical profession were not identifying them in that way. It had been taken as an assault on their character by those with repetitive strain injury, who were not acknowledged as being ill by either doctors or employers (Reid et al., 1991 cited in Radley, 1994). Radley (1994) suggested that once a diagnosis had been made by the doctor, the patient may have been relieved and felt that they could legitimately seek treatment and play a sick role. This diagnosis may also have increased acceptance and support from others. Radley (1994) argued the importance of uncertainty as a reaction to illness, and identified three different strands. The strands were the meanings attached to: symptoms, a confirmed diagnosis and the future course of the illness. The
reaction to uncertainty may have varied according to context and the course of the illness (Molleman et al., 1986 cited in Radley, 1994).

To summarise, both the Leventhal (Leventhal et al., 1992) and Radley (1994) approached understanding illness with an emphasis on the importance of the individual’s perspective. Leventhal and colleagues (1992) emphasised how the cognitive and emotional factors were intrinsic to illness representation. They suggested that a person’s understanding was underpinned by schematic and conceptual memories. Radley (1994) gave more emphasis to contextual factors; suggesting the importance of the interaction between the individual and the world around them. Three relevant research studies will now be discussed, highlighting the importance of the individual’s perspective in understanding health and illness.

Current research

The initial study was chosen as the participants had received negative results from a diagnostic investigation and comparisons could be made with NCCP sufferers in that regard. Savidge et al. (1998) investigated, using a qualitative methodology, 21 women’s perspectives of chronic pelvic pain. They interviewed participants 12 to 18 months after they had received negative results from a laparoscopy indicating no organic cause for their pain. The results suggested that the majority of women held explicit beliefs about the cause of the pain prior to the laparoscopy. Many of these causes were linked to stressful events, some of which were related to damage to their reproductive system, others were associated with bereavement or family illness. Doctor–patient communication was another theme highlighted in the analysis. One
aspect was the perceived lack of clarity from the GP, resulting in a negative impact on
the sufferer. This was mainly due to too many possible causes being given for the pain.
On receipt of the results from the laparoscopy, some sufferers were given an
explanation for their pain. However, those who could not make sense of this cause
perceived the interaction in a negative rejecting way. Those that were given no
explanation reacted either by relief, that it was not anything serious, or reported
confusion and concern. Other themes identified were personal impact, not being
believed, emotional impact, uncertainty and feeling stuck, for instance being left with
unanswered questions. This study highlighted the rich data that could be collected from
a qualitative study and gave insight into individual’s understandings of their illness.

The second study considered chronic back pain and again raised the importance of
feelings of uncertainty. It also placed emphasis on an individual’s identity and place in
society. Osborn and Smith (1998) investigated the personal experience of nine women
suffering from chronic benign lower back pain, using an Interpretative
Phenomenological Analysis (IPA) methodology. From the interviews conducted, four
main themes emerged. Firstly, searching for an explanation of their back pain,
highlighting how sufferers felt confusion and uncertainty. The second theme was
comparisons with others and, previous and future perceptions of self. Comparison
incorporated impact on self-concept. Thirdly, the perception of not being believed and
how that impacted on their lives, for instance being perceived as malingering when
taking time of work with back pain. Finally, withdrawing from others, this was often
through fear of being misunderstood or rejected because of the chronic pain.
Although there were some similarities between the pelvic pain and back pain studies, individuals’ perspectives differed, as may be expected. What was highlighted in both pieces of research was the development of insight into how people might make sense of their experiences. The same was true of the final study. The investigation looked at individual’s perception of vulnerability to heart disease (Senior et al., 2002). They interviewed seven people suffering from familial hypercholesterolaemia (FH), which was a genetic risk factor for heart disease. The study used an IPA methodology and the resulting themes were: causal attributions for FH; the process of making these attributions; the consequences of the attributions; and coping with the risk of heart disease. All of the participants attributed the FH to a genetic cause, although some sufferers suggested other possible causes related to lifestyle, including experiencing stress. The consequences of attributing the FH to a specific cause often related to allocation of blame. The coping mechanisms used when considering risk to heart disease included acknowledging but playing down the risk. This often involved comparisons with those worse off. There was also a perception of FH being unproblematic and a manageable and a controllable risk of heart disease.

All three studies gave insight into how people perceived their illness in a life context. The importance of individual perception could help guide changes in healthcare procedures, therapeutic interventions and health promotion strategies (Smith et al., 1997). The individual’s illness representations were particularly important if the cause was uncertain, as they were likely to use these as a means of understanding their experience (White, 2001).
Conclusion

From the review of the literature above, NCCP has been identified as a sizeable problem both for the sufferer and the health service. There have been difficulties in distinguishing this health problem from a cardiac pathology. The consequences impact on health resources and can have a negative effect on the individual.

Cognitive, emotional and physical symptoms have been associated with NCCP. In spite of this, the aetiology was unclear, but it may be composed of physiological and psychological components. Psychological treatments have been shown to be effective. However, it was uncertain which aspects of therapy were effective. Also, a substantial proportion of sufferers did not consider psychological input appropriate, and the reasons were unclear.

Rationale for this research

A range of NCCP components appeared to have been identified, yet a clear understanding of how these connected together had not. The review of the literature on NCCP has identified the need for a more holistic prospective, to consider how the individual made sense of illness in their life context.

It was argued that meaning develops through the process of reflection and interaction with others, which was hard to quantify, but qualitative methods recognised its importance (Crossley, 2000). In qualitative research the aim was to gain an understanding of individuals’ experiences and focus on the meanings they attributed to those experiences. For instance, how do people live with illness or what do people do
when doctors do not give them a diagnosis? Therefore, the researcher decided to draw on a qualitative method for this study.

Willig (2001) stresses the need to introduce concepts of epistemology in order to place qualitative inquiry in a scientific context. Epistemology was a philosophical approach concerned with how we know what we know. For instance, social constructionism focused on how a person’s experience was a product of their history, culture and language. As a consequence, a situation or event could have several truths; for example, the glass was half empty or half full. Therefore, a social constructionist approach centred on the variety of ways people constructed reality and the associated implications of that reality. More empirical approaches were based on the assumption that a person’s perception of an event provided the facts associated with that event. The social constructionist approach freed the researcher to explore the possibility of different meanings and perceptions. The researcher felt a social constructionist approach was appropriate for the current research.

It had been argued that phenomenological research methods were appropriate when investigating people’s experiences, to gain insight into their understanding (Willig, 2000). Phenomenology focused on subjective rather than objective understanding of the world. Interpretative Phenomenological Analysis (IPA) was a qualitative research method which explored an individual’s experiences, reporting in detail on the phenomenon under focus. IPA aimed to access the individual’s sense of being in the world (Smith, et al., 1997).
IPA was an explorative method of research which was data driven. It would take a person’s spoken or written word to indicate an insight into a subjective perceptual process. This approach recognised the investigator’s active part in the research process; nevertheless its aim was to comment on the individual’s thinking about the phenomenon being investigated.

IPA was considered a more person-centred methodology than many other research techniques (Smith et al., 1997). It required minimal input from the interviewer to allow individuals greater freedom of expression. The flexibility of data collection highlighted unanticipated factors which may have otherwise been hidden (Shaw, 2001). Therefore, IPA was chosen as an appropriate method to investigate the sufferer’s perspective of NCCP.

**METHOD**

This section initially provides a description of the research aim, design and sample size. This is followed by details of those involved in the research, including the recruitment setting. The final part of the method section is concerned with the development of the interview schedule, the research procedure and the criteria used to monitor quality within the study (see Figure 2).
Aim of the research

This research was concerned with, and aimed to explore, how sufferers experienced non-cardiac chest pain (NCCP).

Design

The research employed a qualitative methodology, Interpretative Phenomenological Analysis (IPA). The aim of IPA was to access the individual’s experience and understanding of a specific phenomenon. This study followed clear IPA guidelines regarding the analysis of the data (Smith et al, 1999). Through the use of semi-structured interviews, the investigator interpreted the participants’ experiences to give an indication of the insiders’ view. Through engagement with the data, interpretations were produced for each individual and links with other participants were made later.

Sample size
Due to the demands of the analysis, IPA did not easily lend itself to large sample sizes. Smith (1995) suggested that to be able to keep a mental picture of each individual during the analysis, and consolidate themes with others within the sample, five or six participants would be advisable.

Over fifty people were approached and given introductory details of the research; exact numbers were not recorded (see Appendix 1 and 2 for letter of introduction and patient information sheet). Six people agreed to be interviewed; five of these were appropriate. The one participant excluded did not fully meet the inclusion criteria (see Appendix 3 for list of criteria).

**Research Setting**

**The Recruitment Location**

Individuals attended a Rapid Access Chest Pain Clinic in a city hospital in the East Midlands. The clinic provided a dedicated service for over 2000 patients per annum. It had been nationally awarded Beacon Status as a result of providing a fast, flexible and accessible service. It provided an early cardiac assessment for those who could have developed cardiac pain. It was a service where urgent referrals were seen within 48 hours and the remainder seen within two weeks.

The criteria for access included chest pain that was new, of recent onset or worsening symptoms. The age limit included all women over the age of 40 and men over the age of 35. The clinic involved having an ECG, exercise ECG, X-ray, blood test, a physical
examination by a doctor and discussion about an individual’s medical history. The whole process took approximately three and a half hours.

The Participants
The five people recruited comprised of two men and three women; their ages ranged from 47 to 63 years of age. All participants were currently employed, either part or full-time. All were white with English as their first language. Two participants described their religion as Church of England, two had no specific religious beliefs and one described themselves as an atheist. All five participants lived with their spouse; all had children but only two had them living at home. The five participants had experienced NCCP for over six months.

The Researcher
Qualitative methods have utilised reflexivity as a way of making the investigator’s assumptions as transparent as possible. This was a process where the researcher reflected on their own position in relation to the topic being studied. Consideration was given to their viewpoint and how it could have influenced the research process. Radley (1994) suggested that in qualitative health psychology research one was required to highlight the interaction between the investigator and the participants. He described three levels to be considered: (1) the investigator (2) the impact of the investigator on the research process (3) the impact of the research on the investigator. At this point details about the investigator will be given, while the other two points will be considered later in the final section on conclusions and general discussion.
The investigator was a final year trainee clinical psychologist, female and in her early forties. She has had an interest in health psychology for over 10 years, since studying at undergraduate level. She has worked in a chronic pain management service for 18 months which fuelled her interest in the experience of pain. The investigator was currently working in a clinical health psychology department within the National Health Service, but has not been specifically involved in the treatment of cardiac or chest pain patients.

The investigator had no previous experience of the qualitative research process. Nevertheless, she had taken a critical health psychology stance, where central issues included qualitative methods, meaning, experience of health and illness, context and understanding (see Crossley, 2000). Using Madill and colleagues’ (Madill et al., 2000) description of epistemological positions, the investigator regarded herself as a contextual constructionist. Contextual constructionists believed that results were mediated by the context in which the data was collected and analysed (Madill et al., 2000).

In terms of therapeutic stance, the investigator considered herself to be eclectic; however, the majority of her experience had been in the use of cognitive behavioural approaches.

Finally, a research journal was kept throughout the research project to help reflect on the process and act as a memory aid.
Interview Schedule

IPA used semi-structured interviews to gather data. It was assumed that the spoken word was a reflection of an individual’s perceptions and beliefs about their interactions with the world. Semi-structured interviewing was a method of collecting data which was highly appropriate for investigations into the processing of information which had a personal context (Smith, 2001).

The semi-structured interview worked from an interview schedule that acted as a guide rather than a rigid set of instructions. One of the aims of the semi-structured interview was to establish a more natural setting, by building a rapport with the participant and using a more flexible approach to asking questions. The subject matter would generally be participant led, although the investigator would aim to keep the conversation within related topics. This allowed the participant to take the conversation into areas not necessarily contemplated by the investigator. The data collected from the semi-structured interview was a far richer source of information than the structured interview (Smith, 1995).

Constructing an interview schedule prior to the investigation was beneficial in several ways (Smith, 1995). First, it highlighted the specific areas the investigator wished to cover. Second, the preparation allowed time to consider possible areas of difficulty in the interview, for instance a sensitive topic, and how it might be dealt with. Finally, having a clearer understanding of what would be discussed allowed the investigator a higher level of concentration on what the participant was saying, and thus could contribute to the building of rapport.
Smith (1995) suggested guidelines for constructing a semi-structured interview in IPA. These guidelines were used for this current research project and are outlined below.

1) Identify the broad themes to be covered in the area under investigation. For instance, personal description of the health problem, the impact on the individual, and the coping strategies used.

2) Consider the most appropriate order in which to place the questions, leaving more sensitive topics to later in the interview. This would allow the participant to feel more relaxed with the investigator and the interview process.

With health issues Smith (1995) suggested that all questions could be considered sensitive and therefore advocated that the initial focus could be on the illness, followed by its impact on the patient.

3) Consider the questions to be used within the broader themes, and their structure. For instance, avoid questions that were leading or value-laden. Also, questions should be phrased in clear and common language and be open-ended.

4) Identify possible follow-up questions and prompts to encourage a richer response from the participants. These should be used only when necessary, to minimise the likelihood of the participant being led by the investigator.
Smith's (1995, p.14) interview schedule, used to investigate patient's experiences, was employed as a template and adapted for the current study. From the literature, thoughts and attributions associated with the NCCP were highlighted as important. These could impact on how a sufferer managed the illness. Therefore, thoughts and beliefs related to the cause of the pain; its impact and how the symptoms were managed, appeared to be appropriate areas for investigation. These three aspects were expanded to produce 14 questions in total (see Appendix 4). For example, one of the earlier questions was 'could you explain what you initially thought the cause of the chest pain was'.

To summarise, the semi-structured interview was split into three sections: the health problem, the impact on the individual, and the resulting coping strategies. The questions were structured so that they were open-ended. Value-laden questions were avoided, as were uncommon words or phrases.

**Procedure**

**Literature Review**

The nature of interpretative analysis meant that the interviewer would use their own frames of reference to translate an individual's narrative. It was therefore decided not to investigate, or refresh the researcher's mind of the general literature on health and illness perceptions prior to the interviews. This aimed to reduce the likelihood of the general knowledge in this area shaping the results.
Ethics

The local health authority gave initial ethical approval for the current project (see Appendix 5). Subsequently, the protocol was amended and ethical clearance was given on two further occasions (see Appendix 5). First, for reasons of time management, recruitment was allowed without the investigator’s presence. Second, unexpectedly high proportions of the non-cardiac patients were referred on for other investigations, which lead to recruitment problems. Therefore, the exclusion criteria were amended to include those who were referred for other non-cardiac investigations.

Recruitment

At the final stage of the clinic appointment, once all results had been collected, the patients with no heart problems were given the negative results. The inclusion and exclusion criteria were checked at this point, and the appropriate patients were introduced to the research project (see Appendix 3 for set of criteria).

The cardiac doctor introduced the research to prospective participants in a letter with a reply slip and stamp addressed envelope (see Appendix 1). This allowed the prospective participants to respond in their own time. A patient information sheet was also attached; giving further details about the research (see Appendix 2). If further details were required the investigator or staff nurse responded.

Once the reply slip was returned, the investigator contacted the prospective participants by telephone and arranged an appointment to conduct an interview.
Interview

All interviews took place in the participant’s home or in a hospital consulting room. Both settings allowed an uninterrupted discussion. Each participant was asked to complete a consent form (see Appendix 6), which included approval to inform their General Practitioner (GP) of involvement with the research (see Appendix 7 for GP letter). Each participant was also offered the opportunity to receive feedback on the data analysis. All consented to contact with the GP, and four out of the five participants requested feedback.

General preliminary questions were asked to establish age, religion, work and marital status. The interview procedure was outlined. The interview was guided by the interview schedule (see Appendix 4) and lasted up to 60 minutes.

Analysis

The analysis was based on IPA (Smith et al., 1999). Through this process interview transcriptions were analysed one at a time. Themes were drawn out to capture the ideas about the area being investigated; in this case non-cardiac chest pain. Using the interpretation of transcripts, the investigator identifies themes that were then collated to form meaningful groups.

An interview was transcribed and read many times to gain a sense of the participant’s general perspective. The researcher reflected on what the participant meant by their
expressions. It was an iterative process of considering and revising interpretations.

Notes were made in the transcript margin of points of interest and preliminary interpretations (see example below).

**Preliminary Themes**

<table>
<thead>
<tr>
<th>Emily</th>
<th>Started to do stuff, when I had the 2\textsuperscript{nd} one I think there was more fear there, because one, you almost, this has happened, but its gone away and its gone down, I'm okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewer</td>
<td>Mm.</td>
</tr>
<tr>
<td>Emily</td>
<td>You know but when it happened the 2\textsuperscript{nd} time.</td>
</tr>
<tr>
<td>Interviewer</td>
<td>Mm.</td>
</tr>
<tr>
<td>Emily</td>
<td>And it was such a carbon copy.</td>
</tr>
<tr>
<td>Interviewer</td>
<td>Mm.</td>
</tr>
<tr>
<td>Emily</td>
<td>There was no difference the build up, the length of the pain, at that time I couldn't even pull in I sort of just stopped and put hazard lights on=</td>
</tr>
</tbody>
</table>

The transcript was then reread to ascertain emerging themes. To illustrate, the extract above from Emily's narrative; two chest pains were experienced in quick succession, she comments on how one was the carbon copy of the other. The preliminary theme was 'similarity', but through the iterative process this was revised to 'comparison with previous symptoms'.

The revised themes were then compared throughout the transcript to determine any possible connections. Through this process, umbrella terms (super-ordinate themes) were identified to give a framework for the revised themes (sub-themes). For example, a super-ordinate theme of 'understanding' may have incorporated several sub-themes, such as 'trying to make sense', 'comparisons' and 'not knowing'. Finally, when all the transcripts had been analysed, similarities and differences were identified between
participants and overlapping themes were documented. The data analysis process is described further in the analysis and discussion section below.

Quality Criteria

Various attempts had been made to evaluate the quality of qualitative research. For instance, Henwood and Pigeon (1992) described quality guidelines from a Grounded Theory perspective and Elliot et al. (1999) from a phenomenological approach. However, different approaches made different assumptions (Willig, 2001). The researcher considered Elliot et al. (1999) appropriate to be undertaken by this study.

Elliot et al. (1999) suggested seven factors to address when evaluating qualitative research. These were adopted for this study.

(1) Owning one's perspective
The investigator declares their theoretical, methodological and personal perspectives associated with the research area.

(2) Situating the sample
The investigator includes a participant’s details that are relevant to the research, for instance, age, gender and ethnicity.

(3) Grounded in examples
The investigator utilises examples from the participant to illustrate the process of analysis, as well as the interpretations made. This allows future readers to observe the assumptions made and provides an opportunity to challenge the interpretations.
(4) Providing credibility checks
The investigator should check the credibility of their themes and categories interpreted from the data, for instance, by checking with the participant, other researchers or colleagues.

(5) Coherence
The investigator interprets the data in a way that is clear and structured, as well as, highlights nuances.

(6) Accomplishing specific research tasks
The research aims are systematically and clearly described to allow the reader to understand how meanings were attained. The limitations of generalising results should be acknowledged.

(7) Resonating with the reader
The investigator should present the results in such a way that the reader has a clearer understanding of the patient’s subjective view and appreciation of the area; in this case NCCP.

The majority of these stages were undertaken; however the researcher considered ‘providing credible checks’ was inappropriate for this study. This stage encouraged the researcher to check the reliability of the interpretation with the participant. However, it was through the transparency process that the researcher’s interpretations were explained. The interviewer’s understanding of the participant’s narrative would change, as would the sufferer’s, through the process of consultation. This was supported by Barbour (2001, cited in Salmon, 2003), who argued that the respondent’s validation is a method which could corrupt rather than enrich the research.
The five participants were recruited from a rapid access chest pain clinic, after receiving negative results for cardiac problems. The data used in this analysis consisted of their transcribed audio-taped interviews, all of which lasted no longer than one hour (for the full transcripts see Addendum). It should be noted that much of the following discussion and conjecture is not suggesting that generalisations could be made from this research process. But it hopes to open up debate and consider different understandings to the experience of NCCP.

Initially a guide of the use of extracts will be given. Also, for ease of reference, the analysis process will be outlined. This will be followed by a brief description of the background factors and their relevance. Finally, three super-ordinate themes will be discussed in turn (see Figure 3).

Figure 3: Framework for the Analysis/ Discussion section.

Analysis/Discussion
- Use of Extracts
- The Analysis Process
- Background factors
- Super-ordinate Themes
  - 1: Understanding
  - 2: Impact
  - 3: Support
- Summary of Results

Use of Extracts

Extracts from the transcripts were be used to aid clarity and support the process of analysis and were written in italic. The extracts were referenced with false names, to
protect anonymity, and were followed by a line number which would correspond to their transcript. For example “Emily.L306” would relate to Emily’s transcript line 306, which would be the start of the excerpt quoted. Words were placed in brackets to indicate actions, for instance ‘(laugh)’, or clarifying information, such as “he (doctor)”. Gaps in the narrative denoted by three full stops, “…”, were used to make the extract succinct and to avoid details not relevant to the focus. For instance “I went back to the doctors and I ’cause I was worried.” would be quoted as “I went back to the doctors... ’cause I was worried”. Finally, words were underlined if the participant said them with emphasis.

The Analysis Process

There were four levels of analysis. Initially, the transcripts were analysed individually in levels 1, 2 and 3; followed by investigations on a group basis in level 4 (see figure 4). This process and the stages are consistent with IPA (Smith et al., 1999).

Figure 4. Levels of Analysis

```
<table>
<thead>
<tr>
<th>Interview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
</tr>
<tr>
<td>Pre-transcript analysis: Brief initial thoughts and reflections on the interview</td>
</tr>
<tr>
<td>Level 2</td>
</tr>
<tr>
<td>Micro-transcript analysis: Line by line analysis of the transcript</td>
</tr>
<tr>
<td>Level 3</td>
</tr>
<tr>
<td>Macro-transcript analysis: Interpretation of the transcript as a whole</td>
</tr>
<tr>
<td>Level 4</td>
</tr>
<tr>
<td>Multi-transcript analysis: Emergence of themes across five transcripts</td>
</tr>
</tbody>
</table>
```
The individual analyses will be described briefly here for ease of reference. Level one of the analysis was a brief reflection of the interviewer’s thoughts and impressions of the participant after the interview. Level two focused on a line by line interpretation of the data. Level three attempted to stand back from the fine detail in level two and consider broad themes across the whole transcript. For a detailed example of a participant’s transcript analysis levels 1 to 3 see Appendix 8.

Comparisons were made across the group at the first three levels to form the analysis at Level 4 (see Figure 5).

Figure 5: Stages of Analysis

![Figure 5: Stages of Analysis](image)

Here, consideration was given to all five transcripts to identify themes emerging in parallel across the narratives. The term theme was categorised in two ways, sub-theme and super-ordinate theme. Sub-themes were used here to represent a topic or an idea identified within a transcript, for instance, ‘heart as the cause of the chest pain’. Super-ordinate themes were a master list of factors used as umbrella terms to group sub-themes together. For example ‘understanding’ could have included the sub-theme ‘heart as the cause of the chest pain’. This enabled structure to be given to a vast amount of information and allowed investigation in a systematic and manageable way.
The super-ordinate themes were made up of a collation of sub-themes brought together through connections in the transcripts. The main focus of this analysis was the sufferers’ perspectives on the experience of non-cardiac chest pain. However, there were also background details about the participants that were worth noting. These were not directly incorporated within the main focus. For an overview and summary of the factors involved in the analysis process and the resulting themes see Figure 6.

Figure 6. The Analysis Process

Background Factors Super-ordinate Themes Sub-themes Clinical Implications

Marriage Work Age Life Events CHEST PAIN Understanding Impact Support Cause Not knowing Comparison Context Daily activity Emotion Symptoms Control Image CP results Self-support Availability of supp't Support - others Impact on Communication, Intervention & Information dissemination

The results reported here initial compared background details including the pain characteristics from each participant. However, the main focus of this analysis was the exploration of level 4. To aid clarity, each analysed sub-themes would be discussed and linked to current literature before going on to the next.

Background Factors

The background factors included marital status, work status, age, stressful life events and pain characteristics. They were mentioned as possible influences on the way chest
pain was perceived. Religious beliefs were also recorded, but no obvious impact was identified, therefore they not considered further. The recognition of these factors aimed to increase transparency in the interpretive process.

All the participants were married and lived with their partners. This appeared to be influential in the sufferer's perceptions of their chest pain.

"I mean my husband was there he knows what state I was in, if I had been on my own well suppose people may think I had been exaggerating the whole thing" Emily.L306

Sufferer's were either employed part or full-time. This seemed to shape how they measured the impact of the chest pain.

"I haven't taken any days off (work) with it (chest pain)" Josh.L222

Three of the five participants were in their early sixties (Abby, Emily and Ben) and two were in their late forties (Kate and Josh). The person's age appeared to differentiate their general perception of physical well-being. For instance, when asked about health and illness, those in their sixties talked frequently in terms of death and dying.

"you think well what am I actually goin' to die from, you know, sometimes" Abby.L489
In contrast, the younger participants often spoke in terms of preventing illness by healthy eating and exercise.

"we do eat quite healthily, I'm not saying I never have chips because I do (laugh). But certainly not to excess" Kate.L648

All five people interviewed spoke of stressful life events. Some implicated them as possible causes of their chest pain.

"I think that (family troubles) was a lot to do with... the first lot of heart trouble" Abby.L24

In addition, across the five sufferers the characteristics of the chest pains varied, three gave reports of one-off chest pain which was very different to their regular chest pain. They responded to this one-off pain by contacting the health professionals within a day (Emily, Ben and Kate).

"I went to the doctor the next day" Ben.L391

The remaining two (Abby and Josh) reported chest pain that had persisted over a few months and the contact with their doctor was not so immediate.

"I first noticed the chest pains about six months ago... I didn't really put any account to it... but then I started feeling a little unwell
and then these chest pains seemed to come back, that's when I
decided I needed to get it checked" Josh.L4

Nevertheless, there was some consistency in the pain that brought the sufferers into the
health service. Everyone implied that this pain stopped prior to, or since visiting the
chest pain clinic.

"touch wood I've not had it since I've been up there (chest pain
clinic)" Abby.L360

Regular pain remained for three chest pain sufferers (Emily, Ben and Kate). In addition
Ben and Kate reported suffering from chronic pain and Emily from asthma.

"I'm in pain all the time... I really started having troubles with my
back since 31, 32 (years old)" Ben.L630

To summarise, five factors were identified as possible influences on the way the
sufferers perceived their chest pain. These factors were marital status, work, age, lif-
events and pain characteristics. The variation in the chest pains highlighted the
usefulness of examining both similarities and differences. This allowed a detailed
exploration of the sufferers' perspectives within the process of analysis.
Super-ordinate Themes

From the analysis three super-ordinate themes emerged: understanding the chest pain, its impact on the sufferer, and the associated levels of support (see Figure 7). These will now be considered in detail.

Figure 7: Summary of Super-ordinate Themes

1: Understanding

Through the five narratives there were indications of how the participants made sense of their experiences of chest pain. It is the means of making sense that has been given the umbrella term ‘understanding’. It collates four sub-themes which include: the possible causes of chest pain; not knowing the cause; using comparisons; and using context as a way to consider the possible cause (see Figure 8). The sub-themes will now be explored in a little more detail and with the use of transcript extracts to give support to the interpretations.

Figure 8: Super-ordinate Theme 1 - Understanding

Cause

At times, all the sufferers accredited the origin of the chest pain to the heart, but also considered other causes and highlighted how other people influenced their decision
making. It is for this reason that this sub-theme has been divided into three factors: heart as the cause, other causes and the influence of other people.

Heart as the cause. When attempting to understand the cause of the chest pains participants considered the possibility of having problems with their heart. Some of the participants were more specific and stated that they feared they were experiencing a heart attack. The following excerpts give an example from each sufferer. They highlight the different levels of conviction as to the certainty that the heart was the cause.

"I always thought it was heart problems ... I used to (gasp) I'm going to have a heart attack" Abby.L89

"I suppose I thought I was having a heart attack that was the nearest thing I got to thinking" Emily.L159

"Just lying in bed the pain hit me, a fantastic pain, I really thought I was having a heart attack" Ben.L386

"You are just aware it's across your chest so you tend to think, you do think at the time, heart" Kate.L53

"I mean it passed through your mind is it something to do with your heart" Josh.L76

Also, there seemed to be no consistency across the sufferers on the dominance of a cardiac causal attribution. Attributions appeared to change over time and circumstance. For instance, through the experience of the chest pain all participants had visited the chest pain clinic and encountered a thorough investigation of their heart and given results that indicated they had no heart problems. The impact on their beliefs about the cause varied. One person still believed his heart was a possible source of the pain.

"Well it's only sort of at the back of my mind" Ben.L684
Another person considered it a possibility in the future, implying that there may be some underlying weakness in her heart.

"even though I knew in the back of my mind I've had this and I've had it checked out ... I would go... because you just never know what's round the corner" Kate.L734

In contrast, other sufferers appeared to put the possibility of heart problems completely out of their minds.

"they say well there’s nothing wrong with your heart, that goes out your head then doesn’t it" Josh.L98

If the chest pain experience left a considerable doubt of a cardiac cause, and no other acceptable cause is prominent, then a high level of uncertainty may be felt (see extract below).

Emily: The breathlessness I’m used to.
Interviewer: Yeh.
Emily: But that wasn’t, although the breathlessness was there, certainly the worst breathlessness I’ve ever had=
Interviewer: Mm.
Emily: =tied up with chest pain was so foreign to what I’ve ever experienced =
Interviewer: Mm.
Emily: =that you can’t think of logical explanations and, or you think it’s got to be something=
Interviewer: Mm.
Emily: =I suppose you, because viruses contain such different makes of sort of-
Interviewer: What, what makes you, what made you think it was a virus?
Emily: Lack of any other reasons, of any explanation (laugh), I think.
Interviewer: Yeh.
It's like one of those things oh it must, it's a bit like saying you know tummy troubles, it must be a bug. You know so but I don't know and I don't know what they'll come up with.

As a result if ever I get it, a true explanation, quite likely yeh sort of knowing what it is, is somehow more consoling than not knowing.

In this extract, Emily went through the process of trying to find familiarity, looking for symptoms that she had experienced before, seemingly to feel safe and in control. She talked of the experience being alien to her which triggered the thoughts of there being something really wrong. However, she was reflecting back, and appeared to be trying to justify her concern for her heart, when she says “you can't think of logical explanations”. She then seemed to jump forward to the point where she is able to give more logical thought to the symptoms. She found the idea of a virus acceptable to her, but this appeared only to be temporary as she still expected a true explanation.

Perhaps the causal attributions do not need to be absolute to be of benefit. People may benefit from a temporary answer. This may have been a coping strategy to avoid a constant thought of not knowing.

To summarise, all participants spoke of considering their heart to be a possible cause of the chest pain. This supports Eifert (1992), who made the assumption that this was a key feature of those suffering from NCCP. However, the level of conviction to this attribution appeared to vary amongst the participants. This may be due to how much
sense this cause made to the individual (Leventhal et al., 1992). The variation may also relate to whether the individual had any strong beliefs in other causes, see below.

When participants did consider their chest pain to have a cardiac cause, not everyone considered it to be a heart attack. Leventhal et al. (1992) suggested that the degree to which symptoms are perceived to be a health threat impacts on the coping strategies. For instance, it has been shown that the belief in experiencing a heart attack influences the time taken to seek medical help (Dracup et al., 1995). The narratives imply that having a chest pain is not the same for everyone, even if there was agreement of a possible cardiac pathology, other causes were considered to varying degrees.

Uncertainty has been identified as an important factor in chronic illness and linked to distress (Radley, 1994). Also, Klimes et al. (1990) indicated that those suffering from NCCP show some positive reactions to being given an explanation for their symptoms. This was supported by Emily’s narrative, see below.

"something consoling about in a way, if you know what it is and its something that has got treatment then you get it treated" Emily L295

The positive reaction may be associated with taking control or having someone or something to blame. By giving the NCCP an identity, it may have allowed the person to externalise the pain; put it outside themselves. This perspective could have given distance from the ailment and reduced feelings of distress or attack on self identity.
Finally, the level of acceptance of having non-cardiac chest pain was also inconsistent. This was of interest as the belief in a cardiac cause had been associated with a higher frequency of pain and disability (Van Peski-Oosterbaan et al., 1999). Although, participants had not given explicit explanations as to why a cardiac attribution was still considered; it raised awareness that negative results do not guarantee the removal of a causal belief.

Other causes. There were other ideas as to the cause of the chest pains. These were divided into those which appearing to have their origin with the sufferer and those which were acquired from other people. The former will be discussed here; the latter will follow.

In general, the other possible causes for the chest pain related to a current physical ailment.

"I think it stemmed from having thyroid trouble" Abby.L656

This interpretation may have been a means of taking control and not having to sit with uncertainty.

"I always associated it with stress... I'm one of those people it goes to the stomach, causes dyspepsia and er I believe a lot of the chest pain comes from that" Ben.L16
It may also have been a comfort to the individual to consider that the chest pain was not an additional health problem, but related to something they already had, and for which they had some level of understanding.

“But you just have to think I don't want anything else wrong with me. When I walked out of the hospital the other week I was so relieved” Kate.L88

After receiving the results from the chest pain clinic, attributions often seemed to revert to previously considered non-heart causes.

“I mean if it's not heart trouble, it's not... but I think this 'as stemmed from me having thyroid trouble” Abby.L653

However, a number of attributions appeared to be from new sources. Some new causes looked as though they were the influence of staff at the chest pain clinic, these will be considered in the next section. Others new sources, without any evidence to the contrary, were interpreted as originating from the sufferer. For instance, several participants felt that the symptoms could have been partly psychological.

“since I've been to the access clinic I haven't really experienced much pain. Maybe it is in here (pointed to head) (laugh)” Josh.L53
Some sufferers concluded that the cause of the chest pains were due to common ailments. In the following extract Emily was asked what made her think it was a virus.

"Lack of any other reasons of any explanation (laugh) I think" Emily. L270

In contrast other participants appeared to draw no causal conclusions.

"I've not had it since that Saturday I've not had it again that certain pain so I'm thinking, no it was nothing" Kate. L164

So to summarise, the sufferers considered various non-cardiac causes alongside the heart. Many of these were related to recent or existing ailments. This supported Leventhal et al., (1992) who argued that schematic memory, such as past experiences of illness, was part of the individual's process to understand and manage health threats.

However, not all non-cardiac causes were related to recent experiences, some suggested that they could: have no cause, be in part psychological or be due to a virus. This again implied an ambiguous situation where other causes were considered because people felt they needed a reason (Klimes et al., 1990). It has been suggested that the search for reason is an attempt at gaining a sense of control (William & Thorn, 1989 cited in Scharloo & Kaptein, 1997). It may be that making a decision rather than having a reason is helpful. One of the participants appeared to be content with having no cause.
This may have been a conscious decision to avoid an ambiguous situation, therefore reduced distress.

Similarly, one sufferer spoke of attributing the chest pain to a virus because of a lack of any other explanation. This is not uncommon. Cope et al. (1994) highlighted that viral infections were frequently cited as the cause for physical symptoms and illness. It has been suggested that this attribution reduces feelings of guilt or blame (Powell et al., 1990 cited in Cope et al., 1994).

Thoughts were raised that the chest pain may have a psychological element. This is in contrast to previous studies that emphasised how sufferers’ believe there is no psychological component to NCCP (e.g. Mayou et al., 1997). This diversity implied that there were levels of acceptability of psychological explanation and not all NCCP sufferers reject this attribution. It also raised the awareness of the variability between sufferers.

Influence of other people. Through the narratives it appeared that other people did influence the individual’s beliefs about the cause of the chest pains. However, the level of discussion varied. In some cases the variability may have been due to the nature of the chest pain; whether it was a one-off incident or a regular experience. For instance, Ben reported how he did not gather his wife’s opinion when considering his regular chest pains.

“No I mean, I don’t discuss it with her (wife)” Ben.
However, he did report his wife's opinion when experiencing a more extreme one-off pain.

"she said that I don't think you've had a heart attack" Ben.L648

The level of influence seemed inconsistent across the five participants. Some of these ideas appeared to be accepted.

"she(wife) said it's probably stress then. She could be right to a point" Josh.L157

In contrast, other people's suggestions were not believed.

"the very thorough lung session firstly at hospital and then at the infirmary erm and as yet although the test results arn't out you always go back to that, or I do, to the virus, you know" Emily.L237

This inconsistency may be due to the ability of the sufferer to make sense of the suggested cause.

"the nurse did actually say to me... do you get a lot of indigestion?...she said...while you're eating don't talk, 'cause that causes a lot of wind... I do tend to do that... I think a lot of it is indigestion" Abby.L612
In summary, the analysis highlighted that other people do identify possible causes for the chest pain. Most of the participants did give time to reporting other people's causal attributions. This is in support of recent research arguing that causal attributions from a spouse can be as important as the individual's (Sensky et al., 1996). It has been interpreted that chest pain sufferers can also be influenced by these suggestions. However, the level of influence appears to vary within and between individuals. The variation in the level of acceptance may have been due to the participants' ability to make sense of the suggestion. This supported the view that health and illness information needed to make sense in the individual's life context (Radley, 1994).

In addition, the character of the chest pain may have dictated whether opinion was sought. The level of perceived threat may have mediated the individual's need for reassurance that nothing was seriously wrong. This was supported by research which has shown that causal beliefs can have a direct effect on help-seeking behaviour (Blaxter, 1983).

Not knowing.

In an attempt to make sense of experiencing chest pains, most sufferers appeared to seek out reasons for these symptoms. In the extract below, Emily contemplated the difference between knowing and not knowing. She decided that there were comforting properties to knowing. In addition, relief appeared to be gained from being able to take action when having a health problem. But there was no mention of the effect if nothing could be done. Emily also indicated concern about not having a diagnosis, fearing that other people may judge her as imagining the chest pain.
Yeh sort of knowing what it is, is somehow more consoling than not knowing.

What is it about knowing that that make, it's a bit easier do you think?

Erm I think if you know something then you deal with it, if it's a virus =

=and it's a one off and the chances of getting another one are about the same as anybody whose never had any trouble, anything, the chances are so small that you don't worry about it, =

Mm.

so it's something consoling about in a way, if you know what it is and its something that has got treatment then you get it treated. Not knowing as well you think, well if they can't find anything people might think it wasn't anywhere near as bad as they said, and you might think I was almost creating it, you know what I mean.

Emily.L283

Some participants gave the impression they had a strong need for an explanation.

"Once can be an odd bout, twice okay might not be a reason, but having it again... there must be some reason for it" Emily.L911

Other participants seemed to be less concerned about knowing the cause.

"it was just a bit of a wondering well what is it, like" Josh.L240

In contrast, Kate appeared to avoid searching for a reason for the chest pain.

"Perhaps because there's a family history, in a way that makes it worse, you do ignore it as well in some ways" Kate.L144
Also in this ambiguous situation sufferers did acknowledge that they did not know the reason for their chest pain.

"I don't know, I don't know what er occurred. There was no reason for it" Ben.L613

To summarise, participants acknowledged not knowing the reason for their pain but the need for an explanation varied. There may have been a feeling of certainty from the acceptance of not knowing, which in itself may have increased the sense of control alleviated anxiety. The state of not knowing might have been related to the difficulty in associating previous experience to the current chest pain, and therefore its cause.

"the breathlessness... tied up with the chest pain was so foreign to what I've ever experienced that you can't think of logical explanations" Emily.L259

This would support Leventhal et al. (1992) suggestion that schematic memory is important in making sense of symptoms.

**Making comparisons**

Making comparison was defined here as the consideration given to two or more thoughts, feelings or experiences that had some level of similarity or difference. The use of comparison frequently showed how individuals appeared to make sense of the experience of chest pain. However, the type of comparisons could vary within one individual. For instance, Abby used two different comparisons to aid understanding.
"Like me, she (mum) always used to say oh I've got a pain here, got a pain there, you know" Abby.L305

"you see somebody having a chest pain... on the telly... you think oh Christ is that what I've got" Abby.L358

This highlighted how rather than a single comparison, a whole range could be used by an individual to help understand an experience. For instance, links could be made with: previous experiences of self other people, other illnesses and other pain, see extract below.

Kate: Over the last few months, I have had different pains =
Interviewer: Okay.
Kate: which I haven't acted on because I've always convinced myself that it wasn't the heart, which have been a slight tightness, pains on left and right side, never all the way across =
Interviewer: Oh.
Kate: so but it has always been, I have thought chest =
Interviewer: Yeh.
Kate: and with the family history, sillily ignored it, okay. So that, I've had that, I can't say what brought it on I hadn't actually done anything different that I was aware of, erm limited mobility anyway so if I do do something out of the ordinary it tells on me the next day.
Interviewer: Mm.
Kate: Whether it was just that, until the pain that actually sent me to the hospital which was totally different to the others.
Interviewer: In what way was it different?
Kate: It was down the middle of my chest where you get heartburn and I knew it wasn't heartburn because I have that all the time, from me medication =
Interviewer: Mm.
Kate: and I was hot and sweaty, so that's what actually sent me in in the end (laugh), to the hospital.

Kate.L6
In Kate’s transcript extract she described how she fleetingly compared herself with other members of her family. She implied that she quickly decided to dismiss this comparison, as it could lead to thoughts of cardiac pathology due to her family history of heart problems. It appeared that this comparison did not have a positive or calming effect. To cope, she denied the possibility of a cardiac cause and searched for other information to back up her decision. She then considered what she had done recently and compared it to her normal activity. However, this did not give her a reason for the chest pain. She highlighted the fact that she was often in pain anyway from arthritis and decided that may be the cause.

Kate’s thoughts then seemed to change and she considered the difference between the regular pain and the pain that triggered her to go to hospital. The location of the pain led her to compare it with heartburn. Finally, she distinguished the pain from other ailments by the additional symptoms. This difference appeared to trigger her to seek medical advice.

It seemed that Kate had used comparisons to help her identify a cause for the chest pain and subsequently the course of action she would take. It also indicated that by making comparisons the sufferer could eliminate possible causes of the chest pain.

Another reason for comparisons may be to gain comfort. In the following extract Abby spoke of who she could talk to about her chest pain and highlighted the likeness between her and her daughter-in-law. It is interpreted that comfort was gained from
talking to other people in a similar situation. Although this was not explicitly expressed, Abby had spoken of her options in who she could and could not talk to.

"she's had a lot of problems with heart trouble well an' well not heart trouble but like me" Abby.L166

Nevertheless, the comparisons might not have always led to comfort; they might have resulted in uneasiness, as highlighted in Kate's extract above. Ben also described how he compared the one-off pain with other experiences of pain implying that it resulted in fear rather than comfort.

"It was really, really extreme. Frightened me you know, that sort of thing doesn't usually frighten me" Ben.L384

In summary, comparisons were present in all five narratives, and it appeared that people used them in many and varied ways. One use appeared to be the elimination of a possible cause for the chest pain. Research had suggested that sufferers of chronic illness used comparisons as a way of managing uncertainty (Mollenman et al., 1986 cited in Osborn & Smith, 1998). However, comparison could also result in fear which may have lead to anxiety symptoms if not alleviated. The variety of their uses and consequences may be linked to the context in which the comparisons are made.

Using context

The process of trying to understand the experience of chest pain often appeared to consider contextual or situational factors. Contextual factors may have included the
environment, individual’s thoughts and their feelings around the time of chest pain.

One way this process seemed to work was by individuals scanning their recent memories for anything unusual in the time prior to the onset of the chest pain.

"Don't know what caused it that day, hadn't eaten anything out of the ordinary or anything like that" Kate.L169

If anything unusual was found then it appeared to be considered as a possible cause of the pain or an influence on its perception.

"She said it could have been stress 'cause in work I've had quite a lot of stress lately with applying for different jobs" Josh.L149

However, the immediate context was not always quoted as influential; several participants attributed the effect of work and family troubles spanning back months or years. For instance, Abby referred to family problems which had occurred two years ago as being influential on her chest pain.

"I think that (family troubles) was a lot to do with ... the first lot of heart trouble" Abby.L24

There was also variability in context factors within an individual. It seemed that where there was inconsistency in context, the sufferer would conclude there was no pattern to the chest pain. The following extracts are from Ben’s narrative.
"There's nothing consistent about it really, although the more stress
the more conflict there is, then the more chest pain there is" Ben.L257

"If I get a pain I mean I couldn't really attribute it to anything
specifically. I mean it might be because I've taken something down
from the shelf and I've tweaked a muscle" Ben.L959

These extracts indicate how complex and unpredictable this pain can be.

To summarise, there appeared to be an increase in understanding about chest pain from
the use of context. This supported the literature which suggested that context was
important in understanding health and illness (Leventhal et al., 1997; Radley, 1994).
The identification of a probable cause may have been a positive consequence of using
context in making sense of an event.

The contexts used vary in time relevance; some participants used recent information
whereas others consider stressful life events from several years ago. This is similar to
Savage et al., (1998) results which found that stressful events were considered as causal
attributions for chronic pelvic pain symptoms. Bauman et al. (1989 cited in Leventhal
et al., 1997) have argued that stressful life events are favourable attributions for somatic
symptoms; especially if the symptoms are unfamiliar. Finally, if there was no pattern in
the chest pains contextual factors, it may have suggested to the sufferer its
unpredictable nature. It had been argued that beliefs about being able to control pain could have a positive effect on the sufferer's symptom tolerance (Skevington, 1995).

2: Impact

All of the participants were asked about the impact of the chest pain on their lives. Impact was considered here as the influence of the symptoms on different aspects of someone's life. Through the analysis process six sub-ordinate themes emerged from the transcripts. Chest pain appeared to impact on people's: daily activities, emotions, symptoms, sense of control and self image (see Figure 9). In addition, the receipt of negative results from the heart investigations at the chest pain clinic was reported as impacting on the sufferers and their families (see Figure 9).

Figure 9: Super-ordinate Theme 2 – Impact

Daily Activities

This sub-theme was divided into two aspects, work and non-work activities. All sufferers were employed and so work was defined here as paid employment. A non-work activity covered other aspects of the individual's functioning, such as driving or sleeping.
All participants reported that the chest pain had not stopped them working. For instance, Josh stated that due to the mild nature of the pain it had not stopped him carrying out his job.

"Might last for half an hour, it might last an hour, erm but it wasn't that bad for you to stop work" Josh.L124

In contrast, the reason Kate suggested a low level impact was that it was day time and she had distractions from the pain.

"When it's day time it's obviously easier to cope with, because you just carry on and ignore it to an extent" Kate.L690

Work may have acted as a distraction from the pain and therefore reduced the perception of its severity (Skevington, 1995). However, it was worth noting that none of the experiences of extreme one-off chest pain happened in working hours, for instance they occurred at weekends and evenings. This raised questions as to the triggers of the pain and how the symptoms were perceived, as pain could not discriminate time or day.

The next focus will be non-work activities. The extracts were split to distinguish between the extreme irregular and the regular chest pains. The initial quotes related to the irregular symptoms, where the impact seemed to be extreme in some cases and less so in others.
"I think the pain was so intense... I couldn't speak to my husband" Emily.L98

"I went to sleep and it wasn't there when I got up, I felt a bit sore funny enough but it wasn't there when I got up" Ben.L654

The consequences appeared to vary in length of impact, for instance some were immediate responses.

"I was driving... which was quite frightening because I keep pulling the car over (laugh), stopped four times" Kate.L248

In contrast, other sufferers spoke of long-term changes in lifestyle.

"It made me since erm that I carry a mobile phone, which I've never done before" Emily.L128

The following extracts are associated with the more regular chest pains, which seemed to be less intense. The impression was given that the impact was generally less extreme. Some participants reported no impact at all on their daily activities.

"I haven't you know sat in the house wondering what the thing is I've just carried on" Josh.L186
However, others reported how the chest pains did influence their functioning, for instance going off to sleep.

"I know once or twice in bed I've laid awake 'til it's gone before I dared go 't sleep" Kate L201

Also, Abby reported how the pain interrupted her housework.

"Say I'm hoovering and I think oh, it hurts me, I'd just leave the hoovering, I'll sit down 'til it goes off, then I'll go back to it" Abby L589

To sum up, the impact of experiencing chest pain appears to be partly dependent on its characteristics: extreme one-off pain or regular less severe pain. As might be expected the more severe pain tended to have a more extreme and immediate impact but happened outside working hours. Regular chest pains had not stopped individuals from working, probably due to the lack of severity or the ability to use distractions.

Nevertheless, which ever chest pain was experienced, sufferers tended to report some level of impact on their functioning. The length of effect may have varied; some had been long-term influences, others more immediate and short-term. In this current study, participants suggested that the impact was minimal. It was possible that this was related to the strength of cardiac attributions (Eifert, 1992). Nevertheless, as disability had been associated with poor prognosis (Mayou, 1997), impact on daily activities was important to investigate.
Emotions
Sufferers reported certain emotions in association with the chest pains. Emotions were considered here to be feelings expressed as a response to the chest pain. Fear was the emotion most frequently reported and seemed be linked to concern that the chest pain indicated a heart attack.

“I used to (gasp) I’m going to have a heart attack... just the thought of it and it frightens me” Abby.L96

However, Josh did not report being fearful or frightened but spoke in terms of stress and worry.

“I suppose you get stressed yourself just thinking about it, or you get worried about it” Josh.L188

Emotions were reported for other reasons than thoughts of having a heart attack. Kate spoke of the fear of not receiving treatment, more than the fear of having a heart attack itself.

“we all know with heart attacks... that them few minutes can make the difference. So that was the fear not what was going to happen to me in one way but who was there to help me” Kate.L395

To summarise, if emotions were reported they tended to be negative, such as fear and worry. The thoughts that were linked to the emotions were generally related to having a
heart attack. However, one person felt more concern for not getting help with the heart attack, rather than the heart attack itself. Fear and worry may have been related to perception of control. It appeared worth noting that perceived loss of control had been important in the understanding of chronic pain and depression (Skevington, 1996). A mediating factor between fear and control may have been the degree of warning of the pain. In the next extract Emily implied feeling fearful because of the startling nature of the experience.

“one minute it was fine and the next minute was, you know, shock horror” Emily. L169

Early warning signs of the chest pain may have reduced the degree of impact of the symptoms, if effective coping strategies were used. However, no sufferer reported any warning signs or symptoms prior to the chest pain. This raised the issues of if there were warning signs and sufferers awareness. It may have been the startling nature of the pain that triggered anxiety like symptoms which had long since been associated with NCCP (see Introduction). Also, it might have implied that there was a heightened awareness of chest symptoms, which would have supported Eifert’s (1992) Psycho-Biological Model.

**Bodily Symptoms**

In association with the chest pain, people reported additional physical symptoms such as breathing difficulties, feeling hot and sweaty and dizziness. However, the additional symptoms were not explicitly identified as being a consequence of the chest pains.
"But within a couple of minutes it was just awful. I was absolutely couldn't breathe properly erm my face was completely wet" Emily. L42

"I usually feel a bit down... sometimes I go a bit light headed" Ben. L673

The sufferers did not necessarily have all symptoms; one participant reported only the chest pain. Josh when asked if he had experienced any emotions or physical symptoms related to the chest pain, his response was negative.

"No I wouldn't say so no" Josh. L197

To sum up, the number of symptoms experienced alongside the chest pain varied from none to several. This supported the difficulty found in identifying distinguishing features highlighted in the literature reviewed earlier. The perception of the threat the chest pain triggers may have been a mediating factor, and would help explain the variation in additional symptoms. This explanation would be supported by the self-regulation model (Leventhal et al., 1992).

Control

Control was considered here to be the ability to change future events in some way. Most sufferers did not refer directly in their chest pain experiences to the significance of perceived control. However, the researcher felt control was worth commenting on as
it was considered to be underlying some of sufferers' emotional responses. Where participants talked in passive terms it was interpreted as they felt they had no control. For example, the following extracts implied that the pain was happening to them; they had to accept it and there was no action they could take to change it.

"I just think well what's this, you know... and that's how I feel. But soon it goes off. I'm alright again, you know" Abby. L580

"I think there was a certain degree of panic... because of the intensity of the pain it almost takes over" Emily. L170

One sufferer did talk in terms of control. Ben reported not having control over the stress which he perceived as the root cause of the chest pain, and how that was his own fault.

"If stress causes these things I ought to be able to control stress more" Ben. L809

There were references made to not having any warning of the symptoms which were interpreted by the interviewer as indicating perceived lack of control (as mentioned earlier, in relation to fear).

"if you don't feel very well when you start off then something happens, oh well that's been building up, but it wasn't like that. one minute it was fine and the next minute was, you know"
Sometimes, when sufferers were experiencing chest pain, they appeared to look to other people to take control of the situation. For example, Emily looked to her husband to relieve her of her symptoms.

"It was that severity of pain, just take it away" Emily.

Generally perceived levels of control were not explicitly mentioned but were implied. Some sufferers seemed to engage a passive coping style in relation to the experience of chest pain. This may have been linked to the ability to predict and possibly control the pain. Previous research has shown passive coping styles to be associated with reduced functioning (Scharloo et al., 1998). Understanding the use of such coping styles may impact on levels of disability.

Sometimes control seemed to be given to others. This may have been an attempt to indirectly gain some sense of control. In addition, as mentioned above, seeking reasons for the pain has been identified as a means of gaining control. The implication was that a sense of control could have been a positive factor and should have been taken into account when attempting to understand NCCP. Other studies have suggested that perceived control may act as mediator between pain and its impact (Fisher & Johnston, 1998).
This sub-theme was concerned with how people see themselves and their perception of the way other people see them. All participants reported that experiencing chest pain had not significantly altered their perceptions of self. For instance, none considered themselves to be ‘ill’ because of the chest pain. In response to being asked whether the chest pain had made a difference to how he saw himself, Josh implied there had been no change.

“No not at all” Josh.L264

However, sufferers were sometimes concerned about the impression their experience of chest pain had on the way they were perceived by other people.

“It really happened you know. I mean because my husband was there he knows what state I was in” Emily.L305

“It’s important that someone doesn’t think I’ve made a fuss over something that was pathetic” Emily.L314

Some sufferers gave examples of not wanting to feel like they were wasting other people’s time or generally being a burden. For instance, one participant appeared to show concern about being perceived as over utilising the health service.
“I’m not one of these people that would be going to the doctors every five minutes. I’m not” Josh.L16

In contrast, sufferers frequently reported that the experience of chest pain had not altered the way others people saw them. However, their narratives implied that was not necessarily so absolute. For instance, Kate’s son asked a question about what would happen if she was not around.

“he said I thought Mum what are we going to do if you’re not here” Kate.L475

This may have implied that he began to see her differently, possibly recognising that she was not infallible. Similarly, it seemed that Emily’s family adjusted their image of her after the experience of irregular chest pain.

“I think they (family) are fairly used to me being okay...it’s a bit sort of, have you been alright, no more problems and of course S (daughter) been keeping a close watch, which is really nice” Emily.L470

In addition, it appeared that a family’s perception may have altered once the cardiac results were received. For example, Kate was asked about changes in people’s perceptions of her since experiencing the chest pain.
She implied that her family may have been concerned about change, but since the negative cardiac results were received, those concerns had been dropped.

In summary, the importance of self image has been highlighted in chronic illness (Radley, 1994; Osborn & Smith, 1998). In this study, when asked directly, sufferers suggested that there was little or no change to their self image, or other people's perception of them. However, their narratives implied that was not necessarily so. This may have indicated that changes were subtle and not identified when first asked. This implied that the results from a question alone were a less accurate reflection of a situation than a wider exploration. Also, it may have implied that other sources of information could be helpful. Family and friends views may have added to the understanding of the sufferers experience.

Sufferers spoke about how other people saw them differently at times. They also talked of their concern about how they might be perceived by others. This might have been associated with concerns about being believed. Finally, some participants appeared to change their perceptions after receiving chest pain results. It is this specific event that will now be considered in more detail.

**Chest Pain Results**

The responses from the sufferer and others, after gaining negative cardiac results were the topic of this sub-theme. In general, comments from sufferers and their spouses
implied that they were relieved and pleased to know that heart problems were not the cause of the chest pain.

“When I walked out of the hospital the other week, I was so relieved” Kate.

“he’s (Emily’s husband) very grateful for the treatment that I’ve had, you know, he said you’ve had a good M.O.T.” Emily.

Emily also reflected that if the heart investigations had not been so soon after the experience of the chest pain, the pain’s impact may have been very different.

“I might of had a whole different perception on all of this, if that hadn’t of happened” Emily.

To sum up, the results from the chest pain clinic seemed to impact on the sufferers in a positive way. This result supports similar findings in chronic pelvic pain (Savidge et al., 1998). The chest pain clinic being a rapid access facility also appeared to have had a positive impact on at least one sufferer’s whole experience. This supported the literature which suggested that lengthy engagements with the health service investigating possible cardiac pathology could be detrimental to the sufferer (Mayou, 1997).
Summary

To summarise, the chest pain's impact on work and non-work activities often seemed to be dictated by the characteristics of the pain. No sufferer reported an impact on work activity. Also, no sufferer regarded themselves as being ill with the NCCP. Both these points may have protected a sufferer from taking on a sick role. This response may have differed if the pain experienced at work had been one-off extreme pain, rather than the reported regular milder symptoms. However, pain can not discriminate day or time, which raised the issue of possible psychological mediating factors.

Nevertheless, the regular chest pains, as well as the one-off symptoms, often had an impact on non-work activity such as driving and sleeping. There were not indications as to why these activities were the setting for the pain incident. Sufferers reported experiencing varying numbers of additional symptoms and negative emotions in association with the chest pain. The fear or worry experienced could be linked to a sense of control over the pain. The importance of control although generally not overtly mentioned, was implied. Sufferer's reports often indicated feelings of no control or little control; this could have been due to acceptance of the pain impact, or the unpredictability of onset.

The impact of experiencing of chest pain did not seem to affect a person perception of self. However, it appeared to evoke concern over how other people may have perceived them, for instance worrying they would be perceived as making a fuss. Also, other people's image of the sufferer did seem to change in some cases. The change seemed to be the recognition that their loved one had a level of vulnerability. Nevertheless, the
receipt of negative cardiac results appeared to impact positively on both the sufferer and their spouse. Also, the rapid access facility to the chest pain clinic looked as if it reduced the possible negative impact of at least one sufferer’s experience.

3: Support

Support here was considered to be assistance with managing the experience of the chest pain. Through the five narratives the sufferers referred to seeking or gaining support. This super-ordinate theme was investigated through the exploration of three sub-themes: participant’s coping strategies, the level of seeking help and its availability, plus support received from other people (see Figure 10).

Figure 10: Super-ordinate Theme 3 - Support

<table>
<thead>
<tr>
<th>Self</th>
<th>Availability</th>
<th>Others</th>
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Supporting self

Supporting self was a sub-theme which investigated sufferers adopted methods of coping. Coping strategies were considered here to be ways of dealing with potentially anxiety provoking situations. The extract below indicated how Kate coped with an experience of extreme pain when driving on city roads.

Kate

_The frightening thing was I was sat in the car, I’d actually thought if I get out and collapsed on the pavement, will anybody take any notice because you know we see people around don’t we and we are all guilty of it, I suppose we walk past on the drunk or after taking drugs and things and I’m on a bit of road where I didn’t imagine there’d be many pedestrians. And I think if I get out now and collapse what_
would happen? If I stay in the car will people just drive past me, that was my worst thing, that was my one fear, was that if something happens now whose going to come help and that was the first time I stopped=

Interviewer  Yeh.
Kate  =the other times it was on slightly better roads where there was more people about and I thinking if something happened now they would see me (laugh) you know=

Interviewer  Yeh, yeh.
Kate  =but that was me biggest thing was whose around, because you know it, we all know with heart attacks and things that them few minutes can make the difference. So that was the fear not what was going to happen to me in one way but who was there to help me, I'm thinking do I press on the horn, do I (laugh) keep me hand on the horn in case. Yeh.

Interviewer  Yeh.
Kate  So for them couple of minutes that passed you know all these thoughts are going through really.

Kate.L375

Kate initially talked of her fears around gaining help. She considered different coping strategies; getting out of the car or staying where she was. However, both of these options raised doubt in her mind that either would get her the help she needed. She implied her strategy was to drive on in the hope of finding a different option. In her subsequent stops she felt safer and considered that she was more likely to be helped. However, thoughts were triggered of how peoples attention would be gained and the speed at which help would be received. The intended coping strategy was to use the car horn. All these plans appeared to be fuelled by the fear of being alone and of dying. The continuation of how Kate coped on that day came further in her narrative (see below).

Kate  It had only come on for a little while at a time and every time I stopped and it had sort of passed and I'd cooled down a bit and put the windows open=

Interviewer  Right.
Kate  ~drive a bit more and came in and thought, yes I'm goin' to ring the doctors. And at the time of speaking to the, 'cause on a Saturday you get the emergency people, that was quiet hard work because I think I
was actually feeling it then, a little bit fearing things and she’s going through some of the questions and whether I wasn’t clear or whether she wasn’t listening properly but I was getting quiet aeriated, which is not like me, I’m normally really calm on the phone with other people. And that sort of seemed to take for ever to talk to her and sort of describe what was going on you know. So once the phone call was done then I felt a bit better and I just come in and sat down really, thinking phew (laugh) I’m home, that was the thing I’m home I think (laugh).

Interviewer Yeh often a comfort isn’t it.
Kate Yeh because there was other people here and so. 

Kate explained why she changed her planned coping strategy of seeking help when on the road. Stopping the car appeared to have reduced the chest pain and so she used this mechanism to eventually get her home. Once home she felt that the way to manage this situation was to get medical advice. The strategy had been effective she felt relieved after contacting her doctor’s surgery. It appeared that the combination of stopping activities (driving), being in company and seeking medical advice had been helpful coping strategies when experiencing the chest pain.

Nevertheless, coping methods varied across the group, although distraction was used by several participants. Coping strategies also varied according to the characteristics of the pain, therefore the two types of chest pain were considered separately. When experiencing regular chest pains not all participants specifically identified coping strategies, some implied that the low level impact did not warrant it.

“No (I don’t do anything about the pain) ... because it doesn’t generally last all that long” Ben.L957
Other sufferers seemed to imply they did little in the way of coping strategies, but actually appeared to use distraction to cope with the pain.

"You get into what you're doing and you don't recognise it if you like, just vanishes away" Josh.L128

During the day, Kate also used distraction, but reported that at night a different strategy was required; self-talk.

"I suppose when you're in bed... you always think about things more anyway so, when it's day time it's obviously easier to cope with, because you just carry on and ignore it to an extent" Kate.L688

"I would lay there thinking it will go away in a minute and it did, I was always fine" Kate.L206

Abby reported that she took a rest from what she was doing until the pain subsided.

"I'll sit down 'til it goes off" Abby.L590

With the irregular chest pains the coping strategies varied, both in style as well as time scale. Kate, as mentioned earlier, took steps to get medical help the same day, others went to the doctors the following day.

"came home went to bed went to the doctors the next day" Emily.L60
Two of the sufferers experienced the one-off pain while driving and coped by stopping the car on several occasions and attempting to cool themselves down to alleviated their symptoms.

"I stopped the car, just opened the doors" Emily.L47

One sufferer implied that he just went to sleep.

"I went to sleep and it wasn't there when I got up" Ben.L654

To sum up, coping strategies varied not only according to pain characteristics but also to the context. Distraction appeared to be used by several people to cope with the regular pain. This was a researched anxiety management strategy. With the one-off pain, sufferers appeared to seek medical support with differing degrees of urgency; some contacted the health service the same day, others left it to the following day. Seeking medical advice had been identified as a means of reducing distress from an ambiguous chronic illness. The variability in seeking help may have been dependent of the perception of the pain. However, Kate highlighted the importance of having company. Also, seeking support may have been mediated by the perceived availability of help, which was the next focus.
Perceived support availability

This sub-theme considered the limitation and availability of support plus use made of it. Some sufferers reported concern about being alone and having no support at hand when experiencing the chest pain.

"I just thinking, oh I'm on me own, you know. But I think well we've got a mobile now an' I can, you know so" Abby.L600

References were made to the limitations or restrictions on support available from other people. This may have been due to individuals restricting the number of people they spoke to about their chest pain

"I don't really say a lot to them... 'cause I think well they think you're a hypochondriac don't they you know" Abby.L171

"the only person I've discussed it with really is me wife" Josh.L143

Also, it could have been due to the limitations of those people close to them.

"once or twice in bed I've laid awake 'til it's gone, before I dared go t'sleep, but I never mentioned it to my husband because he would panic" Kate.L201
To sum up, the perceived support from others may have been shaped by how much they share their experience. However, it also could have been dictated by their perceptions of the other person's ability to help. Nevertheless, it is implied that being alone and perceiving no available support can cause concern. Previous research has suggested that seeking social support is significantly related to better functioning (Scharloo et al., 1998). Therefore, the ability to ask and the perceived availability of support may have been important in the sufferer's management of NCCP.

Support from others

Support from others considered reported help and advice received in relation to the chest pain. The vast majority of sources were spouses, other family members or health professionals. All sufferers did seek medical advice, although some stated that their spouse encouraged them to do so.

"He (husband) said we'll have to go doctors you know we can't carry on like this, so that's what I did" Abby.L103

Some of the support received from the sufferer's spouse related to identifying the cause of the pain.

"if I'd had the classic symptoms my wife would have had the ambulance... there you know, she said that I don't think you've had a heart attack 'cause you haven't whatever, not hot and sweaty or clammy, that sort of thing" Ben.L645
Family members also appeared to give support by monitoring the sufferer’s health.

“And of course S(daughter) been keeping a close watch (over me),
which is really nice” Emily.L473

Spouses also assisted sufferers either by just being present or helping while they were experiencing pain.

“he came and helped me out (of the car) and laid me down on settee” Emily.L409

“my youngest son... said do you want me to come with you mum” Kate.L301

The health professionals seemed to mainly support the sufferer by giving health directives or advice on diagnosis.

“I went to the doctor the next day, and gave me an ECG and that sort of thing, said I don’t think it’s heart he said but I’m going to send you along just in case, which was very good” Ben.L391

To sum up, support was gained mainly from family and health professionals. The help came in the shape of diagnosis, monitoring health, being present and assisting in times of pain. Generally, the spouse seemed to have been a positive source of support.
Summary

To summarise, support came from three main sources self, family and health professionals. The sufferers supported themselves with a variety of coping strategies, which could be distinguished by the characteristics of the pain. For instance, those experiencing extreme pain reported going to their doctors within 24 hours. The family supported the participant by suggesting a diagnosis, being present and monitoring the sufferer's health. The health professionals assisted with diagnosis and medical advice. However, it appeared that the use of support varied partly due to the sharing of information, but also to the perceived capability of their spouse to help. Finally, it seemed that being alone and perceiving no available support could concern the sufferer. Kate commented that if someone had been with her she would probably have perceived the pain differently.

CONCLUSIONS AND GENERAL DISCUSSION

This final section will briefly review the findings from the analysis and discussion. This will be followed by the clinical implications, methodological issues and the investigator's reflections on the research process. Suggestions will be given for future research and finally concluding comments will be made (see Figure 11).
Summary of Findings

Three main themes emerged from the data. (1) Understanding: which included sub-themes; cause, not knowing, comparison and context. (2) Impact: which included sub-themes; daily activity, emotion, symptoms, control, image and chest pain results. (3) Support: which included sub-themes; self-support, availability of support and support from others (see figure 6, repeated from above to aid clarity).

Figure 6. The Analysis Process
Clinical Implications

Points have been raised throughout the analysis and discussion. The associated clinical implications will now be explored.

Uncertainty

The sufferers indicated a level of uncertainty associated with the cause of their chest pain. Leaving a sufferer with feelings of uncertainty appeared to cause distress. Several of the participants had been referred on for further investigations after being given negative cardiac results. This may have identified causes for some sufferers. However, this could have been a delaying process to leave them with unexplained symptoms. This may have promoted a pattern of behaviour, such as searching for a ‘true’ cause. Those with unexplained symptoms have been identified as potential frequent hospital visitors seeking a cause to the pain (Nezu et al., 2001). Making a decision about the causal attribution may have benefited the sufferer, even if it was to conclude there is no identifiable cause. This may have required discussion with others. A NCCP support group may have provided a like-minded arena for such discussion. It may have also required the ‘no identifiable cause’ to be raised as a possible diagnosis along side other causes, such as oesophageal spasm. This may have allowed the sufferer to have an identity for their symptoms and facilitate externalising the NCCP. This may have resulted in reducing distress and impact on self identity.

Also, the further investigations did not appear to be in line with the sufferers beliefs about the cause. To some extent, this may have left the sufferer dissatisfied with the service, although there was no evidence to back this up. It appeared that if the causes
that made sense to the sufferer and were congruent with their belief system, they were more likely to accept them. More emphasis on a joint discussion about potential causes of the chest pain and future investigations may be beneficial to the sufferer.

**Cardiac attributions**

Several sufferers also spoke of not completely dismissing the thought that the chest pain could be cardiac. These situations had the potential for being associated with levels of disability and NCCP (Van Peski-Oosterbaan *et al.*, 1999). The results suggested that it could not be assumed negative results would eliminate the cardiac causal beliefs. There may have been benefit in reassurance being given at a later date. This could have been in the form of a six-month follow-up appointment, or a support group where such fears may be explored.

**Understanding NCCP as an ever changing process**

The narratives indicated that the sufferers understanding of NCCP was an ever changing process, which can be influenced by other people. This influence could be used to facilitate how the sufferer perceived their symptoms. Therefore, they have been opportunities for interventions to enhance the management of the NCCP. This supported the recent studies highlighting effective psychological treatment (Van Peski-Oosterbaan *et al.*, 1999).

In addition, it highlights that when gathering information from the sufferer, health professionals would benefit from getting current views rather than assuming previous understandings were still valid.
Psychological components

Two of the sufferers raised the possibility of psychological components. This had positive implications for the use of psychological interventions. However, the gap between considering psychological elements to NCCP and actually accepting them was not understood and required further investigation. Nevertheless, the researcher suggested that a forum for exploring the possibility of psychological components, such as a support group may have facilitated an educated choice for the sufferer.

Secondary gains from attributions

The transcripts indicated that there might have been secondary gains from a causal attribution; reduction of uncertainty was considered earlier. Another gain was to assume the NCCP was related to a current ailment and the denying the possibility of an additional health problem. This highlighted that causal attributions could have associated implications for the sufferer. In health consultations, it may have been beneficial to enquire about what a cause implied to the sufferer, hopefully giving further insight into understanding their perspective. To the sufferer the associated implications may have affected how they engaged with the health service. For instance, there may have been heightened anxiety around a cause which triggered memories of a family death. This highlighted how context was required to get a better understanding of sufferers' experiences.

Being believed

There are no visible scars or bruises and the sufferer may find it hard to prove they have NCCP. One sufferer raised concerns about being believed. To a large extent other
people have to trust the sufferer narrative. It may have been beneficial for those health professionals involved with NCCP sufferers to be aware that this could have been a sensitive issue. In addition, an environment involving other NCCP sufferers or chronic pain sufferers may have increased feelings of being believed and accepted. One participant did indicate that talking to people who had similar experiences could be helpful.

**Warning signs**

Several sufferers indicated there were no contextual factors or warning signs for the onset of the chest pain. There may not have been any detectable indicators. However, the non-detection may have indicated that there was a raised awareness of the chest area of the body and other symptoms were not generally attended to. This would be in line with Eifert’s psycho-biological model (Eifert, 1992). It may have also indicated that there was scope for raising awareness and increasing the perception of control, as well as reducing impact. Therefore, increasing general body awareness may have been helpful. This could have been explored in discussion with an appropriate health professional, such as a clinical health psychologist.

**Questions and answers**

The narratives indicated that questions may not have always triggered answers that gave a good reflection of the sufferer’s situation. Through broader discussion a better understanding of the sufferer’s experiences may have been achieved. This has implications for consultations with health professionals. It emphasised the possible benefit from a semi-structured interview; used regularly by clinical psychologists.
It may have been beneficial to have a semi-structure interview as an integral part of the service. This may have led to clinical audits possibly identifying those who would be more likely to be disabled by the NCCP and early interventions. The semi-structured interview may also have impacted on the way sufferers perceived their pain.

Another implication was the advantage of other sources of information in the understanding of the NCCP experience. This could have affected the manner in which clinical interviews were conducted. For instance drawing on the knowledge of the spouse may have been beneficial.

**Support**

Finally, the narratives indicated that for those suffering from NCCP, support could have been beneficial. For instance, being alone with no perceived source of help may have increased the impact of the chest pain. Therefore, it may have been worthwhile in a clinical interview to establish the sufferer’s support network. It may have been that those with little support would have benefited greatly from a NCCP support group.

**Summary**

In summary, many of the clinical implications could have been incorporated in psychological consultations, psycho-educational support groups and psychological interventions. There were also implications when coming in contact NCCP sufferers for health professionals in general.
Methodological Issues

Using a qualitative methodology has been criticised for not being able to generalise the results. It has been argued that the onus should be on other researchers to demonstrate that research is applicable or generalisable to other contexts rather than it being up to the qualitative study (Erlandson et al., 1993). This research was regarded as exploratory with the implication that it may open up the area for further research. Although the results did not lend themselves to being generalisable, it had been suggested (Salmon, 2003) that they can:

1. Equip the researcher or health professionals to think or act differently in the future
2. Help to pinpoint new hypotheses
3. Trigger the rethinking of existing assumptions.

There are several issues that were considered worthy of note regarding the research process. These were divided into four topics: the recruitment context; the participant; the investigator and the IPA research technique. The recruitment context was considered to be the chest pain clinic and the associated health professionals. The participants, not only considered those involved in the study but the means by which they were recruited. The investigator considered the role of interviewer, as well as the front person for the research project. Finally, the research method considered general methodological difficulties and possible areas of improvements.
The Recruitment Context

The five subjects were recruited from the chest pain clinic after receiving negative cardiac results. However, several difficulties arose from this process; the difficulty in getting volunteers and the invitation approach. The difficulty in recruiting participants impacted on the time the investigator could be present. This led to clinic staff recruiting on behalf of the investigator. Although staff were informed of the inclusion and exclusion criteria, it was not always clear that these boundaries had been used. It may have improved the process by spending more time explaining the project and how the inclusion and exclusion criteria were decided.

Also, on reflection, it appeared that not including patients who were receiving treatment or therapy from mental health services may have at times been misinterpreted. Nurses reported that many of the patients were on antidepressants from their GP and initially this may have filtered out some of the prospective subjects for the research. However, this point was addressed during the recruitment phase.

The process of recruitment may not have been conducive to volunteering. The research project was introduced to patients; they were given details to take away to read and asked to opt in by returning a reply slip. This put the onus on the individual to be proactive to get involved with the research. This style of recruitment may have always been problematic. But the difficulty may also have been related to the client group. In previous research they have been shown to be particularly difficult to recruit (Sanders et al., 1997; Mayou et al., 1997; Van Peski-Oosterbaan et al., 1999).
Nurses reported that at times patients were so keen to depart from the hospital they did not attempt to introduce the research project. Again, this may have shaped the patients invited to take part in the project. On reflection, this may have been avoided if the research had been introduced as an integral part of the patient's clinical appointment.

**The Participant**

The recruitment process was self-selecting which raised the questions of why people did or did not volunteer. Within the details given about the project, the prospective participant was informed that the researcher was a psychologist. This detail may have impacted in several ways. The patient may have felt that the health professionals were implying that the NCCP was psychosomatic. However, this was addressed by the investigator and by clinical staff when recruiting. It was also addressed in the information sheet. This was done by emphasising that no implication was being made that the pain was psychological. However, recruitment procedures did not get regularly monitored and so this message may not have been standardised. Therefore, some patients may not have volunteered believing that their pain had no psychological basis (Mayou et al., 1997). However, this was shown not to be true for all patients as two of the participants considered that NCCP may have been partly due to psychological factors.

In contrast, if the patient knew the research involved an interview with a psychologist they may have felt this would be a good opportunity to discuss their problems. Therefore, this may have shaped who volunteered. For instance, volunteers may have been more articulate or unconcerned about discussing their thoughts and feelings. Recruitment may also have been biased towards those generally feeling stressed about
their life situation. It was worth noting that all participants did speak of stressful life events within their interview.

In addition, those who volunteered may have been the people who felt guilty for wasting the health professional’s time, when there was nothing wrong with their heart. As a consequence, they volunteered to ease the guilt and give something back to the service. One participant specifically spoke of concern towards wasting health professional’s time, when going to the casualty department.

“I felt really, really guilty about that (treatment in the casualty department), so I wouldn’t like to think that all that was a waste of anybody’s time” Emily. L326

People may have avoided the project in the fear of their life problems being investigated in the interview. There was an attempt to safeguard against this by highlighting the topic to be discussed in the interview. However, this fear may still have influenced recruitment. It was interesting to note that one participant, prior to recording the interview, mentioned that they may not tell the truth. From the investigator’s perspective this message was seen as an indication of concern as to what the interview might prove to disclose.

On reflection there was a potential problem with self-selection; those who did require help may not have volunteered for research or potential help. Therefore, to include a semi-structured interview as part of the clinical process may have been beneficial.
The Interviewer

Using a psychologist as the interviewer this may have impacted on the information the participant felt should be disclosed. As mentioned earlier, all sufferers mentioned stressful life events, when these were not specifically asked for. However, it may have been that this is a significant factor or point of reference within NCCP sufferers' narratives.

The interviewer was not trained in the research style of interviewing. A more flowing conversation may have resulted if practice had been increased and the recruitment had not been sporadic. A quick succession of volunteers would have allowed easier transfer of skills from one interview to the next.

The interviewer's style would have shaped the interaction of the interview and consequently the understanding developed through the process of the conversation. For instance, the clinical priorities may have dominated the interview process, such as reflecting back to the interviewee.

Finally, the inclusion of psychological causes of chest pain may have been a demand characteristic. The participants may have felt they should mention this possible cause because they were being interviewed by a psychologist. Further exploration in the interview may have indicated whether this was a demand characteristic.
The Research Method

IPA (Smith, 1996) was the qualitative method used, where the data was collected from semi-structured interviews. However, data sourced by interviews have been criticised for their reliance on the participant's ability to articulate their story (Willig, 2001). In addition IPA has been criticised for assuming language to be representative of the experience, rather than the experience itself (Willig, 2001). Willig (2001) suggested that more attention could be made to the role of language.

It was acknowledged by the researcher that this was the method of choice, making a subjective decision that IPA fit the enquiry: sufferers’ perspectives of NCCP. This subjective decision making was part of the research process (Salmon, 2003). By the nature of subjectivity another researcher may have chosen a different approach.

Reflection on the Research Process

As a novice to IPA, and qualitative methods in general, it was a daunting but exciting step to take to embark on this project. The predicted areas of potential difficulty were associated with confidence in the use of a different research process. There was a feeling of isolation when analysing the data which the researcher was informed by experienced qualitative researchers as not being unusual. There was an excitement in unravelling of different layers of the participant's experiences. The cyclical process of the analysis could at times feel over whelming, but more often led to cognitive sparks where a new connection was made within or between participants.
The process of analysis was a very time consuming one and there were thoughts of wanting to rush on. This may have been partly due to the time pressures of the research. It may also have been due to the feelings of uncertainty of where the research was going to lead. However, to get a worthwhile understanding of an individual’s perspective time was needed, and on reflection there was no regret in the hours spent repeatedly going over the transcripts.

The process led the researcher to regularly reflect on what the participant was meaning by their narrative. There were concerns about whether the interpretations were correct. It was difficult to acknowledge at times that it was the researcher’s best interpretation of the sufferer’s understanding that was being produced. However, there was comfort in making the research process as transparent as possible, therefore leaving it up to future readers to identify other potential interpretations.

It was also difficult at times with the analysis as high levels of concentration were required. The researcher found that it was necessary, on occasions, to leave a transcript if thoughts were constantly drifting. In addition, if concentration was achieved it was beneficial to carry on until the transcript analysis was complete.

Being a psychologist, the semi-structured interview approach to data gathering appealed very much to the researcher. The initial thoughts were that the research interview would be similar to a clinical interview. However, there were subtle differences. There was an aim with the research approach to minimise impact on the participant’s understanding of their experience. In a clinical interview there could be
many points of reflection and clarification, which may potentially have altered the client’s understanding. In the research interviews it was often difficult to refrain from reflecting and clarifying. Also, the questions used in the research interview were aimed to be non-leading and open. This was also, at times, difficult to balance whilst putting the client at ease and facilitating the expression of their thoughts and feelings. This learning process affected the way in which the researcher later carried out clinical interviews in daily practice. The style appeared to less verbally involved, leaving more space for the client to reflect.

Different participants affected the researcher in different ways. This may have impacted on the way the questions were asked or the ease of the conversation. On reflection the concern was this may have affected the depth of interview. However, there was no evidence to support that.

**Future Research**

Some possibilities for future research have already been mentioned where appropriate. Additional suggestions will now consider different perspectives as potential sources for investigation.

The research interviews took place soon after negative cardiac results were received. It may be beneficial to carry out a longitudinal study to investigate the potential alterations to sufferers’ causal attributions, impact and coping strategies. This may lead to a better understanding of the prognosis of NCCP.
In the current research, there was a reliance on memory to gain sufferer’s causal beliefs prior to the negative cardiac results. This reflection may have been influenced to a degree by the experience of attending the chest pain clinic. Therefore, to interview sufferers at an earlier stage may give a different perspective.

The spouse’s view on how their partner experienced the pain may add to the general understanding. Additionally, it may be beneficial in the management of the symptoms, as the spouse may be a source of support.

Professional’s perspectives may give insight into the possible impact of the communication factors when sufferers engage with the health service. This could help shape the management of those with anxiety due to uncertainty.

Finally, the rapid access clinic used in this research was a relatively new service. Those sufferers who have had a different experience of discovering they had NCCP could give very different perspectives. Therefore, it may be worthwhile to research the sufferers who have already been identified as non-cardiac through other services and who are seeking further help from their GP. Again, the patient and the doctor’s perspectives may be helpful.

Final Comments

Research on illness historically has been dominated by the professional’s assessment and the outsider’s account (Atschuler, 1997). Through government initiatives the patient has been promoted as a great source of information in the healing process (Department
of Health, 1997). There is a strong support for the use of person-centre approaches to treatment, for instance, patients are encouraged to be involved in the decisions about their care (Department of Health, 2001).

However, in western society doctors are looked upon as the ones with the answers to our health problems. People go to their doctors in the hope of giving them some certainty about what their symptoms indicate. In spite of this there is little focus given to incidents where our medical profession do not know what causes us to feel the way we do. It is the patient's feeling of not knowing and the possible consequences that appear to lack attention. Yet surely these are the individuals that are likely to return time and again to the health service in search of an answer. It is not easy to sit with uncertainty.
Appendix 1

**LETTER OF INVITATION**

Date:

To:

Dear

Re: The Sufferer’s perspective of Non-Cardiac Chest Pain

A research study is being carried out at the Rapid Access Chest Pain Clinic, by Lindsey Hume, Trainee Clinical Psychologist.

The study has been designed to investigate individuals’ views and opinions of their chest pain. The involvement of a psychologist does not indicate that your pain is thought to be imagined or unreal. The study is interested in how people cope with and understand their pain. If you agree to participate, you will be asked to answer questions about your health in general and more specifically the chest pain.

As you have recently been seen at this hospital for chest pain, your responses would be very valuable. It is hoped that the results of this study will help to improve the services offered in the future.

If you would like to take part in this study, details of which are given on the information sheet attached, please complete the reply slip enclosed with this letter and return it in the pre-paid envelope. You will then be contacted to arrange a convenient time for the interview, which should last no more than one hour.

Thank you for taking time to read this letter and I hope to hear from you soon.

Yours sincerely

Dr
Hospital Specialist in Cardiology

Rapid Access Chest Pain Clinic
Reply Slip:

**Study title:** Sufferer's perspective of Non-Cardiac Chest Pain

- I am interested in taking part in the above study and agree to Lindsey Hume contacting me:

- I understand that I am under no obligation to take part in the study

**Name:** .................................................................

**Address:** ............................................................

..........................................................................................

..........................................................................................

..........................................................................................

**Telephone No:** ..........................................................

**Date:** .................................................................

Please return in the enclosed pre-paid envelope to:

Lindsey Hume
Rapid Access Chest Pain Clinic

Thank you
Appendix 2

PATIENT INFORMATION SHEET

Study: Sufferer's Perspective of Non-Cardiac Chest Pain

Principle Investigator: Lindsey Hume

Contact: You may contact Lindsey Hume at the Rapid Access Chest Pain Clinic, Telephone number.

1. What is the purpose of the study?

The aim of the study is to gain some understanding of the experience of Non-Cardiac Chest Pain, in other words chest pain following negative results from the Cardiologist. The aim is to use this information to improve the healthcare and treatment for patients.

2. What will be involved if I take part in the study?

(a) An interview with the Principle Investigator, which will last one hour.

(b) The interview will take place at a location convenient to you, such as the Glenfield Hospital or your home, and require only one visit.

(c) It is anticipated that you may find it helpful to discuss in detail the experience of suffering from Non-Cardiac Chest Pain. However, you may withdraw from the study at any time without justifying your decision and without affecting your normal care and medical management.

(d) If you would like to be sent some information on the results of this research study please indicate on the consent form.

3. Will information obtained in the study be confidential?

(a) The details of the interview will not be recorded in your medical records. All notes made from the interview will be treated in with the usual degree of confidentiality under the data protection act.

(b) You will not be identified by your name in any documents produced relating to the study. Names and any identifying information will be changed to ensure that you remain anonymous.

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As part of normal practice, however, a standard letter will be sent informing your GP of your involvement in the study. If you have any objection to your GP being contacted please indicate on the consent form.

(c) The interview will be recorded on audio-tape, only as a memory aid for the Principle Investigator. Nevertheless, the tape will be given a code and stored in a securely locked cabinet at the Principle Investigator's office base.

4. **What if I am harmed by the study?**

Medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

5. **Will I receive out of pocket expenses for taking part in the study?**

Travel expenses will be paid, within reason, for attending the interview. Please ask the Principle Investigator if you have any queries.

6. **What happens if I do not wish to participate in this study or wish to withdraw from the study?**

If you do not wish to participate in this study or if you wish to withdraw from the study you may do so without justifying your decision and your future treatment will not be affected.

If you have any further questions please do not hesitate to contact, the Principle Investigator, Lindsey Hume at the Rapid Access Chest Pain Clinic

Version: 3
Date: 11th March 2002.
Appendix 3

Inclusion and exclusion criteria

Inclusion criteria:

1) aged over 18
2) able to speak fluent English
3) currently experiencing non-cardiac chest pain (NCCP)
4) have experienced NCCP for a minimum of three months

Exclusion criteria:

1) currently undergoing further investigations or treatments for the NCCP*
2) currently receiving treatment or therapy from mental health services
3) currently participating in another research project

*this stipulation was omitted before the commencement of the study.
Appendix 4

Interview Schedule

Chest pain
1. Can you tell me the brief history of your chest pain problems from when you first noticed the pain?
2. Could you explain what you initially thought the cause of the chest pain was?
3. Have your thoughts changed about the cause?
   Prompt: if so, how have they changed? What would you say was different?
4. Have family or friends shared thoughts about the cause of your chest pain?
5. How do you feel when you are in pain?
   Prompt: physically, emotionally, mentally.
6. How does the chest pain affect your everyday life?
   Prompt: work, interests, relationships.
7. If you had to describe what the chest pain means to you, what would you say?
   Prompt: what words come to mind? what images?

Affect on self
8. How would you describe yourself as a person?
   Prompt: what sort of person are you? Most important characteristics: happy, moody, nerdy.
9. Has having chest pain made a difference in how you see yourself?
   Prompt: if so, how do you see yourself now compared to before you had chest pain? How would you say you have changed?
10. What about the way other people see you: members of your family? Friends? Colleagues? Has this changed?

Coping strategies
11. What does the term illness mean to you? How do you define it?
12. How much do you think about your physical health?
13. Do you see yourself as being ill?
   Prompt: always, sometimes? Would you say you were an ill person?
14. On a day to day basis how do you deal with having chest pain?
   Prompt: do you have particular strategies for helping you? Ways of coping (practical, mental).
Appendix 5

Letters of approval from ethics committee
Dear Miss Hume

RE: Project Number: 7820  [Please quote this number in all correspondence]
Sufferer's perspectives of Non-Cardiac Chest Pain

We have now been notified by the Ethical Committee that this project has been given ethical approval (please see the attached letter from the Ethical Committee).

Since all other aspects of your R+D notification are complete, I now have pleasure in confirming full approval of the project on behalf of the University Hospitals NHS Trust.

This approval means that you are fully authorised to proceed with the project, using all the resources which you have declared in your notification form.

The project is also now covered by Trust Indemnity, except for those aspects already covered by external indemnity (e.g. ABPI in the case of most drug studies).

We will be requesting annual and final reports on the progress of this project, both on behalf of the Trust and on behalf of the Ethical Committee.

In the meantime, in order to keep our records up to date, could you please notify the Research Office if there are any significant changes to the start or end dates, protocol, funding or costs of the project.

I look forward to the opportunity of reading the published results of your study in due course.

Yours sincerely

Dr
Research and Development Business Manager
11 November 2002

Miss L. Hume
Trainee Clinical Psychologist

Dear Miss Hume

RE: Project Number: 7820 [Please quote this number in all correspondence]
Sufferer's perspectives of non-cardiac chest pain — our ref no: 6692.

We have now been notified by the Ethical Committee that this protocol amendment dated 13th September 2002 has been given ethical approval (please see the attached letter from the Ethical Committee).

Since all other aspects of your R&D notification are complete, I now have pleasure in confirming full approval of the protocol amendment dated 13th September 2002 on behalf of the University Hospitals NHS Trust.

This approval means that you are fully authorised to proceed with the project, using all the resources, which you have declared in your notification form.

The protocol amendment dated 13th September 2002 is also now covered by Trust Indemnity, except for those aspects already covered by external indemnity (e.g. ABPI in the case of most drug studies).

We will be requesting annual and final reports on the progress of this project, both on behalf of the Trust and on behalf of the Ethical Committee.

In the meantime, in order to keep our records up to date, could you please notify the Research Office if there are any significant changes to the start or end dates, protocol, funding or costs of the project.

I look forward to the opportunity of reading the published results of your study in due course.

Yours sincerely,

[Signature]

Dr. [Name]
Dear Ms Hulme

Re: [Please quote this number in all correspondence]
Sufferer's perspectives of Non-Cardiac Chest Pain

We have now been notified by Research Ethics Committee that the protocol amendment (as set out below), to the above study, has been approved by Chairman's action (please see the attached letter from the Ethical Committee).

- To alter the exclusion criteria in the research protocol by omitting "Currently undergoing further investigations or treatment for non-cardiac chest pain"

I therefore have pleasure in confirming approval of this amendment on behalf of the University Hospitals NHS Trust and also confirm that, as this does not alter the resources which you originally declared in your notification form, you are fully authorised to continue with this study.

The study remains covered by Trust Indemnity, except for those aspects already covered by external indemnity (e.g. ABPI in the case of most drug studies).

May we take this opportunity to remind you that we will be requesting annual and final reports on the progress of this project, both on behalf of the Trust and on behalf of the Ethical Committee.

In the meantime, in order to keep our records up to date, could you please notify the Research Office if there are any significant changes to the start or end dates, protocol, funding or costs of the project.

I look forward to the opportunity of reading the published results of your study in due course.

Yours sincerely

[Signature]

Head of Nursing/Service Manager for Research and Development
Appendix 6

PATIENT CONSENT FORM

Study: Sufferer's Perspective of Non-Cardiac Chest Pain

Principal Investigator: Lindsey Hume

This form should be read in conjunction with the Patient Information Leaflet, version no 4 dated 11th March 2002. Please bring this consent form with you to the interview.

I agree to take part in the above study as described in the Patient Information Sheet.

I understand that I may withdraw from the study at any time without justifying my decision and without affecting my normal care and medical management.

All the information will be treated as confidential.

I understand that the interview will be tape-recorded and I may have a copy of the tape/transcript if I request it.

I understand medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS i.e. compensation is only available if negligence occurs.

I have read the patient information leaflet on the above study and have had the opportunity to discuss the details with Lindsey Hume and ask any questions. The nature and the purpose of the interview to be undertaken have been explained to me and I understand what will be required if I take part in the study.

I agree/do not agree * to my GP being notified of my participation in this study.
I would/would not* be interested in receiving information on the results of the study.

*delete as appropriate

Signature of patient: ............................................................. Date: ...............................

(Name in BLOCK LETTERS) ...........................................................................................

I confirm I have explained the nature of the Trial, as detailed in the Patient Information Sheet, in terms which in my judgement are suited to the understanding of the patient.

Signature of Investigator: ............................................................. Date: ...............................

(Name in BLOCK LETTERS) ...........................................................................................
Appendix 7

GP Notification Letter

Date:

To:

Dear Dr.

Research Study: Sufferer’s Perspective of Non-Cardiac Chest Pain

I am writing to inform you that Mr/Mrs/Miss............... has agreed to participate in the above research study. The study is being carried out at the participants’ home /xxx Hospital by Lindsey Hume, Trainee Clinical Psychologist. The aim of the study is to gain some insight and understanding of how Non-Cardiac Chest Pain is experienced by the individual.

Patients are being asked to participate in an hour long interview, answering questions about their health in general and more specifically the chest pain.

It is hoped that the results of this study will help to inform the best approach to Non-Cardiac Chest Pain sufferer’s health care and treatment packages.

If you have any queries, please feel free to contact me, on the telephone number below.

Yours sincerely

Lindsey Hume,
Trainee Clinical Psychologist

Rapid Access Chest Pain Clinic
Appendix 8

Example of analysis levels 1-3

Interview 1: Abby

Level 1: Initial thoughts

The initial thoughts on this interview were how Abby appeared to be affected by the use of an audio-tape recorder, as once the interview had been completed and the machine had been switched off she seemed more at ease, her shoulders relaxed and she gave further details on the topic area.

Abby was a married woman who lived with her husband. She worked part-time at a school. She was in her early sixties. Her chest pain was regular but not continuous.

From the investigator’s initial reflection it seemed that Abby’s perception of her health and illness predominantly involved gaining a sense of knowledge from those around her, as she made reference to many people in her narrative. There was a strong sense of her maternal role throughout the interview.

Level 2: Description of Themes

From the line by line analysis five main themes were drawn from the data, see Figure 12.

Figure 12. Abby: Five main themes related to chest pain

<table>
<thead>
<tr>
<th>Themes</th>
<th>Understanding</th>
<th>Control</th>
<th>Predictability</th>
<th>Impact</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-trying to make sense</td>
<td>-lack of control</td>
<td>-not knowing</td>
<td>-daily routine</td>
<td>-others</td>
</tr>
<tr>
<td></td>
<td>-comparison with past</td>
<td>-sense of control</td>
<td>-certainty</td>
<td>-on emotion</td>
<td>-self</td>
</tr>
<tr>
<td></td>
<td>-comparison with others</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Understanding involved Abby's making sense of information, where she appeared to organise it into knowledge that was congruent with her attitudes and beliefs. There were times when this seemed to be done by comparisons with her past experiences and thoughts. The first extract related to the point in the narrative where Abby was responding to questions regarding the history of her chest pains, and the second relates to Abby's understanding of the cause.

"I've felt alright since I've been there, so whether it was psychological thinking, you know, it was coming back" L70

"I just thought it was like I'd had it before" L143

Abby made comparisons with other people as a means of acquiring understanding. These extracts are part of her description of how she was feeling and an image she had when experiencing chest pain. The first compares her experience of symptoms with her mother's, the second with media portrayals of having a heart attack.

"Like me, she always used to say oh I've got a pain here, got a pain there, you know" L305

"you see somebody having a chest pain don't you. You know if you see somebody on the telly having it, you know, you think oh Christ is that what I've got" L358

The next theme was control, or more specifically, lack of control or no sense of control, the latter experiencing passivity. The first example implied the perception of no control, the second indicated that Abby approached the experience of chest pain in a passive, non-controlled way.

"That's a bit scary you know with illness... sometime, you know, you think your body's gonna give up at sometime or other" L508
"I just think well what's this, you know... and that's how I feel. But soon it goes off, I'm alright again, you know" L580

The third theme was predictability which incorporated such aspects as uncertainty, and seeking and enforcing security. The initial extract was part of Abby's reporting of her views on illness and indicated her thoughts the inevitability of death and her interest in predicting its cause. The latter excerpt suggests a need for certainty in an anxiety-provoking situation.

"'cause you're goin' to die aren't you?.. Yeh and you think well what am I actually goin' to die from" L501

"Well I feel like, I panic, you know. I feel, well this is it, you know.. yeh, you know, this is, I'm goin' g'die, you know" L288

The next theme was the impact on self, which included the perception of how incidents have affected Abby, either in behaviour or thought. The first extract suggested that chest pain can impact on one's daily routine, and the second how thoughts could impact on emotions.

"Say I'm hoovering and I think 'oh it hurts me', I'd just leave the hoovering. I'll sit down 'till it goes off, then I'll go back to it" L609

"I used to (gasp) I'm going to have a heart attack. You know what I mean?.. I used to get panicky because, I mean, I think 'oh', just the thought of it and it frightens me" L96

The final theme support drew together needing or receiving help through others or by independent means. The initial extract was from Abby's report of seeing a new doctor at her local surgery and indicated that she needed help. The following two quotes implied gaining general support from others, and being self supportive after an episode of chest pain.
"she said 'I've never met you before', I said 'no'. So she said erm 'do you mind me' I said 'no' I said 'I just wanted to see somebody' you know" L136

"We can talk to one another about anything... she tells me things and I can tell her, which I can tell her better than I can me family" L409

"I just thinking, oh I'm on me own, you know. But I think well we've got a mobile now an' I can, you know, so. But I just, then I think I'm alright now so then I get cracking again" L620

In summary, through the interpretative line by line analysis of Abby's narrative there appeared to be five main themes, some of which were more closely associated than others. These could be split into the effects of life events and the ways in which one manages them. For instance, impact considered the effect on Abby of life events, whereas understanding, control, predictability and support, were arguably all associated with coping strategies.

Level 3: Interpretation of the whole transcript

This level of analysis will give an overview of Abby's narrative, considering the macro rather than micro perspective. Here three themes emerged from investigating the transcript: context, collective knowledge and emotionally and/or physically laden events (see Figure 13).

Figure 13. Abby: Three themes covering the whole narrative
This narrative appeared to use context predominantly to tell a story. For instance, she continually used conversation when reporting events.

"so my husband said 'well how long will we have to wait, longer than six months?’, she said 'no it should be probably four to six months’" L25

There was often an emphasis on social context. Abby brought many people in to her narrative to describe experiences. Going through the transcript she mentions over 25 different people, which gave the reader the impression of Abby being someone who expressed herself in terms of relationships and interactions with others more than through her own personal thoughts.

Abby also described events giving detailed surrounding or supporting information, putting accounts into context. An example of this was when she was asked for her thoughts on the cause of her chest pain. She gave the doctor’s suggestion and explains how that may have been possible and describes how the behaviour started.

"I don’t know what it is. He well, he said ‘is its indigestion’ ‘cause I’m a person that tends to eat very quick. You know like I’ve always, like when you’ve had, I’ve had three children an’ you kinda eat you’ dinner don’t you, quick just to.” L80

Another feature of the transcript is the impression of a collective knowledge, whereby understanding is a process of social interactions. It appeared that Abby often informed an opinion gathering details from others rather than solely from her own thoughts. An illustration of this was shown where Abby was explaining what the chest pain means and what images come to mind. Here she uses media images and others’ stories on chest pain.
Abbey: “well it’s like you see somebody on the telly having it, you know, think ‘Oh Christ is that what I’ve got’, you know what I mean?....You know they say it’s like erm somebody bearing down on, you know like a”

Interviewer: “Yeh like a big weight”
Abbey: “big weight, don’t they. But it didn’t feel as bad as that” L358

Through the narrative, in addition to incidents of chest pain, Abbey reports emotionally and physically laden events. These included family difficulties around the breakdown of her son’s marriage and the onset of a thyroid problem. Abby made a link between her son’s plight and her health. After telling the story of her son’s difficulties she reported the perceived impact on herself.

“I think that was a lot to do with the last lot of, the first lot of heart trouble” L254

In summary, Abby generally expressed health/illness and chest pain in terms of social context. The knowledge she gained on life seemed to be dominated by a collection of other people’s perspectives; however there were some exceptions. Abby did bring into her narrative several examples of experiences that were not of chest pain and these appeared to be emotionally and/or physically charged events.
References


Sufferers’ Perspectives of Non-Cardiac Chest Pain

Addendum - Transcripts

By Lindsey Hume

October 2003

Thesis submitted to:

School of Psychology – Clinical Section,

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in partial fulfilment of the degree of Doctorate in Clinical Psychology.
Transcript Notation

This- A dash denotes an unfinished piece of narrative.
That= An equals sign links material that continues on.
? A question mark indicates a question.
(?) A question mark in brackets denotes unidentified material.
under A word underlined denotes emphasis.
(action) A word in brackets denotes an action.
, A comma like break in speech.
. A full stop denotes a natural ending.
Abby
I've got various things I'd like to ask =
Yes.
= and by all means just answer them as freely as you =
Right.
= as you like with them okay. Just to start, to start
with it'd be helpful to have a brief history of the
chest pain problems, when you first noticed the
chest pains, that sort of thing.
Erm, what this time or the time before? I had them
when I had to go in and have the angioplasty.
Well I'd, I'd start from the beginning.
Well that's erm about two year ago. I'd been having
chest pains on and off before that and I went to the
doctor and they said we'll refer you to hospital so =
Ah ha.
= I went to hospital and they put me on the exercise
and all that and they said I'd got angina.
Right.
So that they said we'll book you in for one of these
angioplasties but you'd probably have to wait,
probably six months. And we had decided to go on
holiday, but they said we didn't advise you to fly
so =
Okay.
= so I didn't. So my husband said well how long,
will we have to wait, longer than six months? She
said no it should be probably four to six months.
Anyway I was in in four months and had it done. I
went in for the day and the night =
Mm.
= I came home the next day and just rested. Had a
couple of days off, went back work.. And after that
I felt fine =
Right.
= up until probably late, just before Christmas it
started again and I thought oh not again. But I'd
been on Atentanol =
Right.
= as well. This is the tablet you take=
Angina?
= to like to keep your heart rate at a certain level.
Yeh.
Not that it beats faster or it, an uneven beat.
Anyway I, I went back to the doctors and I 'cause I
was worried about it again. I thought didn't want to
get it back to how it was. So they said, she said, oh
well I said I don’t want to waste anyone’s time. She said no, she said we’ll refer you back up. And I went then, when I seen you.

Interviewer Yeh.

Abby And erm, but they said there’s nothing you know. It’s just she said are you worried about things? I said you get family problems don’t you, and probably she said that doesn’t help.

Interviewer Mm.

Abby And like, and he said to me well you’re getting older, but the doctor said I was really fit for my age. You know so that. And he’s stopped me taking, I don’t take the tablets at all now.

Interviewer Right.

Abby I just, I sst, when I. He said take one every other day for a start don’t just leave them off altogether and then take one twice a week. But now I don’t take any.

Interviewer So you’ve gradually been -

Abby So I’ve brought. He said if you stopped them altogether straight away it could you know it’s too sudden so you have to do it gradual=

Interviewer Gradual.

Abby =so that’s what I’ve done. So and up to now I’ve felt alright since I’ve been there so whether it was psychological thinking you know, it was coming back, but they said there was nothing there so.

Interviewer Right.

Abby But I have had thyroid trouble very bad.

Interviewer Right.

Abby So he said that’s a lot to do with fast heart beat.

Interviewer I see, I was going to ask you, what d’you think that the cause of the chest pain was?

Abby I don’t know what it is. He, well he said is it indigestion? ‘Cause I’m a person that tends to eat very quick.

Interviewer Right, right.

Abby You know like I’ve always, like when you’ve had, I’ve had three children an’ you kinda eat you dinner, don’t you, quick just to. I think I’ve always. My husband says he eats slower chew it better. You know, chew it down more and I don’t, I rush you see.

Interviewer When you originally had the chest pains a couple of years ago, what, can you think back to then and what you thought the cause was then, where you, where you -
No I always thought it was heart problems.
You did okay.
I thought I’m goin’ have a. That’s how I used to feel, I used to (gasp) I’m going to have a heart attack, you know what I mean?
Yeh.
I used to I use to get panicky because =
Yeh.
= I mean I think oh, just the thought of it and it frighten me you see. And I use to say to R (husband) oh I’m going to have a heart attack, he said, and he use to say ‘ave you got it in your arms or you know.
Mm.
But it used to frighten me I think, you know, and that’s why I thought well I. He said we’ll have to go doctors you know, we can’t carry on like this, so that’s what I did.
What about second time?
What las’?
Yeh that’s the feeling I got again. But then I carried on and carried on and I kept thinking it will probably go off and some weeks I felt fine an another week I’d have it back again, so I just thought well. But to try gettin’ our doctors =
Mm.
= every time I rung up, you’d got to wait to get in.
Right.
I rung up you’d got to wait to get in.
Right.
You know and in the end, then I rang and I said I want to make an appointment for so and so, she said we don’t do that now, she said we’ve changed.
What you do is you ring up at half past eight in the morning and we get you in the same day. We’ve changed now so that’s what you do.
Right.
So I rang up early and I got in at eleven o’clock and I’d seen a lady doctor I’d nev’. ‘Cause I can’t, you can’t never get to see your own doctor, very rare.
Mm.
So I seen this new doctor, lady she was, but she were really nice, ever so nice to me, and I felt you know, ‘cause she said I’ve never met you before, I said no. So she said erm do you mind seeing me, I
Interviewer: And at that point what did you think the cause was?
Abby: Well I just thought it was like I'd had it before you know, thought I'd got angina. But they did say I'd got a touch of angina before, but then they put this and they cleared you're arteries isn't it, they widen it. You now and he thought it got to put a stent in but they didn't need to.

Interviewer: Right.
Abby: So erm but I said since I've been up there, whether they've put me mind at rest, that I've not got heart problems =
Interviewer: Yeh.
Abby: =I feel better in me mind.
Interviewer: Yes. It's erm, what about you're friends and you're family and what, what they thought about the chest pain? Did they have any ideas.
Abby: Well I didn't tell anybody very much, I don't tell 'cause I've got three sons an' I mean they do probably worry, well I don't think whether they worry about you or not but. I don't think boys are like girls towards the parents. You know, I mean they always ring me and ask me if you know, just say are you alright mum and I say yes you know. That as far as it goes. But one of me daughter-in-laws mm she's quite good because she's had a lot of problems with heart trouble well an, well not heart trouble but like me.
Interviewer: Yes.
Abby: An' she's just had her gallbladder done and she thinks that was a lot to do with these pains you see.
Interviewer: She thought she was having heart attack but hers was the gallbladder pain.
Abby: Right.
Interviewer: But she all. And I can talk to her about it. I can me other daughter-in-law but you know I don't say really say a lot to them you know. I don't want to keep saying I'm not very well all the time 'cause I think well they think you're a hypochondriac don't they you know. So I just say yes or I'm not too good that's all I say really. Ya know.
Interviewer: What about your husband?
Abby: Oh he's very good.
And what, what did he, did he have any ideas of what he thought it was?

No he just thought I was ba'. He said you worry, he said you worry over the boys and, don't worry over them they've got their lives we've got ours now. He said don't worry about 'em. You know so I try not to but then my eldest son's forty this year you know and I, I mean he's gone through a lot, a lot of problems. He's married again now but I mean he's has, he's been, had a terrible life up until he married J (daugher-in-law), you know.

Mm.

I mean he's a ever such a lovely bloke but he just had a very rotten life, you know with his first wife and he came back home you see.

Right.

He came I mean he was in such a state. And I, I just said to him. He come one night in the middle of the night sobbing and I said just come and he stayed and he stayed for two an a half year.

Right.

But he hadn't got nothing, not got a, he 'adnt got a shirt or anything, he was so poorly. But he's married again and she's lovely. I mean he's got two lovely children, but she was, he was. I mean don't get me wrong it was six of one and half a dozen. I think he was silly with her but he was, he looked terrible. But I mean he's, he looks different bloke now you know so. That was a lot of trouble for us, you know.

Well was, when was that?

Well he's been married four year to this girl you know. She's older than him but she's good for him.

Mm.

You know. But an' but I say that but then when they went on honeymoon they came back, he came back here again one day. They'd only been married a fortnight and he came back and I said where's J (daugher-in-law)? He said we just don't get on mum. I said oh no not again. First place they come is home i'n't it.

(laugh)

And see that all builds up on, you know that takes its toll on ya.

Yeh.

You know and I said, I said well I'm sorry but S (son) I said but you just can't stay again. I said you
can stay for tonight I said so R (husband) said you
got to go home and work it out.

Mm.

She was in bed for the day. But they did work it out
and they’re fine now so.

That’s good.

Yeh but that was a very big thing in our lives.

Yeh.

You know ‘cause the children were goin’, the
grandchildren were going through it awful time.
They were going out begging on the streets. She
were sending up for food an. It was awful an’ we
really, we had to put the children into erm, on the
social six months.

Right.

Keep a, somebody check on them, ya know.

Yes.

They didn’t get took into care, which they could
have been done, but they didn’t so that was awful.

But they’ve worked out ever such great children
now so we, everything’s alright that, you know...

That way?

Yes.

Brilliant.

So that was really a, I think that was a lot to do with
the last lot o f, the first lot of heart trouble, you
know what think.

Yeh, which was about two years ago did you say?

Yeh, and I think I had had it then and I’d had it then
and I’d just left it and left it. You know how you
do.

Right.

But as I say everything’s worked out now so.

I mean, eh, just, just thinking about how you feel
when you’re in pain, you know, you have these
chest pains, can you, can you give me some erm -

Well panic

Panic. And people say it’s probably a panic attack.

You know say I standing like. We went away and I
was standing in the airport in the queue, and all o f a
sudden it come on and I thought oh I’m goin’ faint
or I’m goin’ to have a heart attack here you know.

And that’s how I get, and I think oh I don’t want it,
to do it in front o f everybody. You know what I
mean?

Yeh. So what’s -
(gasp) And I go (gasp).

Yeh, so your breathing changes.

I'm trying to get, you know, I can't get me breath.

Yeh. Is there anything else you notice physically?

Well just, it's just here (across the span of the chest), you know, and it seems to go across there but.

Yeh.

I just, it just how it, it just a pain, you know. An' then I, I'm going (breath in and out), you know like that. An' R (husband) he'll say calm just take your time, sit down, you know, try and get your breath back.

Yeh.

Well I feel like, I panic, you know. I feel well this is it, you know.

Yeh, yeh.

Yeh, you know, this is I'm goin' g'die you know.

Yeh, yeh.

An' I, like I said to R (husband), my mum died at forty-nine ya see.

Right.

And I was only nineteen, and we'd just married.

We'd only been married a fortnight and me mum died, you see. And I always used to say to R (husband) if I get to the age of over forty-nine I'll feel better. Because me grandma died a young age, me mum died at a young age. And I use to think, I use to say to R (husband) I take after me mum a lot, you see. Me mum was like me a worrier.

Yeh.

Like me, she always used to say oh I've got a pain here, got a pain there, you know.

Yes.

And I'm exactly the same. I can see meself in her you know.

Yeh.

And I used to say to R (husband), as I get over fifty I'll feel better.

Yeh, and have you?

I felt better now I've got, but I mean, I think it's 'cause I'm older you know, I mean I think oh I'm sixty-two next week, you know.

Yeh.

I can't believe it, you know.

Yeh.
Abby: But I do used to think it runs in families that if your mother lives to long age you might do, you know.

Interviewer: Yeh.

Abby: But if your mum don’t to, you’re probably the same.

Interviewer: Yeh, often people think like that, yeh.

Abby: ‘Cause I’ve got a girl at, well she doesn’t work at our place now, her mum’s ninety-three and she’s sixty, about sixty-four. Well she’s in hospital at the minute but, I always used to say to, her names J as well, I used to say oh I bet you’ll live to you’re a long, a big age because your mum has.

Interviewer: Yeh, mm.

Abby: You know.

Interviewer: Yeh, yeh.

Abby: It’s in your genes i’n’t it that, you know I always think it runs in families. I mean me dad, he died twelve year ago, so he was seventy-eight when he died.

Interviewer: Right.

Abby: And people say I’m like me dad.

Interviewer: Yes.

Abby: You know people say. I mean I used to work at FV (school) in the kitchens at, she, the boss there used to say you’re just like your dad the things you do, you know.

Interviewer: Mm.

Abby: But I don’t think I am, I think I’m like me mum.

Interviewer: But R(husband) thinks I’m like me dad because I had me dad longer didn’t I than me mum.

Interviewer: Yes, yes.

Abby: So people see me and me dad, you know. ‘Cause I’m the only one as well, I haven’t got any sisters and brothers you see.

Interviewer: Oh right, right.

Abby: No.

Interviewer: Erm, can you describe what the chest pain means to you, erm what sort of words or images come to mind when you think of the chest pain?

Abby: Well it’s like, you see somebody having a chest pain don’t you. You know, if you see somebody on the telly having it, you know you think oh Christ is that what I’ve got, you know what I mean?

Interviewer: Yeh, yeh.

Abby: You know they say, it’s like erm somebody bearing down on, you know like a =
Abby = big weight, don't they. But it didn't feel as bad as

Interviewer No, okay.

Abby It felt just a bad pain=

Interviewer Okay.

Abby =yer know, but to say, touch wood, I've not had it
since I've been up there, so whether it is in my
mind.

Interviewer That's what two weeks?

Abby When did I see yer, two weeks weren't it?

Interviewer About two weeks ago.

Abby Yeh, on a Thursday wasn't it, yeh.

Interviewer Okay, erm, how would you describe yourself as a
person? What sort of person are you?

Abby What? In-

Interviewer Character.

Abby Well I'm happy go lucky, you know. And people
say I'm always the same, and I mean people at
work say I'm, oh you always come in bright and
sparkley. I do and I work with children and they all
love me.

Interviewer (laugh)

Abby I mean I was, I had to. I didn't go one day I was,
weren't very well or sommit I had a don't know
what was the matter, I didn't go, I didn't feel too
good. And the teacher said oh where were yeh?
You wanted to know where's J (client), where's J
(client)? You know so. And like we went on
holiday to Tenerife and I didn't go back work for a
week after 'cause we went away so. And erm this
other teacher had had the last term, she said they'd
been worried, thought you'd left. All the children I
had, last term, thought, 'where's J (client)'? 'She
left?', 'oh I miss her', she been on about you all the
while, they thought you were ill. I said no I've been
on me holidays. I mean =

Interviewer Yes.

Abby = people at work really like me, you know.

Interviewer Yeh, that's lovely.

Abby And I've got a lovely friend who I see every week,
who I used to work with at, when I worked at the
other school. Er she comes to see me every week,
Tuesday, and we go out together and we have a day
in town when I'm not at work you know.

Interviewer Yeh.

Abby And we get on re'. We can talk to one another
about anything.
423 Interviewer That's nice.
424 Abby She tells me things and I can tell her. Which I can
425 tell her better than I can tell me family.
426 Interviewer Yeh, yeh.
427 Abby I can talk to her more in personal problems than I
can talk to me family about. Probably because
they're sons you see.
430 Interviewer Yes, yes could well be. How do you think she
would describe you then?
432 Abby Who T(friend)?
433 Interviewer Mm.
434 Abby Well lovely, 'cause she says I'm lovely.
435 Interviewer (laugh)
436 Abby You know I mean I, she's lovely as well.
437 Interviewer Yes, yes.
438 Abby She's a very considerate person and she's the same
age as me as well.
440 Interviewer Yeh, right.
441 Abby And she's had problems same as I have an' with her
son an' so it's, we've gone through. And we can
talk to each other you see about it.
444 Interviewer Yeh.
445 Abby Yeh she is lovely. If you talk to her she's, she is,
she is lovely.
447 Interviewer What would be, what would you think of as the
most important characteristics of you? What would
you say if you had to describe yourself, what would
be the strongest?
450 Abby Well I'm happily married.
452 Interviewer Yep.
453 Abby We've been married for forty-three years an' he's, I
mean he's lovely and I think he loves me, you
know. An' like me youngest son, he gets married in
August and his girlfriend said if we're as happy as
you and R (husband) been, we can't go far wrong.
458 Interviewer Yeh.
459 Abby So.
460 Interviewer Erm, having the chest pain, has it made a difference
in how you see you're self?
462 Abby I don't know what to say. What the...
463 Interviewer Erm, thinking of before you had the chest pain.
464 Abby Yeh.
465 Interviewer And then, a couple of years ago, and then you had
the chest pain. I just wondered whether you see
yourself differently in any way?
468 Abby No, only older.(laugh).
469 Interviewer Okay, alright.
Abby: Yeh older, and I think well you know, you’re not, you’re six’, you know. I can’t believe I am actually sixty-two, you know what I mean?

Interviewer: Yeh.

Abby: You still think, your body still thinks you, me mind still thinks I’m younger.

Interviewer: Yeh.

Abby: But me body tells me I’m not.

Interviewer: So it’s the age?

Abby: I think it is yeh. It is the age thing. You know like people say. I mean me husband he retires next year and I mean I met him when I was sixteen, you think you know you can’t believe you’re that age.

Interviewer: No, not at all. What about the way that the members of your family see you and has this changed d’you think?

Abby: No, I think, I mean P (son) always say, me youngest son, and he’s thirty-two. He always says I can’t believe like how you are mum, you don’t look sixty-two.

Interviewer: No.

Abby: You know, he says whether it’s the colour of me hair, because me husband’s white. I mean people think he’s older than what he is, but when they look at me they think I’m. I mean the girls at work said, we always send a card to everybody, you know. They said, and I said something about being oh sixty-two next week. They said you’re not sixty-two are you, and I said yeh. They think I really in me fifties.

Interviewer: Yeh.

Abby: So that makes me feel good in a way.

Interviewer: Absolutely.

Abby: But then I think well I wished I was, you know, but er as I say I think it’s the age thing sometimes.

Interviewer: Mm okay. Erm what does, what does the word illness mean to you? How would you define it?

Abby: Scarey, that what you got, what’s goin’ to be in time. You know when you see people with illnesses, you know, it will, what am I goin’ to die from and things like that, you know. ‘Cause you’re goin’ to die aren’t you?

Interviewer: At some stage.
Abby: Yeh. And you think well what am I actually goin’
to die from, you know sometimes. You hear
families say oh so and so’s got cancer and, don’t
yeh?

Interviewer: Yeh.

Abby: Which is awful i’n’t it, yeh. That’s a bit scarey you
know with illness.

Interviewer: Yeh, yeh.

Abby: Sometime, you know, you think your body’s gonna
give up at sometime or other, at one thing, i’n’t it,
you know. So, you know, then R(husband) will say
well don’t start thinking like that but, when you
hear of people you think what’s goin’ to happen to
me don’t yer?

Interviewer: Yeh.

Abby: Yeh. I mean I don’t think it all the while, but =

Interviewer: No, no

Abby: = but it does crop up don’t it

Interviewer: Yeh, yeh.

Abby: Yeh.

Interviewer: Yeh it does. How much do you think about, you
saying there, how much do you think about your
physical health?

Abby: Oh, I don’t think about it a lot, only when I don’t
feel well.

Interviewer: Right.

Abby: When I don’t feel well I think oh what’s wrong
with me now, you know.

Interviewer: Yeh, and what sorts of thoughts go through your
head?

Abby: Oh something else, you know. Like last weekend I
had a very bad migraine headache =

Interviewer: Mm.

Abby: = and I got up on Sunday and I hadn’t slept all night
‘cause everytime I laid down. Anyway I took
paracetamol but it didn’t seem to move it. And then
R(husband) said, he wasn’t in a very good mood
‘cause he aint got any work, so, ‘cause he works for
himself. He says oh something else, you know, and
I thought oh, you know. I wished I hadn’t of said
anything now (laugh).

Interviewer: (laugh)

Abby: But then I, I just passed it off, ‘cause he said oh we
wont go out to see the girls. I said oh yes, I made
meself go out you see, I felt better.

Interviewer: Right.

Abby: I think.
Interviewer Yeh, yeh, I've done same.

Abby If you stop in and sit here and you think about it don't you. You think, well I thinking an' you know but get up an' work it off you know.

Interviewer Yeh.

Abby So I just went out, we went out for a ride an' went to see me granddaughters. An' I felt better then.

Interviewer Lovely, yeh. Erm when you, when you have the chest pain, I know you said the last couple of weeks=

Abby Yeh

Interviewer = you haven't had it but, when you've actually been experiencing the chest pain do you, do you see yourself as being ill?

Abby No, I don't see meself. I mean I don't actually feel ill.

Interviewer Right.

Abby Bodily.

Interviewer No.

Abby I just feel, like I say I panic. I got this pain an' I think why have I got this pain, but I don't feel ill, ill.

Interviewer Right.

Abby I mean I wouldn't go to bed.

Interviewer No.

Abby You know I wouldn't think I'll go bed, you know.

Interviewer Yeh.

Abby I wouldn't do that 'cause I mean I've got to be really ill if I'm going to bed.

Interviewer Right.

Abby But I wouldn't say I felt ill.

Interviewer No.

Abby I just think well what's this, you know.

Interviewer Yeh.

Abby And that's how I feel.

Interviewer Yeh, yeh.

Abby But soon as it goes off, I'm alright again, you know. Think oh well it's gone, you know.

Interviewer So what would you do when you've got it, would you...

Abby I'd just sit down.

Interviewer Sit down.

Abby Or if I had felt it, probably, when I come home from work I'll go and la', I will go and lay on the bed. And perhaps I do go a sleep.
And er I only go for half an hour, I think oh I’ll
have me dinner and I’ll go and I’ll go and have a
lay down. Say it’s not nice enough to sit out so.
And I’ll probably have a sleep, and I’ll wake up and
I feel better, (?) said probably I felt tired.

‘Cause I don’t sleep very well, I’m a very poor
sleeper.

Right. Okay erm I sort of, you explained some of it
there, but on a day to day basis when you’ve been
having the chest pain, sort of, how would you, how
would you deal with it? What way, you said for one
thing you might try and go to bed=

Yes I would.

= and you said about sitting down.

Or I’d sit down. Say I’m hoovering and I think oh,
it hurts me, I’d just leave the hoovering I’ll sit
down ‘till it goes off, then I’ll go back to it.

How long’s that take?

Perhaps sit down for a quarter of an hour, you
know. And have a cup of coffee or =

Yes and what are you thinking about? You

I just thinking, oh I’m on me own, you know. But I
think well we’ve got a mobile now an’ I can, you
know so. But I just, then I think I’m alright now so
then I get cracking again, you see.

So I’m alright then.

So when you went up the chest pain clinic and you
got the results that everything was clear, there
wasn’t any problem. You came back, how did you
feel?

Relieved, you know that I haven’t got any heart
problems.

‘Cause the nurse did actually say to me when I first.

You know that lady, Helen was her name, she said
erm, she said do you get a lot of indigestion? Do
you get a lot of wind? I said yes, you know she
says, and that’s when she said you know when you
eat, you eat slowly, an’ while you’re eating don’t
talk, ‘cause that causes a lot of wind, to go in when
you’re eating.
656  Interviewer  Right.
657  Abby  And I do tend to do that.
658  Interviewer  Right.
659  Abby  You know. I think a lot of it is indigestion.
660  Interviewer  Right, right. Erm, you said you felt relieved when
661  you came back from erm from the hospital. Was
662  there anything that your husband commented on
663  about hearing the news? What did he think?
664  Abby  Well he was very pleased, he said, he came out and
665  came in the car and said well that’s a good thing J
666  (client), you’ve not got heart trouble.
667  Interviewer  Yeh.
668  Abby  He said and that’s the main thing.
669  Interviewer  Yeh. Did you get referred for any other
670  investigations or not?
671  Abby  Yeh, I’ve got to go for a gullet, I don’t know what
672  that is, he said ‘cause he said you get indigestion. I
673  don’t know whether it’s that camera or anything I
674  don’t was it is. He said would you agree to have a
675  gullet examination or something. So of course I
676  looked at R(husband) and said what do you think,
677  he says well you might as well then we’ve sorted
678  everthing out then haven’t we.
679  Interviewer  Yeh.
680  Abby  So I’ve not heard anything, so I don’t know, you
681  know whether he’ll, what it is or.
682  Interviewer  Do you think it could be something to do with that?
683  Abby  I don’t know, I don’t know whether it is, I’m not
684  sure .
685  Interviewer  That’s answered most of my questions. If there’s
686  anything else you want to say about the chest pain,
687  any further descriptions, or any comments you want
688  to make.
689  Abby  No, I think I’ve covered everything don’t you?
690  (laugh)
691  Interviewer  Yeh, yeh.
692  Abby  I mean if it’s not heart trouble, it’s not and that’s
693  good i’n’t it.
694  Interviewer  Yeh, yeh.
695  Abby  You know. But I think all this has stemmed from
696  me having thyroid trouble.
697  Interviewer  You think so?
698  Abby  Mm I think so, I think it has, and I always think
699  back that when I first had thyroid trouble, and your
700  heart beats beat-beat-beat-beat.
701  Interviewer  Right.
702  Abby  Really fast.
Interviewer When did that get -
Abby Oh when I had me last son he was 9 month old.
And I lost two stone in weight in six weeks.
Interviewer Right.
Abby Because you’re all hyperactive you don’t sleep you just drink, drink, drink.
Interviewer Mm.
Abby And I kept thinking, the weight was just absolutely falling off me. And when we lived, we used to live on Benfield Lane, there was an Indian lady lived next to me, she was a nurse. And she says to me one day, she says you don’t look very well, and I said no and anyway I said going to the hospital, no I was going to the doctors, that was it. I said I was going to the doctors, I said R (husband) coming home from work look after the baby. And soon as I set foot in the surgery, it was Doctor Simms, he’s not alive now. He said thyroid trouble, just by looking at me eyes.
Interviewer Mm.
Abby But they put me on tablets. I had to go to the hospital, to the Royal, every, every week and I put weight back on and I never had to have an operation. They thought I. An’ me Mum had exactly the same at the same age.
Interviewer Really.
Abby Yeh, and that’s why I think I’m so like me Mum was, you see.
Interviewer Yeh, yeh.
Abby But I mean it was, well it just, I couldn’t even lift P (son) when he was a baby. He was, ‘cause I just trembled all the while.
Interviewer Oh right. And you think this -
Abby And I think thats why I’ve always had a fast heart beat.
Interviewer Right.
Abby From then you see.
Interviewer Right. So do you feel the fast heart beat -
Abby Yes sometimes, when I’m in bed and you’re laying on that side, this side, I can feel me heart beating. If I’ve been out anywhere, and I go, come home and I got straight to bed, I can’t relax ‘cause me hearts going.
Interviewer Right.
Abby You know. So I all think this stems from then, a lot of it.
Interviewer Can you link the fast heart beat with the chest pain?
Abby: Yeh, 'cause me heart does beat fast when it's there.
Interviewer: Right, yeh, understandable.
Abby: Yeh.
Interviewer: That's brilliant, I mean unless there's anything else you want to say.
Abby: No I think that's all.
Interviewer: We've covered it all.
Abby: You're happy with it all?
Interviewer: Yes that's lovely.
Abby: Yep.
Interviewer: Well, brilliant, thank you very much.
Emily
A couple of things in there, I will just play this back, anything you like, your address, anything, so I can -
Okay, Emily Black, I live at 21 Sheringham Road, Tottenham.
Thank you.
Teach children, and I usually tape them.
Yeh, you pick up so much.
Yes its, you really need to because you have to go in so much detail when I do some of the testing.
Yeh.
That you never could never get, I could never write that fast.
No you can't.
I couldn't get it down, so I have to do it. It also helps children with specific learning difficulty, so when you are doing a story with them=
Yeh.
= you tape it. It works better so they don’t, don’t worry about it.
(laugh) Great, okay. To start off with can you tell me brief history of your chest pain problems and when you first noticed the pain.
Right, I've since a child I've had breathing difficulty, to the point that running, if I run too far even sort of run for quite a short distance, I can get very out of breath, erm played sport, but always like at the back, or that sort of thing=
= so I have had that sort thing in the background, but not to an, yeh not to trouble me in particular, erm but on the particular occasion that it happened about 5 weeks ago =
= was driving my car, felt fine, nothing wrong at all. Had driven about 2 miles on my way to my daughter, and got a chest pain almost where your sort of bra strap is =
= right under, literally drove there safely, with one wheel, one hand on the wheel =
= for the moment and help, but within a couple of minutes it was just awful, I was absolutely couldn't breathe properly erm my face was completely wet from through dripping my glasses=
Mm.
Emily = had steamed up. My husband outside, oh I stopped
the car, just opened the doors and he said it took
about 5 minutes to, to start to subside erm did come
back down, erm I was very anxious to get to my
granddaughters birthday party=

Interviewer Mm.

Emily = so I did drive on, rather foolishly as I was told, and
about a mile further on, exactly the same scenario =

Interviewer Mm.

Emily = played out and by this time very close to my
daughters, and got there, and the pain had subsided. I
was still very breathless=

Interviewer Mm.

Emily = came home went to bed went to the doctors the
next day=

Interviewer Mm.

Emily = who said I should have dialled 999, and was sent
straight to the hospital.

Interviewer Right. You said that was 5 weeks ago, had you, had
you previously experienced chest pain?

Emily Not chest pain only not like that, never that intensity
that you know that is something that I will remember
for as long as I live.

Interviewer Mm.

Emily Previous to that the only time that I’ve had anything
like chest pain, is as I say, if I excursion=

Interviewer Mm.

Emily = you know, run for a bus, even going up W H
Smiths stairs in town =

Interviewer Mm.

Emily = erm not that they are worse than anyone else’s =

Interviewer (laugh)

Emily = but I get to the top I’m, I’m really struggling so -

Interviewer Is that is that a pain?

Emily Yes, it is a pain yes. =

Interviewer Yes.

Emily = it’s sort of a breathlessness but where as the other
was right under=

Interviewer Bit lower down.

Emily = lower down and under my chest and sort of across
sort of radiated in the end although this side seemed
to be the worst erm the other is a completely different
sort of pain. It is more as though its from lack of
breath=

Interviewer Mm.

Emily = rather than that where you’ve been crushed with
somebody was gripping you tighter and tighter.
Mm and what, what, what thoughts were going through your head at that time, because obviously from what you were saying you were hot and sweaty and -

It, it was very much, I think the pain was so intense, not me exaggerating it almost ruled out, I couldn’t talk my husband who couldn’t drive at the time, had an operation on his foot, said what do you want me to do?

Mm. You know, make the pain go away=

Mm. but it was as though you would wrapped up, in that particular pain until it started to subside=

Mm. and then albeit Mum, it was got to get to J(daughters) somehow and nobody else can drive the car and I can’t ditch it=

Mm. started to do stuff, when I had the 2nd one I think there was more fear there, because one you almost this has happened but its gone away and its gone down, I’m okay=

Mm. you know, but when it happened the 2nd time=

Mm. and it was such a carbon copy=

Mm. there was no difference the build up, the length of the pain, at that time I couldn’t even pull in I sort of just stopped and put hazard lights on=

Mm. and it was a road that you’d got to go round us to get by=

Mm. erm it made me since erm that I carry a mobile phone=

Mm. which I’ve never done before, I’ve been told to dial three nines straight away=

Mm. erm and without one and I forgot it one day and I was really wary you know and I’m not usually like that at all.

Who told you to, who advised you to take the mobile phone and ring 999?

Both the doctor, my own family doctor=
Mm.

said I should have done that straight away with that intense chest pain=

Mm

you don’t muck about =

Mm.

and when I went to the hospital=

Mm.

they repeated the thing and when five days later I ended up going down to casualty at the infirmary=

Mm.

erm well I was there for about 8 hours, nine hours, and they said the same then, so on the strength of that I went out and bought a mobile phone. (laugh)

(laugh)

What were your thoughts about what caused it, at the time, your thoughts and fears at the time?

Well look, as to what caused it=

Mm.

I supposed I thought I was having a heart attack=

Yeh.

that was the nearest thing I got to thinking because to go from being fine=

to not to that it was just so incredible, you know its almost if you don’t feel very well when you start off then something happens=

Mm.

oh well that’s been building up, but it wasn’t like that, one minute it was fine and the next minute was, you know shock horror, you know a certain, I think there was a certain degree of panic there, but because of the intensity of the pain it almost takes over=

Mm.

I can’t think of any other way to describe it.

No that’s great, so it was the fact that it was erm, what you’re saying is it came on so quickly that it made you think it might be a heart attack?

Yes, there was I think the intensity of it, you know, it was just I couldn’t think of any other logical explanation=

No, no.

for it and yet when it goes again I think that’s what you’re thinking when you’re having it=

Mm.

but you have such relief when it goes even the second time=
Interviewer: Mm.
Emily: It didn’t go completely because I had only got a couple of corners to go round and if my husband had been capable of driving, he’d driven it, but I couldn’t get out of the car to change places that was almost start number 1 which stopped it but I felt I had to get there somehow= 

Interviewer: Mm.
Emily: and I did do the one handed= 

Interviewer: Mm
Emily: you know not a very good example of how one should behave.

Interviewer: No.
Emily: But logic goes a bit out of the window in those circumstances.

Interviewer: What were, what were the other, erm you said that you got the chest pain, what were the other things that you felt at the time because you were saying?

Emily: My glasses steamed up completely= 

Interviewer: Yeh.
Emily: I was literally, well my husband said= 

Interviewer: Yeh.
Emily: that my whole face was almost dripping, it was that wet =

Interviewer: Yeh.
Emily: and the worst thing was it, I was sort of panting because he kept saying what do you want me to do I couldn’t, I couldn’t answer him= 

Interviewer: Mm.
Emily: because my, I think my whole concentration was between pain and the trying to get some breath, breathing=

Interviewer: Mm.
Emily: so I wasn’t in the mood, I remember thinking when the doctor said that you know you should have had the mobile phone= 

Interviewer: Mm.
Emily: I thought at that point to have got a phone out, and I’m not the worlds best with mobile phones= 

Interviewer: Mm.
Emily: and to turn it off lock and I could no way, that would have been far too difficult thing to do.

Interviewer: ’Cause?.
Emily: To do that, because you know, I don’t know it was just you couldn’t do that, or I couldn’t.

Interviewer: No. What erm did you have any, you were saying your initial thoughts was that it was a heart attack
since then have you had any other thoughts about what the cause was?

Well having been had several ECGs, lots of ECGs and the very thorough lung session firstly at hospital and then at the infirmary erm and as yet although the test results ar’nt out, you always go back to that, or I do, to the virus, you know=

Right.

= I don’t know I can’t think of any it, the ECGs been fine=

Mm

Well having been had several ECGs, lots of ECGs and the very thorough lung session firstly at hospital and then at the infirmary erm and as yet although the test results ar’nt out, you always go back to that, or I do, to the virus, you know=

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Right.
Emily = as a result if ever I get it, a true explanation, Quite
likely.
Interviewer Yes.
Emily Yeh, sort of knowing what it is, is somehow more
consoling than not knowing.
Interviewer What is it about knowing that that make it's a bit
easier do you think?
Emily Erm, I think if you know something then you deal
with it if it’s a virus=
Interviewer Mm.
Emily = and it’s a one off and the chances of getting another
one are about the same as anybody whose never had
any trouble, anything the chances are so small that
you don’t worry about it=
Interviewer Mm.
Emily = so it’s something consoling about in a way, if you
know what it is and its something that has got
treatment then you get it treated. Not knowing as
well you think well if they can’t find anything people
might think it wasn’t anywhere near as bad as they
said, and you might think I was almost creating it,
you know what I mean.
Interviewer Yeh.
Emily It’s a bit like doing something to yourself, they’ll be
loads of tests people saying nothings wrong. They
think its all in the head, made it up, I didn’t, you
know it really happened you know. I mean because
my husband was there he knows what state I was in,
if I had been on my own well suppose people may
think I had been exaggerating the whole thing which
was a bit of a strained muscle or whatever.
Interviewer You describing the importance of other people
acknowledging that the pain was there, how
important is that to you?
Emily It’s important that someone doesn’t think I’ve made a
fuss over something that was pathetic because I don’t
have, I don’t do time off from school. I’m a bit sort
that headaches, I go to school and it will go away I
don’t believe in sitting and feeling sorry for yourself.
The other thing is I think there are so many people
that are really ill and really genuinely ill and need all
these treatments. My treatment under the National
Health must have cost an awful lot, erm when I went
to the infirmary I jumped an awful long queue that
looked like the third world out there, and I’d hate to
think that I did that and there was no real reason to
have an ambulance come out, the instructions of the
hospital. I felt really, really guilty about that, so I wouldn't like to think that all that was a waste of anybody's time spent more valuably with somebody else.

Interviewer: Mm yeh of course, what sort of things has your husband said about it? Did he have any ideas about what the cause was or any beliefs about it?

Emily: At the time I think he was quite panicky erm he felt he said he felt very inadequate. He didn't know what to do for me, he couldn't you know think what he was supposed to do, and didn't know what was happening to me=

Interviewer: Mm.

Emily: I think he like me would be glad of an explanation, erm he would like to know what he could have done to help for next time which you do feel inadequate= I think he like me would be glad of an explanation, the treatment that I've had, you know, he said you've had a good MOT=

Interviewer: Mm.

Emily: = in situations like this, I didn't know what was happening, you know, he could just see this person you know hot, sweaty, couldn't speak, and obviously in a lot of pain, he couldn't deal with it.

Interviewer: Mm, have you discussed it since, since the event, have you talked about it since?

Emily: Well, he's well again he said obviously he won't be in a position hopefully that he won't be able to drive, he can drive now from this week, erm, he's very grateful for the treatment that I've had, you know, he said you've had a good MOT=

Interviewer: Mm.

Emily: = and you know if they can't find what it was then we are both philosophical enough to put it down to one of those things. But I think he almost finds comfort in some sense, even so if it ever happens again, what you do is, with a sort of you know, idiots list of what you do.

Interviewer: Yes, that it's all the practical side of dealing with the situation, I wonder about the emotional side at the time of when it was happening, you were talking about you thought it might be a heart attack, presumably there was some fear there, what sort of emotions do you think were around for you?

Emily: What sort of fear, I think for me there's always that fear of anything happens to me, what would the children do, what would the grandchildren do, its that feeling, it's a bit conceited really, you think you are
so important, I mean it was pathetic that they actually
thought in the midst of all this, was who’s going to do
the sandwiches, which was absolutely ludicrous in
the midst of all that, but=

(laugh)

= I had promised, when I promise to be there at
11 o’clock, 11 o’clock I’m there, I’ve always been like
that =

Right.

= it must be going back to the police force I think,
where you were, where I was a police woman and
time, I’ve been in jobs where time matters, I’ve just
always been that way, and I should have been on my
way, I know it takes 20 minutes to my daughters, but
of course I had to make unscheduled stop. Erm half
of me wanted to go and fetch D (son-in-law), he’s my
very together son-in-law, very practical with
anything. But of course he was helping me with these
32 children coming to the party, so amidst all this,
there’s still that =

Mm.

= you know, I’m going to (?) you down, sounds a bit
funny at the time=

No.

= but somehow or other whether I think all those
thoughts, those thoughts come when the pain was
there it’s bad, but it’s not when it was that space in
the middle, you know I think the thought of all that
came before it as it starting and getting worse when I
was driving one handed=

Yeh, yeh.

= and as it began to go down, after five minutes of
intensity, then and when I, I can remember thinking
when I limped the last two roads, which isn’t very
far, but went forever, you know, please let me be
alright, I don’t want to let V(daughter) down, at this
point.

Mm, and when you got there, did you explain to your
daughter and son-in-law anything?

G(husband) did, G(husband) did, he went, I stayed in
the car for a minute, and then he came and helped me
out and laid me down on settee. And (laugh) laying
down on settee, the pain had subsided, but I was still
really, really breathless and the two grandchildren
were sort of carrying on talking to me, as though
nothing, not peculiar that grandma had come in and
you know me daughter would say grandma’s not feeling very well.

Emily: But knowing that they had hired the village hall you see, so they got the children for the party coming in like 10 minutes, so they had to leave and my daughters recently that I had a very bad virus which has left her with a lot of anxiety =

Interviewer: Mm.

Emily: = and I didn’t want to worry her any more but going off to the party and leaving your mum on the settee, isn’t quite, but by this time they had phoned Susan, my other daughter, who is a nurse, at hospital, the every practical S(daughter)=

Interviewer: (laugh)

Emily: = mum come and do something about her, and she came over, and we left the car, she drove home, and it’s her that insisted that I went to the doctor the next morning.

Interviewer: Mm, did they have any ideas of what they thought it might have been?

Emily: I think they were worried about my heart=

Interviewer: Mm.

Emily: = and you know its, I don’t know if that’s ‘cause it happens near your heart, you know, gripping there, and feels like its, I mean what they think it -

Interviewer: Yeh, erm, has it has the chest pain affected your normal day to day life, has it had any impact at all?

Emily: Other than the practicalities of going down the hospital, organise it around teaching and things, no as I say, the awareness is there. If I start to get, I always drive to the hairdressers a few days ago, and I did start to get a sort of, you know when you straighten’ up=

Interviewer: Mm.

Emily: = and you rub just there, I think it gone to start all over again, you know just there, and I’ve got my handbag on the seat beside me, the phone was inside, and actually I unzipped it and put the phone on the seat beside me=

Interviewer: Mm.

Emily: = you know which. So yes I suppose it has affected, and obviously I will be glad when the results come through, which is not going to be, I don’t see the doctor again until June, but I’ve got, I’m waiting for an appointment which should be, hoping it won’t take long for blood tests.
Mm.

That's the only way sort of remains.

Mm, yeh, you've not noticed any difference with, with your husband or your family around you in any way?

No, I mean they will ring up and say, you alright mum, you know, that sort of thing.

Yeh, is that anything out of the norm, or would they normally do that anyway?

Erm, I think they are fairly used to me being okay, so that's not unusual at the start of the conversation, but it's a bit sort of, have you been alright, no more problems=

Yes.

= and of course S(daughter) been keeping a close watch, which is really nice. (laugh)

(laugh) Erm if you have to describe erm what the chest pain means to you, sort of erm what would you say, what comes to mind, what images comes to mind?

What, that really bad pain in childbirth.

Right, yes, I forgot you mentioned that earlier.

Yeh, it was because it was the only time that I can remember having pain that was almost out of my control you know when you have, you know I've got 3. When you have 3 babies that pain will always stick in my mind as being why am (laugh) I doing this again. It really, really, really bad=

Yeh.

= and that pain was, its almost like out of your control. I know you can get headaches, stomach-ache, and all that, but that's pain that you can cope, like a really, really bad headache, like I've had migraine in the past, you know, but you never have that feeling of, this is something totally foreign to me and something must be really, really wrong.=

Mm.

= I did you know, I did once, a few years back, with my grandson, and had a head. Suddenly there again perfectly alright on the computer, and I suddenly got this violent head pain, absolutely dreadful, and S(daughter) actually again turned up, and she rang about quarter to six, bring her down straight away. And I remember there, it's being conscious of everything but conscious of nothing, I mean that sounds a funny thing to say. Like on that occasion, I knew I was in the car and I felt a big jolt=
Interviewer: Mm.
Emily: = then the hospital 5 minutes, felt like hours, the whole thing was like a nightmare=
Interviewer: Mm.
Emily: =erm, and then had it, put in every detail what they had, lumbar puncture, all sorts of things, transferred round 3 hospitals but they never did know what caused that and that was almost a bit (?)ing really, because that’s perhaps the one other occasion when I’ve had something that almost takes over, you know this is not normal, or not normal than headache pains, when I had the breathlessness, when I was running for a bus or doing something extra exertion,=
Interviewer: Mm.
Emily: = it’s not, there is a reasonable, in my brain, sort of thing, it’s happened before, I know it will go down, I know I will be okay, you know, its only for while its happening and, but I know and sit down for a bit, it, I’m alright.
Interviewer: So that’s breathlessness and sort of pain?
Emily: Yes, sometimes I get the pain, and sometimes I don’t, it’s just pure (quick breathe in and out) breathless or really panting, you know. I run for a bus, its taken half way into town to what I call calm down. But I know by the time I’ve got off that bus I’m going to be fine.
Interviewer: Mm.
Emily: Now, on the head, the top of the head and this chest pain, I didn’t know I was going to be fine, deep down it was a horrible thing I wasn’t go to be at all fine and you know here’s my last steps, and can’t sit back.
Interviewer: How does that link with the childbirth pain then?
Emily: The childbirth pain is different but in a way it’s the same. In intense probably the most painful thing you’ve ever been through, it links in that way, it was that severity of pain just take it away you know, don’t care chloroform me, do anything just stop it, get rid of it.
Interviewer: Yeh.
Emily: But childbirth is different, you know why you’ve been told to expect. You’ve had a baby before and you’ve been there, you’ve come out of it, you’re okay and you’ve got a baby at the end of it, so it’s different in that respect. I’m talking about the intensity of pain it equated with. But the feelings of, what the Dickens is happening to me, and am I going to come out of this, is totally different. And as I say it is only with
that head pain that I did, your biggest feeling in the
world is will somebody stop it.

The, you said that you had this really bad chest pain
twice within the space of a week, was it?

No, no 5 minutes, 5 – 10 minutes, we were on the
way to my daughters.

Did you not have it again, I thought you said you had
it?

No, what happened on the following, that was on the
Sunday, that these two chest pains happened

Okay.

It was, felt fine, drive, felt fine, build up to chest pain,
chest pain, stop car, eventually go down, drove on,
another mile, mile-an-half, exactly the same scenario,
then limped the last bit to J(daughters).

Okay.

So that was the two, they are the only two occasions
of that chest pain, on the following Friday I was here,
and I would say normally, to experience the
breathlessness, and the pain, which is different chest
pain, different place, goes from there instead of round
there, I have to do something outside my normal
trotting around. On that Friday I have inhalers in the
morning, only time I use them, two blue two brown, 7
sorts of breath I do in the morning. On that Friday
morning, I did that as usual, okay, then went into the
kitchen for something, (breathe out) really out of
breath, sat down and relaxed then went upstairs. The
same sort of thing, it carried on for quite a bit so I had
another puff, puff of the blue one, same sort of
scenario, I couldn’t have done anything, even walk to
the front door, the effort was just making ill. So I had
two of, one of them and one of those (inhalers) ¾
hour later, not having ever taken it like that.

S(daughter) was at work, so I thought I would just
give her a ring, she being in the asthma clinic, and
said to her am I doing it right, shall I keep puffing
away at the things or what shall I do?

Mm.

It’s not improving, so I rang down to the asthma
clinic, and S(daughter) was with a patient, but R her
sort of friend there, said erm look, she said, while you
are having, as you have an appointment at the rapid
response chest pain clinic, shall I nip down there and
ask their advice. So she went down there, asked their
advice and she said I’ll ring me back. And about half
an hour later, and I was still feeling the same you
And er I only go for half an hour, I think oh I'll have me dinner and I'll go and I'll go and have a lay down. Say it's not nice enough to sit out so. And I'll probably have a sleep, and I'll wake up and I feel better, (?) said probably I felt tired.

Interviewer Mm.

Abby 'Cause I don't sleep very well, I'm a very poor sleeper.

Interviewer Right. Okay erm I sort of, you explained some of it there, but on a day to day basis when you've been having the chest pain, sort of, how would you, how would you deal with it? What way, you said for one thing you might try and go to bed=

Abby Yes I would.

Interviewer = and you said about sitting down.

Abby Or I'd sit down. Say I'm hoovering and I think oh, it hurts me, I'd just leave the hoovering I'll sit down 'til it goes off, then I'll go back to it.

Interviewer How long's that take?

Abby Perhaps sit down for a quarter of an hour, you know. And have a cup of coffee or =

Interviewer Yeh.

Abby = or a drink of juice or something and I sit there and until I feel as if I can start again, you know.

Interviewer Yes, and what are you thinking about? You distracting -

Abby I just thinking, oh I'm on me own, you know. But I think well we've got a mobile now an' I can, you know so. But I just, then I think I'm alright now so then I get cracking again, you see.

Interviewer Yeh.

Abby So I'm alright then.

Interviewer So when you went up the chest pain clinic and you got the results that everything was clear, there wasn't any problem. You came back, how did you feel?

Abby Relieved, you know that I haven't got any heart problems.

Interviewer Yeh.

Abby 'Cause the nurse did actually say to me when I first. You know that lady, Helen was her name, she said erm, she said do you get a lot of indigestion? Do you get a lot of wind? I said yes, you know she says, and that's when she said you know when you eat, you eat slowly, an' while you're eating don't talk, 'cause that causes a lot of wind, to go in when you're eating.
Interviewer: Right.
Abby: And I do tend to do that.
Interviewer: Right.
Abby: You know. I think a lot of it is indigestion.
Interviewer: Right, right. Erm, you said you felt relieved when you came back from erm from the hospital. Was there anything that your husband commented on about hearing the news? What did he think?
Abby: Well he was very pleased, he said, he came out and came in the car and said well that’s a good thing J (client), you’ve not got heart trouble.
Interviewer: Yeh.
Abby: He said and that’s the main thing.
Interviewer: Yeh. Did you get referred for any other investigations or not?
Abby: Yeh, I’ve got to go for a gullet, I don’t know what that is, he said ‘cause he said you get indigestion. I don’t know whether it’s that camera or anything I don’t was it is. He said would you agree to have a gullet examination or something. So of course I looked at R(husband) and said what do you think, he says well you might as well then we’ve sorted everthing out then haven’t we.
Interviewer: Yeh.
Abby: So I’ve not heard anything, so I don’t know, you know whether he’ll, what it is or.
Interviewer: Do you think it could be something to do with that?
Abby: I don’t know, I don’t know whether it is, I’m not sure.
Interviewer: That’s answered most of my questions. If there’s anything else you want to say about the chest pain, any further descriptions, or any comments you want to make.
Abby: No, I think I’ve covered everything don’t you?
Interviewer: (laugh)
Abby: Yeh, yeh.
Interviewer: Yeh, yeh.
Abby: I mean if it’s not heart trouble, it’s not and that’s good i’n’t it.
Interviewer: Yeh, yeh.
Abby: You know. But I think all this has stemmed from me having thyroid trouble.
Interviewer: You think so?
Abby: Mm I think so, I think it has, and I always think back that when I first had thyroid trouble, and your heart beats beat-beat-beat-beat.
Interviewer: Right.
Abby: Really fast.
Interviewer: When did that get -
Abby: Oh when I had me last son he was 9 month old.
And I lost two stone in weight in six weeks.
Interviewer: Right.
Abby: Because you're all hyperactive you don't sleep you
just drink, drink, drink.
Interviewer: Mm.
Abby: And I kept thinking, the weight was just absolutely
falling off me. And when we lived, we used to live
on Benfield Lane, there was an Indian lady lived
next to me, she was a nurse. And she says to me
one day, she says you don't look very well, and I
said no and anyway I said going to the hospital, no I
was going to the doctors, that was it. I said I was
going to the doctors, I said R (husband) coming
home from work look after the baby. And soon as I
set foot in the surgery, it was Doctor Simms, he's
not alive now. He said thyroid trouble, just by
looking at me eyes.
Interviewer: Mm.
Abby: But they put me on tablets. I had to go to the
hospital, to the Royal, every, every week and I put
weight back on and I never had to have an
operation. They thought I. An' me Mum had
exactly the same at the same age.
Really.
Yeh, and that's why I think I'm so like me Mum
was, you see.
Interviewer: Yeh, yeh.
Abby: But I mean it was, well it just, I couldn't even lift P
(son) when he was a baby. He was, 'cause I just
trembled all the while.
Interviewer: Oh right. And you think this -
Abby: And I think thats why I've always had a fast heart
beat.
Interviewer: Right.
Abby: From then you see.
Interviewer: Right. So do you feel the fast heart beat -
Abby: Yes sometimes, when I'm in bed and you're laying
on that side, this side, I can feel me heart beating. If
I've been out anywhere, and I go, come home and I
got straight to bed, I can't relax 'cause me hearts
going.
Interviewer: Right.
Abby: You know. So I all think this stems from then, a lot
of it.
Interviewer: Can you link the fast heart beat with the chest pain?
Abby Yeh, 'cause me heart does beat fast when it's there.
Interviewer Right, yeh, understandable.
Abby Yeh.
Interviewer That's brilliant, I mean unless there's anything else you want to say.
Abby No I think that's all.
Interviewer We've covered it all.
Abby You're happy with it all?
Interviewer Yes that's lovely.
Abby Yep.
Interviewer Well, brilliant, thank you very much.
Emily
A couple of things in there, I will just play this back, anything you like, your address, anything, so I can -
Okay, Emily Black, I live at 21 Sheringham Road, Tottenham.
Thank you.
Teach children, and I usually tape them.
Yeh, you pick up so much.
Yes its, you really need to because you have to go in so much detail when I do some of the testing.
Yeh.
That you never could never get, I could never write that fast.
No you can’t.
I couldn’t get it down, so I have to do it. It also helps children with specific learning difficulty, so when you are doing a story with them=
Yeh.
= you tape it. It works better so they don’t, don’t worry about it.
(laugh) Great, okay. To start off with can you tell me a brief history of your chest pain problems and when you first noticed the pain.
Right, I’ve since a child I’ve had breathing difficulty, to the point that running, if I run too far even sort of run for quite a short distance, I can get very out of breath, erm played sport, but always like at the back, or that sort of thing=
Mm.
= so I have had that sort thing in the background, but not to an, yeh not to trouble me in particular, erm but on the particular occasion that it happened about 5 weeks ago =
Mm.
= was driving my car, felt fine, nothing wrong at all. Had driven about 2 miles on my way to my daughter, and got a chest pain almost where your sort of bra strap is =
Yeh, yeh.
= right under, literally drove there safely, with one wheel, one hand on the wheel =
Mm
= for the moment and help, but within a couple of minutes it was just awful, I was absolutely couldn’t breathe properly erm my face was completely wet from through dripping my glasses=
Mm.
Emily: = had steamed up. My husband outside, oh I stopped the car, just opened the doors and he said it took about 5 minutes to, to start to subside erm did come back down, erm I was very anxious to get to my granddaughters birthday party=

Interviewer: Mm.

Emily: = so I did drive on, rather foolishly as I was told, and about a mile further on, exactly the same scenario =

Interviewer: Mm.

Emily: = played out and by this time very close to my daughters, and got there, and the pain had subsided, I was still very breathless=

Interviewer: Mm.

Emily: = came home went to bed went to the doctors the next day=

Interviewer: Mm.

Emily: = who said I should have dialled 999, and was sent straight to the hospital.

Interviewer: Right. You said that was 5 weeks ago, had you, had you previously experienced chest pain?

Emily: Not chest pain only not like that, never that intensity that you know that is something that I will remember for as long as I live.

Interviewer: Mm.

Emily: Previous to that the only time that I've had anything like chest pain, is as I say, if I excursion=

Interviewer: Mm.

Emily: = you know, run for a bus, even going up W H Smiths stairs in town =

Interviewer: Mm.

Emily: = erm not that they are worse than anyone else’s =

Interviewer: (laugh)

Emily: = but I get to the top I’m, I’m really struggling so -

Interviewer: Is that is that a pain?

Emily: Yes, it is a pain yes, =

Interviewer: Yes.

Emily: = it’s sort of a breathlessness but where as the other was right under=

Interviewer: Bit lower down.

Emily: = lower down and under my chest and sort of across sort of radiated in the end although this side seemed to be the worst erm the other is a completely different sort of pain. It is more as though its from lack of breath=

Interviewer: Mm.

Emily: = rather than that where you’ve been crushed with somebody was gripping you tighter and tighter.
Interviewer  Mm and what, what, what thoughts were going
through your head at that time, because obviously
from what you were saying you were hot and sweaty
and -
Emily  It, it was very much, I think the pain was so intense,
not me exaggerating it almost ruled out, I couldn't
talk my husband who couldn’t drive at the time, had
an operation on his foot, said what do you want me to
do?
Interviewer  Mm.
Emily  You know, make the pain go away=
Interviewer  Mm.
Emily  = but it was as though you would wrapped up, in that
particular pain until it started to subside=
Interviewer  Mm.
Emily  = and then albeit Mum, it was got to get to
J(daughters) somehow and nobody else can drive the
car and I can’t ditch it=
Interviewer  Mm.
Emily  = started to do stuff, when I had the 2nd one I think
there was more fear there, because one you almost
this has happened but its gone away and its gone
down, I’m okay=
Interviewer  Mm.
Emily  = you know, but when it happened the 2nd time=
Interviewer  Mm.
Emily  = and it was such a carbon copy=
Interviewer  Mm.
Emily  = there was no difference the build up, the length of
the pain, at that time I couldn’t even pull in I sort of
just stopped and put hazard lights on=
Interviewer  Mm.
Emily  = and it was a road that you’d got to go round us to
get by=
Interviewer  Mm.
Emily  = erm it made me since erm that I carry a mobile
phone=  
Interviewer  Mm.
Emily  = which I’ve never done before, I’ve been told to dial
three nines straight away=
Interviewer  Mm.
Emily  = erm and without one and I forgot it one day and I
was really wary you know and I’m not usually like
that at all.
Interviewer  Who told you to, who advised you to take the mobile
phone and ring 999?
Emily  Both the doctor, my own family doctor=
Interviewer: Mm.
Emily: said I should have done that straight away with that intense chest pain=
Interviewer: Mm
Emily: = you don’t muck about =
Interviewer: Mm.
Emily: = and when I went to the hospital=
Interviewer: Mm.
Emily: = they repeated the thing and when five days later I ended up going down to casualty at the infirmary=
Interviewer: Mm.
Emily: = erm well I was there for about 8 hours, nine hours, and they said the same then. so on the strength of that I went out and bought a mobile phone. (laugh)
Interviewer: (laugh)
Interviewer: What were your thoughts about what caused it, at the time, your thoughts and fears at the time?
Emily: Well look, as to what caused it=
Interviewer: Mm.
Emily: = I supposed I thought I was having a heart attack=
Interviewer: Yeh.
Emily: = that was the nearest thing I got to thinking because to go from being fine=
Interviewer: Mm.
Emily: = to not to that it was just so incredible, you know its almost if you don’t feel very well when you start off then something happens=
Interviewer: Mm.
Emily: = oh well that’s been building up, but it wasn’t like that, one minute it was fine and the next minute was, you know shock horror, you know a certain, I think there was a certain degree of panic there, but because of the intensity of the pain it almost takes over=
Interviewer: Mm.
Emily: = I can’t think of any other way to describe it.
Interviewer: No that’s great, so it was the fact that it was erm, what you’re saying is it came on so quickly that it made you think it might be a heart attack?
Emily: Yes, there was I think the intensity of it, you know, it was just I couldn’t think of any other logical explanation=
Interviewer: No, no.
Emily: = for it and yet when it goes again I think that’s what you’re thinking when you’re having it=
Interviewer: Mm.
Emily: = but you have such relief when it goes even the second time=
"Mm. it didn’t go completely because I had only got a couple of corners to go round and if my husband had been capable of driving, he’d driven it, but I couldn’t get out of the car to change places that was almost start number 1 which stopped it but I felt I had to get there somehow=

Interviewer Mm.
Emily = and I did do the one handed=
Interviewer Mm
Emily = you know not a very good example of how one should behave.

Interviewer No.
Emily But logic goes a bit out of the window in those circumstances.

Interviewer What were, what were the other, erm you said that you got the chest pain, what were the other things that you felt at the time because you were saying?
Emily My glasses steamed up completely=
Interviewer Yeh.
Emily = I was literally, well my husband said=
Interviewer Yeh.
Emily = that my whole face was almost dripping, it was that wet =

Interviewer Yeh.
Emily = and the worst thing was it, I was sort of panting because he kept saying what do you want me to do I couldn’t, I couldn’t answer him=

Interviewer Mm.
Emily = because my, I think my whole concentration was between pain and the trying to get some breath,

Interviewer Mm.
Emily = so I wasn’t in the mood, I remember thinking when the doctor said that you know you should have had the mobile phone=

Interviewer Mm.
Emily = I thought at that point to have got a phone out, and I’m not the worlds best with mobile phones=

Interviewer Mm.
Emily = and to turn it off lock and I could no way, that would have been far too difficult thing to do.

‘Cause?.
Emily To do that, because you know, I don’t know it was just you couldn’t do that, or I couldn’t.

Interviewer No. What erm did you have any, you were saying your initial thoughts was that it was a heart attack
since then have you had any other thoughts about what the cause was?

Well having been had several ECGs, lots of ECGs and the very thorough lung session firstly at hospital and then at the infirmary erm and as yet although the test results ar’n’t out, you always go back to that, or I do, to the virus, you know=

= I don’t know I can’t think of any it, the ECGs been fine=

= it doesn’t look as though it was a heart attack=

= erm they say they are 85% sure its not angina=

= and I think the other check was this heart scan I had (?) But (?) I don’t know and their doing all sorts lung and asthma tests at the moment=

= I’m never quite sure that how close that sort of connection is with it, the breathlessness is one thing, the chest pain to me is like a stranger coming in.

= The breathlessness I’m used to.

= But that wasn’t, although the breathlessness was there certainly the worst breathlessness I’ve ever had=

= tied up with chest pain was so foreign to what I’ve ever experienced =

= that you can’t think of logical explanations and, or you think its got to be something=

= I suppose you, because viruses contain such different makes of sort of (?)

What, what makes you, what made you think it was a virus?

Lack of any other reasons of any explanation (laugh) I think.

= like one of those things oh it must, it’s a bit like saying, you know, tummy troubles, it must be a bug.

You know so but I don’t know and I don’t know what they’ll come up with=

No.
Emily = as a result if ever I get it, a true explanation, Quite likely.

Interviewer Yes.

Emily Yeh, sort of knowing what it is, is somehow more consoling than not knowing.

Interviewer What is it about knowing that that make it's a bit easier do you think?

Emily Erm, I think if you know something then you deal with it if it's a virus=

Interviewer Mm.

Emily = and it's a one off and the chances of getting another any trouble, anything the chances are so small that you don't worry about it=

Interviewer Mm.

Emily = so it's something consoling about in a way, if you know what it is and its something that has got treatment then you get it treated. Not knowing as well you think well if they can't find anything people might think it wasn't anywhere near as bad as they said, and you might think I was almost creating it, you know what I mean.

Interviewer Yeh.

Emily It's a bit like doing something to yourself, they'll be loads of tests people saying nothings wrong. They think its all in the head, made it up, I didn't, you know it really happened you know. I mean because my husband was there he knows what state I was in, if I had been on my own well suppose people may think I had been exaggerating the whole thing which was a bit of a strained muscle or whatever.

Interviewer You describing the importance of other people acknowledging that the pain was there, how important is that to you?

Emily It's important that someone doesn't think I've made a fuss over something that was pathetic because I don't have, I don't do time off from school. I'm a bit sort that headaches, I go to school and it will go away I don't believe in sitting and feeling sorry for yourself. The other thing is I think there are so many people that are really ill and really genuinely ill and need all these treatments. My treatment under the National Health must have cost an awful lot, erm when I went to the infirmary I jumped an awful long queue that looked like the third world out there, and I'd hate to think that I did that and there was no real reason to have an ambulance come out, the instructions of the
hospital. I felt really, really guilty about that, so I wouldn't like to think that all that was a waste of anybody's time spent more valuably with somebody else.

Interviewer: Mm yeh of course, what sort of things has your husband said about it? Did he have any ideas about what the cause was or what any beliefs about it?

Emily: At the time I think he was quite panicky erm he felt he said he felt very inadequate. He didn't know what to do for me, he couldn't you know think what he was supposed to do, and didn't know what was happening to me=

Interviewer: Mm.

Emily: = I think he like me would be glad of an explanation, erm he would like to know what he could have done to help for next time erm which you do feel inadequate=

Interviewer: Mm.

Emily: = in situations like this, I didn't know what was happening, you know, he could just see this person you know hot, sweaty, couldn't speak, and obviously in a lot of pain, he couldn't deal with it.

Interviewer: Mm, have you discussed it since, since the event, have you talked about it since?

Emily: Well, he's well again he said obviously he wont be in a position hopefully that he wont be able to drive, he can drive now from this week, erm, he's very grateful for the treatment that I've had, you know, he said you've had a good MOT=

Interviewer: Mm.

Emily: = and you know if they can't find what it was then we are both philosophical enough to put it down to one of those things. But I think he almost finds comfort in some sense, even so if it ever happens again, what you do is, with a sort of you know, idiots list of what you do.

Interviewer: Yes, that it's all the practical side of dealing with the situation. I wonder about the emotional side at the time of when it was happening, you were talking about you thought it might be a heart attack, presumably there was some fear there, what sort of emotions do you think were around for you?

Emily: What sort of fear, I think for me there's always that fear of anything happens to me, what would the children do, what would the grandchildren do, its that feeling, it's a bit conceited really, you think you are
so important, I mean it was pathetic that they actually
thought in the midst of all this, was who's going to do
the sandwiches, which was absolutely ludicrous in
the midst of all that, but=

Interviewer (laugh)
Emily = I had promised, when I promise to be there at
11o’clock, 11o’clock I’m there, I’ve always been like
that =

Interviewer Right.
Emily = it must be going back to the police force I think,
where you were, where I was a police woman and
time, I’ve been in jobs where time matters, I’ve just
always been that way, and I should have been on my
way, I know it takes 20 minutes to my daughters, but
of course I had to make unscheduled stop. Erm half
of me wanted to go and fetch D (son-in-law), he’s my
very together son-in-law, very practical with
anything. But of course he was helping me with these
32 children coming to the party, so amidst all this,
there’s still that =

Interviewer Mm.
Emily = you know, I’m going to (?) you down, sounds a bit
funny at the time=

Interviewer No.
Emily = but somehow or other whether I think all those
thoughts, those thoughts come when the pain was
there it’s bad, but it’s not when it was that space in
the middle, you know I think the thought of all that
came before it as it starting and getting worse when I
was driving one handed=

Interviewer Yeh, yeh.
Emily = and as it began to go down, after five minutes of
intensity, then and when I, I can remember thinking
when I limped the last two roads, which isn’t very
far, but went forever, you know, please let me be
alright, I don’t want to let V(daughter) down, at this
point.

Interviewer Mm, and when you got there, did you explain to your
daughter and son-in-law anything?
Emily G(husband) did, G(husband) did, he went, I stayed in
the car for a minute, and then he came and helped me
out and laid me down on settee. And (laugh) laying
down on settee, the pain had subsided, but I was still
really, really breathless and the two grandchildren
were sort of carrying on talking to me, as though
nothing, not peculiar that grandma had come in and
you know me daughter would say grandma's not feeling very well.

But knowing that they had hired the village hall you see, so they got the children for the party coming in like 10 minutes, so they had to leave and my daughters recently that I had a very bad virus which has left her with a lot of anxiety =

= and I didn't want to worry her any more but going off to the party and leaving your mum on the settee, isn't quite, but by this time they had phoned Susan, my other daughter, who is a nurse, at hospital, the every practical S(daughter)=

= mum come and do something about her, and she came over, and we left the car, she drove home, and it's her that insisted that I went to the doctor the next morning.

Mm, did they have any ideas of what they thought it might have been?

I think they were worried about my heart=

= and you know its, I don’t know if that’s ‘cause it happens near your heart, you know, gripping there, and feels like its, I mean what they think it -

Yeh, erm, has it has the chest pain affected your normal day to day life, has it had any impact at all?

Other than the practicalities of going down the hospital, organise it around teaching and things, no as I say, the awareness is there. If I start to get, I always drive to the hairdressers a few days ago, and I did start to get a sort of, you know when you straigthen’ up=

= and you rub just there, I think it gone to start all over again, you know just there, and I’ve got my handbag on the seat beside me, the phone was inside, and actually I unzipped it and put the phone on the seat beside me=

= you know which. So yes I suppose it has affected, and obviously I will be glad when the results come through, which is not going to be, I don’t see the doctor again until June, but I’ve got, I’m waiting for an appointment which should be, hoping it wont take long for blood tests.
Interviewer: Mm.
Emily: That's the only way sort of remains.
Interviewer: Mm, yeh, you've not noticed any difference with, with your husband or your family around you in any way?
Emily: No, I mean they will ring up and say, you alright mum, you know, that sort of thing.
Interviewer: Yeh, is that anything out of the norm, or would they normally do that anyway?
Emily: Erm, I think they are fairly used to me being okay, so that's not unusual at the start of the conversation, but it's a bit sort of, have you been alright, no more problems= 
Interviewer: Yes.
Emily: = and of course S(daughter) been keeping a close watch, which is really nice. (laugh)
Interviewer: (laugh) Erm if you have to describe erm what the chest pain means to you, sort of erm what would you say, what comes to mind, what images comes to mind?
Emily: What, that really bad pain in childbirth.
Interviewer: Right, yes, I forgot you mentioned that earlier.
Emily: Yeh, it was because it was the only time that I can remember having pain that was almost out of my control you know when you have, you know I've got 3. When you have 3 babies that pain will always stick in my mind as being why am (laugh) I doing this again. It really, really, really bad=
Interviewer: Yeh.
Emily: = and that pain was, it's almost like out of your control. I know you can get headaches, stomach-ache, and all that, but that's pain that you can cope, like a really, really bad headache, like I've had migraine in the past, you know, but you never have that feeling of, this is something totally foreign to me and something must be really, really wrong=
Interviewer: Mm.
Emily: = I did you know, I did once, a few years back, with my grandson, and had a head. Suddenly there again perfectly alright on the computer, and I suddenly got this violent head pain, absolutely dreadful, and S(daughter) actually again turned up, and she rang about quarter to six, bring her down straight away. And I remember there, it's being conscious of everything but conscious of nothing. I mean that sounds a funny thing to say. Like on that occasion, I knew I was in the car and I felt a big jolt=
Mm.

= then the hospital 5 minutes, felt like hours, the whole thing was like a nightmare=

Mm.

=erm, and then had it, put in every detail what they had, lumbar puncture, all sorts of things, transferred round 3 hospitals but they never did know what caused that and that was almost a bit (?)ing really, because that’s perhaps the one other occasion when I’ve had something that almost takes over, you know this is not normal, or not normal than headache pains, when I had the breathlessness, when I was running for a bus or doing something extra exertion,=

Mm.

= it’s not, there is a reasonable, in my brain, sort of thing, it’s happened before, I know it will go down, I know I will be okay, you know, its only for while its happening and, but I know and sit down for a bit, it, I’m alright.

= So that’s breathlessness and sort of pain?

Yes, sometimes I get the pain, and sometimes I don’t, it’s just pure (quick breathe in and out) breathless or really panting, you know. I run for a bus, its taken half way into town to what I call calm down. But I know by the time I’ve got off that bus I’m going to be fine.

Mm.

Now, on the head, the top of the head and this chest pain, I didn’t know I was going to be fine, deep down it was a horrible thing I wasn’t go to be at all fine and you know here’s my last steps, and can’t sit back.

How does that link with the childbirth pain then?

The childbirth pain is different but in a way it’s the same. In intense probably the most painful thing you’ve ever been through, it links in that way, it was that severity of pain just take it away you know, don’t care chloroform me, do anything just stop it, get rid of it.

Yeh.

But childbirth is different, you know why you’ve been told to expect. You’ve had a baby before and you’ve been there, you’ve come out of it, you’re okay and you’ve got a baby at the end of it, so it’s different in that respect. I’m talking about the intensity of pain it equated with. But the feelings of, what the Dickens is happening to me, and am I going to come out of this, is totally different. And as I say it is only with
that head pain that I did, your biggest feeling in the
world is will somebody stop it.

Interviewer  The, you said that you had this really bad chest pain
twice within the space of a week, was it?

Emily  No, no 5 minutes, 5 - 10 minutes, we were on the
way to my daughters.

Interviewer  Did you not have it again, I thought you said you had
it?

Emily  No, what happened on the following, that was on the
Sunday, that these two chest pains happened

Interviewer  Okay.

Emily  It was, felt fine, drive, felt fine, build up to chest pain,
chest pain, stop car, eventually go down, drove on,
another mile, mile-an-half, exactly the same scenario,
then limped the last bit to J(daughters).

Interviewer  Okay.

Emily  So that was the two, they are the only two occasions
of that chest pain, on the following Friday I was here,
and I would say normally, to experience the
breathlessness, and the pain, which is different chest
pain, different place, goes from there instead of round
there, I have to do something outside my normal
trotting around. On that Friday I have inhalers in the
morning, only time I use them, two blue two brown, 7
sorts of breath I do in the morning. On that Friday
morning, I did that as usual, okay, then went into the
kitchen for something, (breathe out) really out of
breath, sat down and relaxed then went upstairs. The
same sort of thing, it carried on for quite a bit so I had
another puff, puff of the blue one, same sort of
scenario. I couldn’t have done anything, even walk to
the front door, the effort was just making ill. So I had
two of, one of them and one of those (inhalers) ¾
hour later, not having ever taken it like that.

S(daughter) was at work, so I thought I would just
give her a ring, she being in the asthma clinic, and
said to her am I doing it right, shall I keep puffing
away at the things or what shall I do?

Interviewer  Mm.

Emily  It’s not improving, so I rang down to the asthma
clinic, and S(daughter) was with a patient, but R her
sort of friend there, said erm look, she said, while you
are having, as you have an appointment at the rapid
response chest pain clinic, shall I nip down there and
ask their advice. So she went down there, asked their
advice and she said I’ll ring me back. And about half
an hour later, and I was still feeling the same you
Interviewer: The nurse of the rapid access?

Emily: Yes, the rapid access, and she’d spoken to the doctor, the one who I saw when I was there, the -

Interviewer: Dr G.

Emily: That’s it, lovely he’s lovely, spoken to him and he had said I was to go straight to the infirmary, I was not to drive myself and not to go in my own car with S(daughter), and I was to dial 999 for an ambulance, but I couldn’t believe it.

Interviewer: Mm.

Emily: Woow, you know, I’m not that bad sitting in the chair, I said I’m okay. No with what’s happened to you, you must do that, and they’re sending S(daughter) back home. Do it now, so I did. Well within, before S(daughter) get here, she left straight away, they were brilliant down there, along came, first of all, a man on his own, a paramedic.

Interviewer: Oh right.

Emily: Well, he was positively nasty, he really was, erm, put it like this, there’s not much like wrong with you, why did you dialled, so I said, look I’m really sorry, this isn’t my idea, but I’ve got instructions this is what I’ve been told to do by the doctor. Any way that’s when S(daughter) came who virtually told him she wasn’t very impressed with his bedside manner. Then the ambulance with two paramedics turned up. I think my blood pressure went up, They were just as different, they said I shouldn’t say this but he’s not worth his weight in washers. And so that was a comment from his colleagues. They were lovely, but I was put on an oxygen mask, they were great, and I say when we got down to the infirmary, I was wheeled out and they wouldn’t let me stand up. Any way we got down and people were trying to, well it was the corridors, people standing, it was incredible, and I came straight through this into a cubicle, ECGs been fitted in.

Interviewer: Mm.

Emily: It must have been about 12.00 and we left eventually about 7.30. But as I say I couldn’t fault them, they were great, how they cope you couldn’t find people. All try in corridor so and so, it was an incredible
Interviewer: Did they actually give you any, any erm feedback, what had been going on?

Emily: No, I had a German doctor who came, and it was him who quoted the ‘I don’t think you had a heart attack it could be angina’, he named something else, to do with lungs, pulmonary, it was, I mean I know quite a bit about that I did (?) nursing stage one in my career, and but it wasn’t a word I’d heard of. Again, it wasn’t a normal thing he said that’s I need to do some more tests, then they said they were going to keep me in overnight, and then gave me the choice.

Interviewer: But on that instance, you didn’t actually have any chest pains?

Emily: Not, no this is what I say, so I didn’t know, but I think the feeling was, is it connected or isn’t it. I didn’t know and I still don’t know, and you know the nice doctor, he said, he didn’t know whether I did the one last week, whether there was any connection or purely a coincidence.

Interviewer: Right.

Emily: So I don’t know, but yeh, quite, quite different.

Interviewer: But on that instance, you didn’t actually have any chest pains?

Emily: Erm, organised. Somewhat bouncy, I get down but can soon bounce back. I say the only illnesses I’ve had, I don’t I’ve been at school 2 half years, and had a half day off to go up to hospital, was, they said Ooh, you’ve lost your record. Erm so I don’t do illness in that sense, but can you know a couple of scares. I had two breast lumps, and erm a lump which came out, I can deal with, but it frustrates me, but its fine most of the time I do (?) if its something like that and I feel that it could I suppose cancerous, I could have that idea sort of thing, ‘cause my father died of cancer.

Interviewer: Right.

Emily: It’s, you know, I dealt with it because the girls would have said aren’t you sort of worried? Funnily enough, I know this sounds really stupid, but to me my heart, doesn’t set me into a flat spin, in the way the word cancer does.

Interviewer: Right.

Emily: It’s different.

Interviewer: What way is it different to you?
Partly because of the memory of how my father was, and my cousin also the same age also died of cancer, and no way, you know that is not me. I’ve always thought about heart attack as something quick, here you are today, and gone.

And if I’ve got to have not the very nice choice between the two, the heart attack if somebody said, you know that danger will be there with you, but otherwise you are going to live a normal life, then okay, then I wouldn’t get myself, I wouldn’t even mind I think. Most of my life I could get on with it. If somebody told me I got cancer and told me may be I’d live 10 years, that hold much, much more fear, and could easily go to pieces with that, I would say.

Emily And if I’ve got to have not the very nice choice between the two, the heart attack if somebody said, you know that danger will be there with you, but otherwise you are going to live a normal life, then okay, then I wouldn’t get myself, I wouldn’t even mind I think. Most of my life I could get on with it. If somebody told me I got cancer and told me may be I’d live 10 years, that hold much, much more fear, and could easily go to pieces with that, I would say.

Interviewer Right, you were saying that erm the erm scares that you had sent you into a panic.

Emily Yes the ones where I thought were cancer was yes.

Interviewer And what does that panic mean to you, what do you mean by?

Emily I think, I put my life on hold I remember at the time I was asked to go for a deputy principleship at the school and the interviews were due fairly much around the time, it was near the end of the school summer term, and they said go ahead, you know, go ahead go for it. And I remember using the words if I’m still here in September, I don’t care whether I’m on the bottom rung of the scale or what, I don’t want to know. It all suddenly seemed very unimportant, the job seemed very unimportant. So I would dwell on it. I got very tearful, I couldn’t talk about it, because and I looked on the black side. With this, I did exactly the opposite, you know until somebody tells me what’s wrong, I shall quite cheerfully not worry about, I haven’t worried about any of the tests that I’ve been through that.

Interviewer Mm.

Emily The tests when its, when I had the breast lump removed, and that then I convinced myself that I’d got cancer=

Interviewer Right.

Emily = so its been a different attitude.

Interviewer Quite a contrast.

Emily Yeh.

Interviewer Okay, erm what would you say were the most important characteristics of yourself as a person, if you had to describe yourself?
Emily: Erm, my characteristics, if I'm going to do something, I'm going to jolly well do it= and get through it, erm, I suppose family I'm very involved with the family, like I take on their worries, probably a bit more than I should, I just to prove that I'm always there for them whatever happens, family matters a lot.

Interviewer: What makes you think you take on more than you should?

Emily: Well, in a way, you could say that you know your children have gown up, and their lives in a way, and their children's problems, is down to them, erm I can't quite think of it like that.

Interviewer: (laugh)

Emily: The only time I almost get rid of all that is each year my fortnights holiday is a cruise and when I'm out there, I don't ring them and say to them, how are you, because I know what they will say, fine, and I can tell when fine means fine, and when fine doesn't mean fine.

Interviewer: (laugh)

Emily: Erm I would spend the rest of the holiday worrying that something awful happened and they weren't telling me.

Interviewer: Yes.

Emily: So, I work on the principal that a fortnights holiday if its an emergency they will get me, sea to shore line, if not, I'm at sea and I'm going to forget it.

Interviewer: (laugh)

Emily: Otherwise erm, I sort of, yes watch over them, (laugh) don't worry about that, and try to find solutions to their problems. Determined not to let age

Interviewer: (?

Emily: Don't do age, no don't do. I will not grow old. I will not grow old gracefully, I'm not even growing old then to be graceful, to be graceful then.

Interviewer: (laugh)

Emily: Erm, don't know what else to say really.

Interviewer: Okay. It's an understanding of who you are, really.

Emily: I can understand that.

Interviewer: Has the-

Emily: I would add to that perhaps friendship, means a great deal, and I have got a very good sets of friends, who've been colleagues, and even though we've changed schools now, we still there, and that means a
lot to me, and being able to be happy with that, you
know being miserable and holding grudges and all
that, I mean is a sheer waste of time. I mean yeh I get
down, like anyone else, I get tearful erm but if I'm
not getting on with somebody, I deal with it, I go
back to them and talk about it.
So you would approach them and sort it out, is that
what you're saying?
Yes, I would say, you got a problem, you know, lets
sort out, and great we've sorted that out and get back
to normal. You know, can't bear the silences and
grudges, rah! My regret, that's what my regret was, I
got a phobia about flying and to some extent, driving,
that does complicate factors doesn't it.
Right, what is it about that?
It stems by, I used to love both, but I used to drive for
a living, being in the police force, I've been trained, I
loved to drive, but when my middle daughter was 9,
so we're talking 27 years ago, had a very bad road
accident, hit by a stolen car both went through the
windscreen. And in the same year went on a flight
which got stuck in a great storm, tossed and turn and
everything. The two coming together and gave me the
sheer terror and really did try fly a few times but I
tried again too soon, tranquilisers, crazy (laugh), you
name it I tried it. Still dreadful on planes can't
breathe, can't drink, tingle, convinced gonna die, erm
which is why I go on cruises, 'cause they don't go in
the air.
So you know, bit of regret now, I'd love to go, I like
travelling and you can't really travelled far without
an aeroplane.
No, but you were saying your driving as well.
Driving yes, I have a brain speed limit sort of thing,
anything over 50, 60 at the absolute most is a
maximum with me, motorway driving I hate, I
because the way the crash happened. It was a head on
collision, I always took a route with(?) the only
thing that saved J(daughter) life when she went
through the windscreen, that I could turn the wheel an
she end up on the grass rather than on the road, which
she would have been hurled into their path and I was
trapped in the car. And I always knew that there was
a way out, and on a motorway being in the middle of
the fast lane you really haven't got a way out. So that
and country (?) So there's been some restriction, I'm
okay on routes I know but I can panic very easily and
it’s the out of control thing, life is very much in my
control and there are times when things start to go out
of control, I start you know tearful or what have you
and lost it. Does that -

Mm when you say you’ve lost it, tearful and lost it
what do you mean by lost it?

I stop being in control of me, I don’t want to cry, I
don’t want to be upset, I don’t want to think that
death is sort of 5 minutes away, so that’s what I call
lost it, I’ve lost control.

Mm does it make any difference if anybody else is
driving?

They’ve got to go by my rules, in fact, it could be
worse, because if I know the driver, or its friends.
who know how I feel, drive steadier, if you said I will
give you a lift up to somewhere in the county, I
would warn you before I started, please do not put
your foot down, and you know if your going to
Nottingham do you mind not going on the motorway,
would you go on the other way.

Yes, okay. What does the term illness mean to you?

It depends, if its an illness that a bug, virus, flu,
something like that, then illness means an
inconvenience, that everybody has, do what you have
to, carry on your normal life as much as you can and
if you can’t then you cope with it. If it’s an illness,
and we are talking about an illness, a terminal illness,
then it’s a different ball game, obviously and
depending on what the illness is, and how that illness
would carry on, it’d be very different in the way I feel
about it. I feel strongly that people should know the
choices, have their dignity, I’ve signed a living will.

Mm.

And when I seen people with motor neurone disease,
and while I’m still sane, then I would say there is a
point where I would say enough’s enough, bye-bye. I
feel really strongly that we do it by our rules.

Mm.

And we do it legal, with safeguards and nobody
bumping you off for your money sort of thing
(laugh).

Yes. (laugh)

But other than that, then that’s how I feel about it, I
don’t think you should give way to illness, I think
you should fight it.

Yeh.
And get on and deal with it. I suppose illness is a bit like old age, it scares you, 'cause it stops you doing what you want to do, it changes the you.

What you think of as you?

Yeh, the do what you want to do, selfish things, I don’t want to be left on my own to get older.

You know those sorts of things, none of us do.

No, erm how much do you think about your physical health, do you think?

Not an awful lot, no only if it stops me doing something, unless you’ve eaten something like rotten or what have you, but, d’know not overly much.

Erm, do you see yourself as being ill, with these chest pains, as being ill?

No, because me sitting here talking to you isn’t ill, you know, that’s ill if I couldn’t sit and talk to you (laugh).

(laugh) So being ill means not you are not able to talk to people?

Yes being ill means you are not able to do what you normally would do, yes both in mind and body.

Right. Erm the last question I’ve got, I’m not sure quite whether it fits with your experience of the chest pain, but erm, 'cause the question is on a daily basis, how do you deal with the chest pain, well you are not actually having it on a daily basis?

No.

So I think perhaps we have gone through how you dealt with it at that time, but maybe its worth asking, how do you think you would deal with it if it came up again, what would be your plan, how would you see yourself?

My plan would be ring 3 9’s if I could get to the phone going or working, I think that would be the more sensible approach and K(husband) came.

Yes.

But if it was coming back, I hope it doesn’t come again. But I think the ambulance would, I think that would be a better move, yeh. Then there would have to be a reason for it.

What makes you say there would have to be a reason?

Well, once can be an odd bout, twice ok might not be a reason, but having it again, you say this space and timing, there must be some reason for it, and I would like to find out what that reason was.
Yes. (laugh)

Okay, that's lovely, I've asked you lots of questions, is there anything you want to ask me before we finish?

No just, what exactly do you hope to get out of this sort of thing?

The idea behind the research is to get people's understanding of having a chest pain, now if we get an understanding of having a chest pain, I'm not saying that everybody would be same, but if we get some sort of understanding, of how people experience it, then maybe that can feed in to what services can be offered within say the rapid access clinic or wherever.

That is excellent.

I totally agree.

Excellent.

So it is more about getting a better understanding, because so many people come in with non cardiac chest pain and a lot of those may not go out with an answer about what it's about, so if we can understand how they are experiencing it, although they won't, not everybody's going to be the same by any means, but if there are any ties that we can come up with there that might be helpful to give us an insight, okay we've given you negative results this might help that might help, it might help shape the NHS service from having that sort of non diagnosis in effect.

Yes, I think what was very positive, was that I went to a doctor, I was sent to the hospital, almost don't go home, go now, within 10 minutes of getting there I was having an ECG and then being told that now you can go to next Thursdays clinic. You go to the rapid access, now that was a terrific boost in a way, better than saying, well you've had that, and we will refer you to in 3 months time you might get an appointment.

Oh I know.

Now I might of had a whole different perception on all of this, if that hadn't have happened.

What, the speed of response?

Yes, speed of response was fantastic, and if nothing else comes out of all this, then I've had a very good mot, thank you.

(laugh)

You know, (laugh) you know you have haven't you.
I think it's a brilliant service, I really do.
Really good, you know, I hope it been of use.
It's been lovely, thank you very much.

THE END
Ok, erm just to start with, can you tell me a brief history of your chest pain problems, and when you first noticed the pain?

Years ago, literally years ago, erm, I honestly couldn't tell you, 20, 30 years ago, 20 years ago.

Really, that long ago?

Oh God yeh.

Can you remember what happened when you first started to-

Erm, well I had high blood pressure around about that time, I started taking medication I guess around then. I mean it wasn't permanent chest pain, it was only spasmodic=

Yeh.

every now and again, and I think, as I said to you before I always associated it with stress. And I've known, I mean I'm one of those people that er, if I have any I mean I, I face aggravation I don't try to avoid it, which the wrong thing, and that goes to the stomach. I'm one of those people it goes to the stomach, causes dyspepsia and er=

Yeh.

I believe a lot of the chest pain comes from that and I don't know what the relationship is between acid reduction and the chest pain=

No.

because it's in a different position but it's definitely there, my chest pain goes underneath my boobs, as it were.

Yeh, yeh. When you said that you face aggravation, and you think that's perhaps the wrong thing to do, what makes you think that?

Erm, be careful what I say now.

Say what you want to say.

Mm, I had to fend for myself very much when I was a kid, I had a bullying father=

Right.

very, very nasty piece of work. I eventually left home when I was 16=

Right.

erm, and I suppose it's a hangover now. I'm not as bad now, as an adult, as I was a child, but er I had to fight so hard to maintain my own identity that erm, I think it did become part of my make up=

Yes.
Ben said to immediately go, as soon as someone threatened me, I'd go. And I still do that up to a point, it's controlled now, far more controlled, I've got older. In fact the last year or so, I think I've, since I suffered this depression, I have been better, I'm much better at handling conflict.

Interviewer: Okay.

Ben: But I only knew one way to handle conflict, and that was to win it.

Interviewer: Yeh, go on the attack?

Ben: Yeh.

Interviewer: Okay, so talking about 20 or so years ago, when you first felt these chest pains, and they came and went, they weren't there all the time?

Ben: No. I get severe pains in my back as well.

Interviewer: Right. All across your back or?

Ben: In my, in, at the same time, I usually get around about the lungs, the middle of my back.

Interviewer: Right, and that's at the same time as chest pain?

Ben: Quite often, yeh.

Interviewer: Do you think that's all to do with the stress?

Ben: Yes I do, yes.

Interviewer: Is that from work stress or general?

Ben: Any stress coz I don't give in to stress, that's the problem.

Interviewer: So when you say you don't give in to it, what, can you give me an example of how that works for you?

Ben: I'm very independent, I won't necessarily go and let anyone help me, I face it. I never walk away from trouble you see that's the problem. No matter what it is, I never walk away from it, er any kind of stress really.

Interviewer: So you just battle on?

Ben: Yeh.

Interviewer: Okay. Erm.

Ben: It's a bit obsessive really at times.

Interviewer: What, that you just go for it?

Ben: Yeh.

Interviewer: Does that concern you?

Ben: Yeh, yeh it does.

Interviewer: Do you think you've always been like that?

Ben: Yeh, yeh I do.

Interviewer: Do you think other people have seen you like that as well? If somebody had to describe who you were and what sort of person you were like?

Ben: They would say I was aggressive.
Interviewer: Aggressive okay, how else would they describe you?
Ben: I don’t know, a quite a caring person. I would hope they would describe me as caring, interesting. I’ve got a very fully developed, healthy sense of injustice having come from where I came from.

Interviewer: Mm?
Ben: There’s a classic example, my ex-wife, we had, our middle son had leukaemia a couple of years ago and he was very, very desperately ill, and I became the emotional scapegoat for everyone to the extent that my wife, my ex-wife, actually fitted me up with the police and told them I beat her up and I got, they had me arrested.

Interviewer: How did that make you feel?
Ben: Well I still hate her, this is what I mean by being obsessiona=*

Interviewer: Yes
Ben: =this is really in the back of my mind, I mean I really, really loathe her, because the one thing that no-one’s ever addressed in this whole thing is the fact that the son who I love dearly dearly, I haven’t seen since, and erm no-one’s ever addressed that, and I can’t get it out of my mind.

Interviewer: Right, it’s a grieving process.
Ben: Oh, he’s not dead.

Interviewer: No I know, but the fact that you’ve not seen him-
Ben: Well, I haven’t got two of my sons anymore, two out of three of my sons don’t speak to me anymore, because they believed that I beat their mother up, because she’s told, since we broke up she’s told everyone, and she even told me once when we were in company how I used to beat her up, and then she suddenly realised who she was talking to and she sort of looked at me strangely, and changed the subject and went on to something else.

Interviewer: That’s hard, that must be very hard.
Ben: And I’ve had this all my life, because I am, I can be aggressive, and I don’t sit still, and I don’t take crap from anyone, I don’t. It’s my fault really, I won’t let people say things to me that I don’t believe in. I don’t necessarily want to have an argument with them but if you tell me something that I don’t believe in, then I will tell you I don’t believe in that=

Interviewer: Yeh.
"that’s it, and that usually creates bad feeling; it doesn’t with me because I’ve got an open mind about these things, I think."

"Yeh."

"and I accept the fact that other people have got different views but most people, as you know don’t like people with different views so if you have a different outlook about something then you get into conflict with them."

"Yes, some people can take straight talking and some people can’t."

"That’s right and I’m a straight talker."

"Ben But I mean even though, it’s very strange to me, I often ponder about it, this is what I mean by being a bit obsessional, how my sons, who grew up with me after all, saw some very, very violent rows between my wife and myself, she was as bad as me I mean just row because we didn’t like each other basically. But they know, they know that I didn’t beat her, they would have seen the evidence, you can’t hide that sort of evidence from kids who are living in the house."

"Interviewer No."

"Ben I mean our friends know because they never saw it because I never did, but she’s gone round telling everyone that the last 10 years every time she opens her mouth how aggressive I am, and that was it, everyone believes I’m a wife beater."

"Interviewer That’s been going on for 10 years?"

"Ben That’s been going on for 10 years, over 10 years."

"Interviewer That must be hard."

"Ben I have often thought that I need counselling actually. I should go for counselling because I need to get rid of it, because it’s baggage, I mean I’ve got baggage from my father still so.

"Interviewer Yeh, about talking it through and processing the stuff, yeh it might, you may well find that helpful."

"Ben But it is very stressful=

"Interviewer Yeh."

"Ben enormously stressful that’s what really caused me to have depression last year to really go into, kicked into depression last year."

"Interviewer What is it do you think, about the situation with your ex-wife that makes it stressful?"

"Ben That I can’t really do anything about it, address it and get rid of it, that’s the point."
Interviewer: You said you went into depression last year, erm and you spoke earlier about it being 3 or 4 months of work, was that your diagnosis or did somebody else-

Ben: No the doctor.

Interviewer: And you feel a lot better since then or still depressed?

Ben: Mainly, this particular cancer is still there, you know, I mean obviously it's never going to go away.

Interviewer: No, not by the sounds of it.

Ben: No it's never ever going to go away.

Interviewer: Yes that's hard.

Ben: Yeh.

Interviewer: When you initially felt the chest pains, I know we are going back a long way now, but when you initially felt them, did you initially think it was stress or did you have any other thoughts about the chest pain?

Ben: Didn't think about it, to be honest with you, I don't think I thought about them.

Interviewer: What you just sort of ignored it?

Ben: Yeh just got on with it, yeh.

Interviewer: Which sounds like what you do with-

Ben: It's me, yeh that's right.

Interviewer: Okay. Erm, so if you went from a point where you were just ignoring it can you sort of explain to me how the process got to where you actually thought it was stress? Did you have any other thoughts as to what might have caused the chest pain?

Ben: Well I think I've known really for a very long time, I couldn't tell you exactly how many years= that it's stress related because I can associate what's happened with the effect it's having on me, obviously it's not difficult. You have a row and then you get this feeling in your chest that you know that erm this discomfort in your chest is to do with you just having had a row.

Interviewer: Has it been that closely linked?

Ben: Oh God yeh, absolutely oh gosh yeh.

Interviewer: So could you take me through an example, so I've got it clear in my head, so you would have a normal day at work say and then come home?

Ben: Well for example, if you get cross with someone on the road=

Interviewer: Okay, yeh.
= and then really go for it, you know screaming and shouting something like that, then I would end up with a chest pain.

And what does that feel like, what sort of pain is that?

It’s not sharp, necessarily, it’s a dull, dull, but quite a strong pain in the chest.

Yeh, and how long did that last and how does that affect you, affect your life?

It can last quite a long time, it can last all evening sort of thing.

Right so it’s three, four hours or something?

Oh gosh, yeh easily yeh. It doesn’t ever really just go away, unless, because sometimes, it all depends again I suppose what sort of mood you are in and how you actually, what level you are operating at that day, but erm=

Yeh?

= I mean you can have a small spat and I can still get it even though I know it doesn’t mean anything and goes fairly shortly.

What within half an hour, hour?

Well a few minutes even.

Oh okay.

There’s nothing consistent about it really although the more stress the more conflict there is then the more chest pain there is.

Okay, so it’s a dull feeling that can last for a couple of minutes up to-

Hours.

Hours, it doesn’t normally go into the next day?

No not usually.

And how do you manage that?

It’s always associated with a guilty feeling.

Really?

So I know I’ve lost it, lost control of the situation.

And how does that make you feel?

Well it’s not very good for the ego.

So you feel guilty that you haven’t kept your anger under control?

Yes.

That’s hard.

I know what’s going on, I mean I’m not stupid. I know what’s going on, and I know it’s been going on for years and years and years and years. Erm, and it’s just part of my makeup, I find it very difficult to do anything about it.
Interviewer: And who do you normally, who is it you normally lose erm. Who do you normally get angry with, is it, are there any particular people, is it certain people, or could it be anybody?

Ben: Could be anyone.

Interviewer: Could be anyone. And do you always feel guilty whether it's somebody in a car on the motorway or whether it's-

Ben: Yes I’ve always got that silly guilt feeling that I shouldn’t have lost it. The way I’m talking you think it happens everyday, it doesn’t, I can’t remember the last time it happened to be honest with you, 3 or 4 months ago, I can’t even remember what it was about.

Interviewer: Yeh.

Ben: But er, it doesn’t happen every day, but er, I do get, because I think I should be able to control those feelings, I’m older and mature, I’m nearly mature, I always said I wasn’t going to mature, (laugh) (laugh)

Interviewer: Yeh keep as a kid, yeh absolutely.

Ben: Yeh, but er I know what it’s linked to, I mean I think I know what it’s linked to any way, I think it’s linked to my childhood, it’s extraordinary that it can last this long, but there again it gets deeply ingrained in you, in your psyche, especially if you’ve been bullied and pushed about, and demeaned.

Interviewer: Oh yeh.

Ben: That was the worst thing about my father he used to like to demean me.

Interviewer: It’s hard. Can you feel-

Ben: To your face and with other people, really seriously, dreadful man. Do you know the thing that sticks in my mind it will always stick in my mind. I was a very good sportsman when I was a professional sportsman, and I used to run with the Harriers and I was sprint champion with the Harriers when I was about 16, 17 something like that and played football for Barking, and=

Interviewer: Crumbs.

Ben: =I was good, my father resented that, he definitely resented that and I remember him coming to an important match, I can’t remember whether it was a Barking match or a school match, I can’t
remember now. It was an important match, and I
played a blinder, this sounds so stupid telling you
this, I was about ten I suppose=

= I came off with all the guys, you know the way
they do, well played Ben all this sort of thing, it
was fantastic, walked up to my dad with a big
smile on my face thinking ah well that will please
him, and he looked at me and said, you big headed
little bastard. Turned round and walked away, and
left me to walk home, now I still remember that
and I still remember the hurt of that=

= and I was 9 or 10 years old, I still remember the
hurting of that.

It's not unusual.

No I know. Basically you see I know, but other
people don’t know because what they always see is
the hard side of me is I’m actually a very
emotional and sensitive person, so I’m a sort of
Walter Mitty really.

(laugh) Yes, do you, do people see that soft side of
you do you think?

Oh yeh.

Oh yeh, I would think so, just by looking at you.
Yes okay. So what you’re saying is it is linked to
stress and often that is about you losing your sense
of control and anger and then feeling guilty.
For example, I handle stress like a job. I’m a
marine engineer, if I was in the engine room and
there was a fire I wouldn’t stress me because I
knew what to do and how to handle it.

Right.

Not having money, I’ve been that I’ve been
bankrupt as well when I had a business and it went
belly up that doesn’t really stress me, not to the
same extent, I can handle that sort of thing that’s
not a problem.

It’s the emotional side?

It’s the emotional side, yeh.

Yeh, that makes sense. Okay.

I often wonder if it’s going to shorten my life
actually.

I’m not sure that I know of any evidence that it’s
going to shorten your life.
Well if it affects your heart of course then it would shorten your life but there's no evidence really that this stress thing does actually affect my heart.

How long ago did you go to the rapid access clinic? I haven't got your records, a month?

Bit more I think.

Okay, and they gave you the all clear.

Absolutely yeh, no problem, but that was a pain I had never had before. That was, no I mean I wouldn't have gone otherwise, that was a pain I'd never ever had before. It felt as though someone had a telegraph pole and they were trying to thump it through my chest I mean it was really really extreme. Frightened me you know, that sort of thing doesn't usually frighten me. Just lying in bed, the pain hit me, a fantastic pain I really thought I was having a heart attack.

And that was what a week or so before you went into the clinic?

Yes about 10 days, yeh. I went to the doctor the next day, and he gave me an ECG and that sort of thing. Said, I don't think it's your heart, he said, But I'm going to said you along just in case. Which is very good. They're very good around here, much better than where we came from.

Near Harebridge, which is the worst hospital in the country, 6 weeks at least to get to see a specialist.

But this is a new system, this service is-

I think the hospital is very good from what I've seen up to date. I've only lived here a year=

Oh right.

=exactly (laugh), I only moved up last year. And that's had a lot to do with my, having a better frame of mind. I mean this is contradictory to what I've just said to you but I got rid of my mortgage last year and moved up here. My wife comes from up here, you see, we are more settled and happier and all the rest of it, so I intend to be obviously more happy and settled and really the only thing I've got that's eating me is this, with my sons obviously.

Yeh.

I think that's quite understandable really.

Yeh, absolutely.

I don't know how to approach it, and er, I've tried to
Interviewer Mm?
Ben =I’ve tried to. I’ve phoned the son that was ill up
and he wanted me to apologise to his girlfriend and
his mother. That doesn’t mean anything to you.
When he was in hospital, he is 30 he’s not a kid
he’s a man, for god sake, he’s travelled the world
and all the rest of it but he is a mummy’s boy
definitely. He always has been a mummy’s boy
and still is a mummy’s boy and easily manipulated
by a woman as well=
Interviewer Right.
Ben =I mean he’s a, normally (laugh)=
(laugh)
Interviewer =he looks at them as guiding lights.
Ben Oh okay.
Ben Erm he’s actually a bright lad he’s a chartered
accountant, he’s not silly. Erm and he was
desperately desperately ill he had acute leukaemia,
as bad as you can get it=
Interviewer Mm.
Ben =and as bad as you can get it. He was in hospital
and I phoned his girlfriend up who’s also a
chartered accountant and she was in a really bad
mood, which isn’t normal and I was in the car
going somewhere and she was in the car and I said,
How is he now. So I thought right I’ll get off this
phone call as soon as I can and so I said alright my
darling never mind I’ll speak to you later if
anything happens give me a call, you know keep
me up to date. I don’t see why I should keep
phoning round I do enough da da da da da. I said
whooo I don’t know where that came from but if
that’s the way you feel I won’t bother, I won’t
phone you any more, it’s as simple as that. I didn’t
lose my temper; lose my cool or anything like that.
Interviewer Yeh.
Ben So when I phoned my son up in hospital a couple
of days later he was okay first of all. All right dad,
why were you rude to J (girlfriend) what do you
mean I wasn’t rude to J (girlfriend). Actually she
was bloody rude to me if you really want to know
the truth and it went from that. Erm it was a
discussion between a man and his son, doesn’t
matter he’s got leukaemia, he brought the subject
up=
Interviewer Yeh.
Ben =he's not, he's not impaired here (points to head).
This isn't the first time something like this has
happened; it wasn't the first time, something
similar to this had happened, where something was
attributed to me, which I didn't say. It could only
come from her or her mother and I think it's
come from her. And my son and I didn't speak for
six months because I said oh sod you I can't mess
about like that, because I know what he's like with
women and I met him by chance in a garage and he
pulled me up and that was it and we were great
pals again very strange and I will always say
sorry=

Interviewer Yeh.

Ben =if I do something wrong=

Interviewer Yeh.

Ben =As part of my character. I will always say sorry.
That's just me and anyway I just said to him about
this, the thing I did which was totally wrong
because everyone had been having a go at me=

Interviewer Mm.

Ben =you see they were using me as the emotional
scapegoat for all this. I said D (son) I'm really sick
and tired of people, you know like J (girlfriend),
your mother and everyone out there. His mother
was slagging me off all over the place to friends
and that sort of thing. Purely and simply I suppose
because she was worried and didn't know what
else to do. I said I don't mind, but the way things
are going I may as well go and cut my throat. Just
a figure of speech, that's all it was a figure of
speech=

Interviewer Mm.

Ben =didn't mean anything. Anyway, she's a drama
queen anyway, when he told her, he obviously told
her. Now whether he blew it out of proportion I
doubt it, she would have blown, she would have
taken it and blown it out of proportion and seen it
as a real crime, anything to have a go at me in any
way. And I was sitting down in doors and I had
just come back from a ride, I had a big bike in
those days, I had just come back from a ride and
knock, smash at the door, well bang at the door,
little cottage we had. And my wife opened the door
and this woman crashed in. I hope you have a good
explanation for me. That's not the sort of thing you
say to me I'm an adult, don't say that sort of thing
to me. And I got out the chair, don’t you come near
to me you’re known to be aggressive Seriously,
that’s the first thing that came out of her mouth as
she came through the door and my wife who can’t
stand conflict at all just disappeared, which I’ve
never forgiven her for incidentally I can’t forgive
her for that, because of what happened
subsequently=

Interviewer

Oh.

Ben
=erm and I just said to my wife go away, my ex-
wife, just leave go I don’t want to talk to you just
go you’re not coming shouting and screaming in
here just go=

Interviewer

Mm.

Ben
=I know what you’ve done now, she said, and gave
me this funny smile. So I didn’t take much notice
of this she obviously had something on her mind=

Interviewer

Mm.

Ben
=anyway I opened the door a little cottage and I
opened the door like that. And she was there and
she threw herself backwards against the door to
stop me pulling it open but of course I pulled it and
she went, slipped down and hit her backside on the
board at the bottom.

Interviewer

The sill yes.

Ben
And I tried to help her up and she wouldn’t let me
help her up, resisted it you know. Anyway I got her
out of the house eventually and it was dreadful and
I was upset about it, obviously I’d got a whole
number of things on my mind.

Interviewer

Mm.

Ben
The next thing I know, about a week later, the
police came and arrested me, seriously. The police
came and arrested me and I will never forgive her
for that and the fact is that I’ve lost two of my sons
because of it as well.

Interviewer

Yeh.

Ben
I will never ever forgive her for that if I can ever
do her a real disservice, I would. That’s the first
person I can ever think of, I’ve ever said that
about, because she’s wrecked my life=

Interviewer

Yeh.

Ben
=wrecked my life. And when I tried to approach
my son, he said I think some apologies are due
that’s why I got in a strop, I said what do you mean
D (son), he said well you’ve got to apologise to J
(girlfriend) and you’ve also got to apologise to my
mother. And I said D (son) even though it means I may never see you again, I’m not apologising for something I didn’t do. If you don’t know me well enough by now, to know what I’m like=

Interviewer Mm.

Ben =then there’s nothing more I can say and that was about a year ago and that’s it.

Interviewer Right, but that-

Ben Why am I telling you all this, it’s got nothing to do with this?

Interviewer Yes it’s alright. Well, what comes out of it is the, what you were saying about, well you’ve been given a label of aggressive and yet when you do get aggressive you feel guilty and it’s doesn’t happen very often, so I suppose, it links in with the stress of situations and you say the build up of stress can-

Ben I’m not very good at foolishness. I don’t like people who are being stupid, you know obviously stupid telling me that red paint down there and I know it’s blue, you know that sort of thing.

Interviewer Why does that annoy you?

Ben I don’t know, I don’t know really.

Interviewer Interesting it’s nothing to do with; well perhaps we will pull it back a bit here. Erm have you spoken to anybody within, at the time it would possibly have been your first wife and your sons, but even now with your second wife have you talked to them about your chest pains, did they know anything about it?

Ben No.

Interviewer So you didn’t share that with them?

Ben No.

Interviewer So there’s nobody that you talk to that would have their opinion on what the cause was?

Ben Oh my second wife.

Interviewer Right.

Ben But she’s clinically aware anyway because she sort of worked in hospitals all her life, sort of hospital groupie you know=

Interviewer (laugh)

Ben =she worked at the hospital. She diagnoses everyone.

Interviewer (laugh) Bless her.

Ben Actually she is quite good.

Interviewer Has she had an opinion on your chest pain or what might-
No, not really. I mean she knows I get stressed out. So she’s taken it as that’s what it is, rather than?

Sorry go on.

No I mean, I don’t discuss it with her. I don’t get it all that often really, not to, certainly never to the extent that took me into there.

Yes, I was going to ask you about that. I don’t know, I don’t know what er occurred. There was no reason for it, that I could remember. there was no actual reason.

There was nothing that ran up to that?

No no, I don’t think so.

You said you were laying in bed and it, and you had a fear of it actually being a heart attack.

Oh God yes, only from ignorance because I don’t know what a heart attack, touch wood, feels like and all I knew is just intense pain, I mean really bad. I mean I’m quite good with pain really because I’m in pain all the time.

That’s because of your back?

Yeh, I’ve just started having injections in my back to see if that can sort it. But er I’ve got worn vertebrea in my neck and I’ve got sacralia problems as well so I get sciatica all the time=

Oh right.

I’m in pain all the time basically, I’ve been in pain all my life really basically since it happened, since I had the accident. I was about 18 and I really started having troubles with my back since 31, 32.

And it’s continued?

Oh yeh, I can feel it all the time.

So going back to this time, you were laying in bed and you were feeling this awful pain was there any other? you had thoughts that it could be, possibly be a heart attack, were there any other symptoms, were you-

No, I wasn’t that was the point, no, no.

Terrible pain.

You weren’t hot or-

No, no, I mean if I’d had the classic symptoms my wife would have had the ambulance in=

Yeh.

=there you know, she said that I don’t think you’ve had a heart attack ‘cause you haven’t whatever, not hot and sweaty or clammy, that sort of thing.

And how long did that pain last?
Ben: Half an hour.
_interviewer:_ And then just went?

Ben: I went to sleep and it wasn’t there when I got up, I felt a bit sore funny enough but it wasn’t there when I got up.

_interviewer:_ And you decided to go to the GP that day did you?

Ben: Yeh I went that day. We can only do that anyway we’ve got a GP that you have to book that day=

_interviewer:_ Right.

Ben: =you can’t book ahead anyway.

_interviewer:_ And he referred you up to the hospital?

Ben: Mm.

_interviewer:_ Alright. Just thinking about when you were actually in the pain, I know that was a specific one off, generally when you’re in pain how do you feel when you are suffering from pain?

Ben: Uncomfortable.

_interviewer:_ Would you like to say any more?

Ben: No.

_interviewer:_ Okay. I was thinking sort of physically perhaps emotionally perhaps mentally those sorts of things.

Ben: I usually feel a bit down.

_interviewer:_ Yeh, anything else. Low in mood perhaps?

Ben: What?

_interviewer:_ Low in mood, what you’re saying, feel a bit down.

Ben: Yeh I’m in discomfort obviously. Sometimes I go a bit light headed=

_interviewer:_ Mm.

Ben: =not always just sometimes, it all depends on how intense I find it=

_interviewer:_ Okay.

Ben: =it’s not usually that intense, it’s more it’s very uncomfortable more than anything else. I’ve always worried about it obviously because I’m, is it and then it goes away and I’m on medication and the blood pressure is okay and all the rest of it so.

_interviewer:_ So you worry about it that it could be to do with your heart even though you’ve had-

Ben: Well it’s only sort of at the back of my mind.

_interviewer:_ Yeh, yeh.

Ben: I mean the pain isn’t that sort of intensity until that time that it all caused you to worry. Because I’ve always got pains you see, this is the problem because of this back problem I get pains everywhere in the neck, in the back, in the legs

_interviewer:_ So you are dealing with that on a daily basis?

Ben: Oh daily yeh, yeh, all the time.
Okay.

I'm in pain now my back is hurting now.

Do you want to sit in a different chair?

No it's not a problem.

Well if you want to stand up and walk around just do it, you know.

No that's fine, I would do.

I have worked with people with chronic pain so I know how difficult it can be just sitting still. How does it, do you think. I know the pain isn't just chest pain it's back pain as well, but just focusing on the chest pain how do you think it affects your daily life?

It doesn't.

It doesn't, okay.

I mean again I just get on with it. I'll tell you when I do get it, ah I will tell you when I do get it I don't think this is related to stress if I sit hunched over for any length of time like in a car when you tend to start slouching in a car=

Yes.

=then I get it, thinking about it, I get out and stretch sometimes it relieves it sometimes not=

Okay.

=But I generally don't get stressed out when I'm driving I know that I just don't get stressed out.

It's been part of your working life I suppose hasn't it?

Yes it always has been.

Okay. Do you think, does it affect your work, or your pastime you know whatever you do in your spare time or relationships?

No.

Okay. Are there any if you had to describe your chest pain what sort of words or images do you think come to mind for you? What does it mean to you?

It's just a pain across my chest it's not like a band round my chest or anything like that it's just a pain across my chest.

Okay.

In fact I've got one now as I'm talking to you now because I'm under stress.

Was it there before you came in today?

No it's right there it's like a dull pain there (pointed to centre of chest)

Talking to me has become stressful for you?
Ben: Mm obviously it's probably what I revealed to you and I'm thinking to myself why did I reveal that it's too near the surface this is one of the things that annoys me all this stuff it annoys me in as much=

Interviewer: Yeh.

Ben: =that it's so near the surface that I'll talk about it like that, you know.

Interviewer: Well you know that all this is confidential.

Ben: I hope so.

Interviewer: It is confidential and although it will be, I will transcribe the interview anything with your name or anybody's else's name will be anonymised so nobody will be able to identify it's you, but if at any time you want to stop the interview just say.

Ben: No it's a laugh, I'm quite comfortable with it I'm an open person anyway as you probably understand, but it just surprises me that I can talk to a complete stranger about it, but it could be related to my general health. It is affecting my general health there's no question about it, it's a huge issue in my life.

Interviewer: Yes, one thing I would say that often it is easier to talk to complete strangers.

Ben: Yes sure, I tend not to talk to my wife about it because it upsets her as well and I don't want to upset her about it, she knows I'm stressed out about it.

Interviewer: This is about your chest pain or your son?

Ben: No no the situation.

Interviewer: Yeh. Okay. I think I've probably already asked this question but how you describe yourself as a person is there any more you want to add on that?

Ben: How can you describe yourself? I can't be that objective.

Interviewer: Well the other way to do it often which is possibly easier is to say if you have one of your best friends standing next to you, not necessarily standing next to you, but if I asked one of your best friends how they would describe you, what words do you think they'd use?

Ben: Loyal, competent, loving, caring, protective, all the classic things that I bring from my background.

Interviewer: Okay that's great. Do you think having the chest pain has made a difference in how you see yourself?

Ben: No.
Interviewer: No okay. Do you think it's made a difference in the way that other people see you?

Ben: No.

Interviewer: From what you've said not many people are actually aware of it. Okay. What does the term illness mean to you, how would you define it?

Ben: That's bloody hard, I suppose it's being influenced by what ever it is to the degree that you would go and see the doctor in one way but I also do understand mental illness, I mean I think that depression is a horrendous, it obviously a mental condition, although it manifest itself in a physical way.

Interviewer: Mm yeh.

Ben: It's one of the things that annoys me, again not annoys me but I think I should be able to control it more. Because if stress, if stress causes these things I ought to be able to control the stress more. I would be better off trying to control the stress. It's find ways to control the stress.

Interviewer: Mm.

Ben: I've had more stress than most people, I mean everyone has stress all the time but there's levels of stress=

Interviewer: Yes.

Ben: =and I mean for example, my father spent his entire, my entire childhood telling me what a nasty horrible little child I was=

Interviewer: Oh.

Ben: =so my expectations of what people are going to think of me these self seeking theories I made, my expectations whether people were going to think I was a horrible little shit you know and they wasn't going to like me. So that affected my behaviour when I was child definitely there's no question about that plus the fact I was an only child and I was bright and I read a lot and well informed about lots of things so I was obviously seen as quite precocious as well. Erm which again my dad didn't like very much but then he didn't like me at all, so that's fairly obvious from the way he carried on. I've got a pain now just talking about him.

Interviewer: That's just come?

Ben: Yes just come as I was talking about him, you see they're deeply hidden these things but they're there and they're real.

Interviewer: Yeh absolutely (laugh) absolutely.
Ben: They are real.
Interviewer: Yes it’s hard.
Ben: I personally think I’ve made a success of my life in many ways because I’ve managed to fight my way out of that. And I got away from there and didn’t allow him to influence me, in fact it’s interesting that I banned him from seeing my children as well for the last 7, 8 years of his life.

Interviewer: Really?
Ben: Yeh, because he was abusive to my son and I said you are not going to be abusive to him, you were abusive to me, your not bloody well getting away with it with your grandchildren, forget it finished. I didn’t speak to him again for 8 years, last 8 years of his life.

Interviewer: How long ago was that?
Ben: He died in ’87. I still hate him.

Interviewer: Doesn’t go away like that does it?
Ben: My friend who’s well into these sort of things, I want to go away, I did go down to a weekend in Devon once to a retreat=

Interviewer: Mm.
Ben: =it was good but I never really got to speak about my problems really ‘cause all these women were there, there was about 12 women and 2 blokes.

Interviewer: Often the way, yeh.
Ben: And C (friend) goes down to Spain, he’s trying to get me down to Spain but he always says the only way to do it is to forgive, but I find it very difficult to forgive. It’s a weakness I suppose, human weakness.

Interviewer: Why do you think it’s a weakness?
Ben: I don’t.

Interviewer: No?
Ben: I don’t actually (laugh) thinking about it I don’t think it’s a weakness. I mean people have done dreadful things to me. My father did dreadful things to me and recently other people have done dreadful things to me, why should I forgive them. But the real reason I should forgive them all is to get rid of the burden.

Interviewer: I’m not saying that you should for give them but-
Ben: Do all of your interviews go this sort of way?

Interviewer: They tend to focus around peoples concerns, yeh.
Ben: It shows you see, there is a link, there’s a real link there and I’m sure you are on the right wavelength.
We all have worries and concerns don’t we. to some degree, it’s interesting what-
But if you have a happy childhood you grow up to be a fairly well balanced sort of person generally. Where if you don’t have a happy childhood you, especially if you well if you’re brought up to think you’re not particularly clever or nice person or anything like that, then you find you are trying 10 times as hard to prove that you are, which is a real stress factor as well.
Yes, because you are striving.
Striving yeh. Whereas you don’t have to if you have got encouragement, love and care and all the rest of it you don’t have to do that you just waffle out through life=(laugh)=and I’m so envious of people that have that I’m ever so pleased for them but I’m so envious of people that had nice good caring relationship, even my mother was selfish really, I mean she, at the end of the day she would complain about the old man the way he treated her but she never left him. She always stuck by him always sided with him. And the whole family was like that incidentally he was a real control freak my father always bulling, bullied the whole family, =
Mm.
=but when I got older and I started standing up for myself erm the family thought I was wrong, strange.
That must have been hard.
Oh it was terrible I haven’t spoken to any of my family since that funeral. In fact I don’t know why I went to the funeral to be honest, the whole family thought you were wrong=
Mm.
I said to hell with them I would rather struggle like than put up with this man=
That’s hard. Okay.
=and he was spoilt to death, favourite son spoilt to death.
Maybe why it’s good to talk to them to see he’s-
Possibly. Anyway best we get back-
Okay. How much do you think about your physical health?
Quiet a lot as I’m getting older, we all think about mortality as you get older or worry about it, I’m
not frightened of dying. I just don’t want to die a messy way that’s all.

Interviewer So you have thought about it?

Ben Oh yeh, I think that’s fairly general.

Interviewer Yeh.

Ben Don’t forget every day we hear about people younger than us dying of cancer or road accidents=

Interviewer Yes.

Ben =or some other horrible disease or just dropping dead of heart attacks=

Interviewer Yes.

Ben =anyway mortality, death is part of life.

Interviewer Yes.

Ben I’m not particularly worried about death just don’t want to cause anguish to the family. I don’t really want to.

Interviewer I think we have nearly finished now. Erm do you see yourself as being ill?

Ben No.

Interviewer You don’t, you don’t regard yourself as ill?

Ben No.

Interviewer On a day-to-day basis how do you cope with the chest pain? Do you think about it or do anything about it?

Ben No.

Interviewer No.

Ben Because it doesn’t generally last all that long if I get a pain I mean I couldn’t really attribute it to anything specifically. I mean it might be because I’ve taken something down from the shelf and I’ve tweaked a muscle=

Interviewer Yeh.

Ben =something like that.

Interviewer How often do you think you get the chest pain?

Ben It varies, honestly I haven’t had it, I suppose I get it 2 or 3 times a week=

Interviewer Okay.

Ben =of an average sort of an average.

Interviewer Yes, on an average how long does it last?

Ben When I’m driving I get it more, I think that’s as I say a lot of it is to do with driving and sitting in that position and you sort of tend to hunch=

Interviewer Yeh, stretching out.

Ben =which I do, nearly all the driving I do is quite long distance so=

Interviewer Oh right.

Ben I’m driving for 3 or 4 hours at a time at least.
Sitting in the one position?

Yes, I don't stop very often just drive.

Yeh, you do when you got that sort of job otherwise you spend all day getting there. So yeh, that I think is a totally different thing altogether I think that is just cramps if you like.

Right okay.

There again I might get stressed by driving, how do I know, I don't feel stressed by driving but I might be getting stressed by driving. I'm quite open to that.

Yeh.

It's a dangerous thing, it's a dangerous playing field out there so.

Yes. but-

I don't feel stressed, I mean I don't have racing pulses and that sort of thing.

No.

I mean even if I've had near accidents that sort of think it doesn't really affect me very much.

Okay. Is there anything else around the chest pain because I've gone through the questions that I was going to ask is there anything else related to that anything else you wanted to say?

No not really. I mean the chest pains really aren't an issue with me although this is what you are looking for they, I never think of them as an issue I mean if I had a chest pain that went on and on and on that I had for 3 or 4 days something like that, then I would go and see the doc, I couldn't get rid of it and I'd go and see him, knowing there was a good reason for it, then I would go and see the doc but that doesn't happen.

Okay.

It doesn't happen. I mean I think since I've been taking an antacid every day regularly=

Right.

=Ravapronsol, however you pronounce it. I get less, I get less chest pain, I think.

So that's helping?

Yeh I think so yeh I think it does yeh, but it's difficult sometimes to separate the pain you get from acid I know I can get that not from having a row with anyone but from having one too many glasses of wine= 

22
Interviewer

1030 Ben

Interviewer

Yeh (laugh).

1031 Ben

=(laugh) or eating too late that sort of thing.

1032 Interviewer

Yeh.

1033 Ben

I got hiatus hernia, but basically chest pains I don’t

1034 think it’s something that concerns me, I don’t

1035 really worry about it, that why I went to the doctor

1036 when I had that extreme pain.

1037 Interviewer

Because it was a lot more intense?

1038 Ben

I mean I’ve always known as I said much earlier

1039 that I know now I always get stressed I always get

1040 pain in my chest and I also get acid production if

1041 I’m in a situation which is aggressive or been

1042 aggressive in anyway or worried of course, same

1043 thing.

1044 Interviewer

Yes the tension goes up.

1045 Ben

When D (son) was ill with leukaemia I mean I was

1046 obviously very stressed out.

1047 Interviewer

More frequent maybe?

1048 Ben

Oh yeh, all the time.

1049 Interviewer

It must have been hard.

1050 Ben

It still is, because as you say I’ve not, I’ve never,

1051 my feelings have never been sort of taken into

1052 account and smoothed out and compensated for.

1053 Interviewer

No. Okay well–.

1054 Ben

I think I will go and get counselling one of these

1055 days. I think I need it, about this particular thing.

1056 Interviewer

I will just turn this off.

1057

1058

1059

THE END
Kate
It's a 45 minute tape so I might turn it over at some point. Right, to start with it'd be really helpful if you could tell me a brief history of chest pain problems, when you first noticed any chest pains, trying to go back to the beginning.

Over the last few months, I have had different pains=

which I haven't acted on because I've always convinced myself that it wasn't the heart, which have been a slight tightness, pains on left and right side, never all the way across=

Right, to start with it'd be really helpful if you could tell me a brief history of chest pain problems, when you first noticed any chest pains, trying to go back to the beginning.

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which I haven't acted on because I've always convinced myself that it wasn't the heart, which have been a slight tightness, pains on left and right side, never all the way across=

Oh.

so it has always been. I have thought chest, =

and with the family history, silly,illy ignored it, okay.

So that, I've had that, I can't say what brought it on I hadn't actually done anything different that I was aware of, erm limited mobility anyway so if I do do something out of the ordinary it tells on me the next day.

Whether it was just that, until the pain that actually sent me to the hospital, which was totally different to the others.

In what way was it different?

It was down the middle of my chest where you get heartburn and I knew it wasn't heartburn because I have that all the time, from me medication=

and I was hot and sweaty, so that's what actually sent me in in the end (laugh), to the hospital.

But the pain before it's so hard to describe, any of the pains that I've had are really hard to describe.

And I can't say any of them were great pains it wasn't (gasp of breath) =

that really hurts, it was always, just aware of it.

So how long did it last, were you going to ask me?

Yes that was the sort of thing, how long do they last generally?

When I had the pains that I went, I actually went to the hospital for, it was just a few seconds=

Right.
=really it was hot and sweatiness with it that was
more worrying than the pain.
Mm.
Erm, the ones before I could say sometimes 15, 20
minutes=
Mm.
=but when it’s in different places you are just aware
it’s across your chest=
Mm.
=so you tend to think, you do think at the time,
heart, but no it’s not, so (laugh).
What makes, how do you, what thoughts are going
through your head to make you make those
decisions?
I think I talk myself out of it, because I’m a bit like
that=
(laugh).
=I never go to the doctor when I should go to the
doctor (laugh).
And the only thing that made me go that day, was
the way that I felt with it=
Yeh.
=erm I have got blood pressure, which is, but it’s
controlled really well=
Right.
=so I was thinking more it’s the blood pressure
rather than heart even then with the feeling hot and
sweaty. Don’t know why (laugh), because you know
with blood pressure you don’t necessarily know
you’ve got it, I didn’t know I’d got it so.
Mm.
So I was thinking it had been more something like
that, but me blood pressures absolutely spot on, all
the time, so there you go.
You were saying that you don’t always go to the
doctors when you think, what’s (laugh) the thoughts
behind that?
(sigh). I think I’ve got enough things wrong with me
(laugh) without finding anything else (laugh)=
(laugh).
=which is a little bit silly really (laugh). But you just
have to think I don’t want anything else wrong with
me. When I walked out of the hospital the other
week, I was so relieved, really, that you know I
didn’t think it bothered me, but to be told no
everything’s fine, it was lovely, phew (laugh).
So that service is, is second to none as far as I'm concerned (laugh)=

The people that don't turn up for it want shooting, you know, yeh.

Yeh, lots of people have said very positive things about the service.

I did feel that I was wasting me time=

Did you?

=but after I'd been, yeh, yeh even then I'm thinking, all this time, when really the infirmary told me (?). But I wasn't thinking angina they were obviously looking for angina, and I hadn't thought that, yet me dad had it=

Mm.

=you know, so I'm still just thinking heart. I know angina is sort of from blocked things to do with your heart isn't it, but I still wasn't thinking along the same lines as they obviously were.

How did the link go between going to the infirmary and going to the chest pain clinic, can you tell me the pathway, as it were?

Yeh, I went to the infirmary, it was a Saturday afternoon, after having the hot sweaty bits and the pain, and they done a couple of ECGs and things.

Doctor was standing there and such, and went, everything seems fine but we will refer you to the chest pain clinic.

Oh I see.

And they said it could be within a couple of days or couple of weeks but it won't be any longer than that=

Yes.

=so you know just from being there I went to the clinic.

So even, what you were saying was even though you'd been to the infirmary, it was still a relief from the clinic.

Yeh.

Which is nice, isn't it? You were saying your initial thoughts were that the chest pain was to do with your heart, did you think-

This time I did suspect that when I went to the hospital it was something, it did frighten me and I did think, is this me heart? Where as the others you
sort of think, no, no (laugh) and ignore it (laugh).

Interviewer (laugh).

Kate =because I'm still here so.

Interviewer Yeh.

Kate So I think perhaps because there's a family history,
in a way that makes it worse, you do ignore it as
well in some ways. I know with a family history you
should take it more seriously, but I think you could
get neurotic about it as well so (laugh).

Interviewer (laugh) true. Have your thoughts changed about
what you think the causes are now then, with the
chest pain? What are your thoughts now?

Kate Well I don't really know what caused it, so you do
think, down another road which the doctor said he
was going to write to my GP=

Interviewer Mm.

Kate =ask for the, what d'you call, endoscope=

Interviewer Yeh.

Kate =to check things out. So I'm a bit dubious about that
so (laugh), as I've been there before because I've got
gallstones=

Interviewer Right.

Kate =a few years ago, so I know what one of them all
about. So d'you think there may still be a cause for it
when I've not had it since, since that Saturday I've
not had it again=

Interviewer Right.

Kate =that certain pain=

Interviewer Right okay.

Kate So I'm thinking, no it was nothing. Don't know
what caused it that day, hadn't eaten anything out of
the ordinary or anything like that so.

Interviewer Mm.

Kate I'm hoping it was just a one off.

Interviewer You talk about other chest pain that you get for sort
of 20 minutes or something, what are your thoughts
around that?

Kate Well I think now because I've been checked out if I
ever got anything like that again it wouldn't worry
me=

Interviewer Right.

Kate =because I'd know whether I've felt it before and
that me heart was quite healthy=

Interviewer Mm.

Kate =so far (laugh) (reached out and touched wood)

Interviewer Touch wood.
Yeh (laugh) I mean I don’t smoke now, and I don’t smoke, we eat quite healthy, not 100% healthy, but quite healthy, so a lot of the factors are taken away anyway, you know.

Yeh. What were your thoughts, I know you were saying you ignored them, but what were your thoughts before with the chest pain, not the one that took you to the infirmary but the others? Yeh, what thoughts were going through your head at the time?

I know you said you tried to ignore it but possibly some thoughts were going through your head at that point.

Yeh. What were your thoughts, I know you were saying you ignored them, but what were your thoughts before with the chest pain, not the one that took you to the infirmary but the others? Yeh, what thoughts were going through your head at the time?

I know you said you tried to ignore it but possibly some thoughts were going through your head at that point.

It obviously didn’t frighten me= because I didn’t act on it. I’m not saying perhaps it didn’t worry me at the time. I know once or twice in bed I’ve laid awake ‘till it’s gone before I dared go’t sleep, but I never mentioned it to my husband because he would panic (laugh).

(laugh) I was going to go there. Because he would panic (laugh), so I would lay there thinking, it will go away in a minute and it did, you know I was always fine so.

So you didn’t have any thoughts about what had caused that where that had come from if you had done anything or?

No. As I say with the arthritis because, if I cleaned a cupboard out today, I would ache from it tomorrow= some part of my body would be telling on it.

(sigh) This sounds really odd but when you live with pain every day, quite severe pains some days, little pains it’s easier to ignore and that was a little pain compared to the arthritis pain I get half the time.

Yes, that makes sense.

So that’s why it’s easier to ignore I suppose.

If I hadn’t got the other it would perhaps have a bigger affect on me.

Yeh, you’d focus on it.

Yeh.

Okay. So what would you say was the difference between the pain that took you into the infirmary and the pain that you generally have on and off anyway? I’m talking chest pain.
Yeh. It was the things that came with it, it was the slight dizziness and just my head was hot and sweaty, because my husband said is it the change, where you're having a hot flush, and I went no because hot flushes go all the way up the body. So you know that was his first thought, you're making it up wife (laugh) and he doesn't normally do that, I went no it was totally different it was just my head and I was hot and clammy, and I'd seen me dad like that.

Oh right.

Yeh, which was quite frightening because I keep pulling the car over (laugh), stopped 4 times. Obviously I didn't go where I was going. I came home and rang the doctors first. Took my temperature that was fine. What were you doing, what was the setting then? I was driving.

Yeh, which was quite frightening because I keep pulling the car over (laugh), stopped 4 times. Obviously I didn't go where I was going. I came home and rang the doctor initially. And told them and they said he'd come out but it'd be a couple of hours and an hour later the doctor rang me, said described your symptoms and told me to go down the hospital=

Right.

Which I had thought about doing first, thought no, see even then I thought no, I'm not going to the hospital, I'm going to ring the doctor, so.

And what made you make that decision? It was the ill feeling with it, it wasn't actually the pain it was the way I felt along side it that made me think there could be something wrong here.

Your first port of call was the GP?

Yeh.

You said that you'd seen your dad like it, what was going on with your dad?

Yeh, my dad had angina=

Angina.

=really bad angina, so he had a heart bypass eventually.

So it was an angina attack that it reminded you of?

Yes I suppose so but I still hadn't thought, I hadn't, even when I went to the clinic, I still hadn't thought angina=

No.
Yet I'd seen my dad hot and sweaty like this with angina attacks, thought about it afterwards (laugh). Yeh but you don't always piece everything together like that.

No.

So what about friends and family and how they viewed, have you shared any of this information, do people know that you have suffered this? You said, was your husband with you when you were driving?

No, I was on my own.

You were on your own.

This is a Saturday afternoon and my husband plays cricket all day. My eldest son was here, erm when I went out and I came back I went I'm just going to ring the doctors and he was actually lying on the settee coz he'd drunk the night before, and he wasn't feeling very well (laugh) = so I actually said to him look P (son) I've rang the doctors, now if I should pass out or anything just ring 999. So it must have scared me to say something like that to him. Erm when the doctor rung back and said go to hospital, my youngest son came in, who's 19, and said do you want me to come with you mum = so obviously I did see, 'cause I came home and knew I was fine and I didn't see my husband until the evening and went guess where I have been this afternoon and that completely threw him, 'cause he worries about me more than I worry about me. So me family knew, my immediate family knew and me husband, me friend who lives over the road her husband knew because he took me down the hospital. I actually had to ring him and say will you run me down because obviously I daren't drive =

Mm.

And I said come down in half an hour if you like, and he come down to me. And I'd left two mobile numbers and if it was anything serious they could ring somebody who was playing cricket with my husband and at some point in the afternoon he could have got a message. So I'd got it covered, as much as I could (laugh) =

(laugh) =

(laugh).

=so obviously I did see, 'cause I came home and knew I was fine and I didn't see my husband until the evening and went guess where I have been this afternoon and that completely threw him, 'cause he worries about me more than I worry about me. So me family knew, my immediate family knew and me husband, me friend who lives over the road her husband knew because he took me down the hospital. I actually had to ring him and say will you run me down because obviously I daren't drive =

No.

=do you want an ambulance? No (laugh). So as soon as me friend knew she rang me up to see if I
was alright on the evening and I didn't tell anyone
else then. Both my parents are now dead anyway. I
didn't want to tell my mother-in-law until I'd been
checked out because she, over the last 12 months
had a stroke and a heart attack =

Interviewer Right.

Kate =so I wanted to keep this information to myself. But
my husband told her anyway and she couldn't say
you've not told me (laugh).

Interviewer (laugh). Did anybody give any opinions on what
they thought it was when you were talking?

Kate No, well actually the mother-in-law said, 'cause
she's got AF, which is where your heart suddenly
gives a quick surge and, 'cause the first time she had
a stroke, it was a clot. And that I think I don't know
whether I've got that right and something. And she
said it sounds like AF I thought, she's diagnosing
me now (laugh) and I went let's wait and see till I've
been hospital so=

Interviewer Yeh.

Kate =she was the first person I rang when I came home
from there, tell her everything was fine (laugh).

Interviewer And you were saying your husband thought.~

Kate I think he really, it really worried him then he
couldn't wait for me to go hospital and be checked
out.

Interviewer Mm. Did he talk to you about it, what he was
thinking?

Kate No he just keep asking me if I was alright then
(laugh) rather than talk about it, he's not very good
at hospitals and things and being about hospitals.

Interviewer Mm, lots of people are like that.

Kate Yeh. I mean I had to go right down with one of me
sons, he'd actually been shot with a pellet gun and
we walked in casualty and I thought he's going to be
on the floor in a minute. It would have been easier if
he didn't come (laugh) so he's not the best person to
do hospitals and things anyway, he'd come and see
me 'cause he has to but he's not very good. So he
will, he won't avoid talking about it but he'll ask
you alright, are you sure you are alright.

Interviewer What about sort of the emotions around, there's two
different chest pains you've been talking about, so
the emotions around perhaps going to the stronger
incident where it was across the whole of your chest
and you had the sweating and stuff.

Kate When I had the sweating it was down the middle.
Sorry, down the middle. Any of the emotions that were around at the time, I mean how did you-
The frightening thing was I was sat in the car, I'd actually thought if I get out and collapsed on the pavement, will anybody take any notice because you know we see people around don't we and we are all guilty of it, I suppose we walk past on the drunk or after taking drugs and things and I'm on a bit of road where I didn't imagine there'd be many pedestrians.
And I think if I get out now and collapse what would happen? If I stay in the car will people just drive past me, that was me worst thing, that was me one fear, was that if it something happens now whose going to come help and that was the first time I stopped=
Yeh.
=the other times it was on slightly better roads where there was more people about and I thinking if something happened now they would see me (laugh) you know=
Yeh, yeh.
=but that was me biggest thing was whose around, because you know it, we all know with heart attacks and things that them few minutes can make the difference. So that was the fear not what was going to happen to me in one way but who was there to help me, I'm thinking do I press on the horn, do I (laugh) keep me hand on the horn in case.

I think, I think because my family are older, things like that I know I've got me foster kids but if you're in trouble and they'd (?), I think other thoughts would worry you more, some people (?) really.

Can you describe any more of the physical symptoms around that time, because you were saying that the pain was going down the middle of you and that your head felt hot and sweaty?

And I was light headed.

Dizzy, which is why I didn't actually get out of the car, I stayed in the car because I thought if I get out I'm on drivers side obviously and then collapsed on
the floor, I'm goin' to be in the way of the traffic as well, so every time I stayed in the car=

Interviewer Right.

Kate =because four times I pulled over on the way, you know where Cambridge roundabout is?

Interviewer Yes.

Kate That's where I was just before there, so I had to go round the roundabout and all the way back through the town which is quite horrific (laugh), when you think, 'cause I was a bit like this (showed shaking hands) (laugh).

Interviewer That's quite hairy traffic coming back through its not quiet roads is it?

Kate No, no that's right. They're not the easiest places to stop sometimes either, had to be very careful.

Interviewer How did you feel once you got back home, were there any different, did you still have the chest pain, what was-

Kate Erm no 'cause it had only come on for a little while at a time and every time I stopped and it had sort of passed and I'd cooled down a bit and put the windows open=

Interviewer Right.

Kate =drive a bit more and came in and thought, yes I'm goin' to ring the doctors. And at the time of speaking to the, 'cause on a Saturday you get the emergency people, that was quite hard work because I think I was actually feeling it then, a little bit fearing things and she's going through some of the questions and whether I wasn't clear or whether she wasn't listening properly but I was getting quite aeriated, which is not like me, I'm normally really calm on the phone with other people. And that sort of seemed to take for ever to talk to her and sort of describe what was going on you know. So once the phone call was done then I felt a bit better and I just came in and sat down really, thinking phew (laugh) I'm home, that was the thing I'm home I think (laugh).

Interviewer Yeh often a comfort isn't it.

Kate Yeh because there was other people here and so.

Interviewer And how did they react?

Kate Well my eldest son never shows much anyway and I say was feeling rather ill on that day and he really didn't say anything. Me youngest one really surprised me, 'cause he went shall I come down to you and he came down and we were there for 3 and
half hours, so, which really surprised me ‘cause I
didn’t think he would (laugh). So and my daughter
had come home. She’s sleeps, always at her
boyfriends and she’d come home and P (son) had
told her where I was and, she said I waited at home
two and half hours. I said well you know what it’s
like at the hospital; it could be been 6 hours. But
she’d obviously, she’d been ringing as well, till I got
back so. So it obviously it worried all them and me
youngest son actually said, he said I thought mum
what are we going to do if you’re not here, and I
went you will have to do your own washing and
ironing wont yer (laugh), you know.

(laugh).

Think go on appreciate me (laugh).

(laugh).

But it’s hard I think for a 19 year old to think about
it. death.

Yes it’s hard at any age.

My sister was only 25 when me mum died=

Oh right.

=so that was, she was the baby baby of the family
and her baby was only 6 months old, so that was
quite dramatic for her.

Yes. Okay. I was just wondering how the chest pain
affects sort of everyday life and whether it impacts
at all on what you do on a daily basis?

No.

No it doesn’t.

No, not even from going to the (?) and waiting to go
to the chest pain clinic it didn’t alter me life in any
way.

If I’d had it again then it may have done but because
I didn’t have that pain which was the one which
frightened me again it didn’t detract.

Okay. If you had to describe the chest pain and sort
of what it meant to you, erm what sort of words
come into your mind?

It’s one of the hardest pains I’ve ever had to
describe.

Mm.

And unless you’ve got it at the time it’s even harder.

I think if you’ve got a pain it’s easy to describe=

Mm.
Kate: =but it intermittently comes and goes. It wasn’t like a pinch pain, you know when you pinch and go ouch=

Interviewer: Mm.

Kate: =I tell you what it wasn’t (laugh), you know=

Interviewer: Okay

Kate: =it wasn’t a crushing pain. When I’ve had it before in different places once before, it’s been as much an ache and then I think because this was down the middle, which if you’ve every suffered from heart burn it’s just where you get that. I can’t describe it (laugh), it, it (sigh) it was a bit more than an ache=

Interviewer: Okay.

Kate: =but it wasn’t a bad bad pain. I really, I had real trouble at the hospital trying to describe this to a doctor=

Interviewer: Yeh, yeh.

Kate: =and I went I can’t describe it really, you know and that was so difficult to, to try to get through I just couldn’t I couldn’t do it there either (laugh), so.

Interviewer: Right okay thanks. Changing a bit the questions now what sort of person would you describe yourself as?

Kate: Someone that keeps going, try to keep on top of things, which is quite difficult sometimes (laugh). Health wise I try to keep on top of things, erm last couple of years emotionally had a real bad time (laugh)=

Interviewer: Right.

Kate: =so I think that as well as everything else, you do think has that affected me is that, you know, is that come on top so. We lost me dad two years ago this coming August and then my sister’s been in different hospitals for different things for 18 months=

Interviewer: Right.

Kate: =so that has been a big strain on all of us, the whole family really got affected. Because it affected me so much with hospital visits and things to begin I was at the infirmary every day for four months=

Interviewer: Oh crumbs, yeh.

Kate: =that it affected everybody else, so. I tried not to ’cause I did it in the day when everybody’s at school and work but obviously things got left which I would normally do, so everybody had to muck in and pull their weight a bit and which they should do anyway (laugh).
Interviewer  (laugh).
Kate  But because, because I do things for everybody they think that’s how I am now, if you like. Because I’m home and I’ve got foster kids, because I do their stuff I tend to do it for the big ones as well, so they’re all spoilt really=
Interviewer  = laugh).
Kate  =’cause they are old enough to do it their selves. So, so I will keep going I will push myself too far sometimes, because I’m determined to do things and then suffer for it afterwards. But I have to do it, I have to do it otherwise I think I may as well go out there and shoot myself really (laugh).
Interviewer  (laugh).
Kate  I’m going to do this bit of painting or I’m going to do this you know, not, not just ordinary everyday housework because I do have a routine with it which I have to have really, you know. To say if tomorrow I’m not very well I don’t do it, then I don’t do it, but I do try and do so much everyday unless there’s something in me knows I can’t do it. So people always say a jolly happy person, which I am, I am most of the time, it’s not, it’s not an act or anything else=
Interviewer  No.
Kate  =that I am (laugh), yeh.
Interviewer  Do you think the chest pains have made any difference in the way that you view yourself?
Kate  No.
Interviewer  No. Okay. What about how, the way other people see you, do you think that has changed in any way?
Kate  Not now we know that everything is alright. If it hadn’t been I don’t know how people would have been.
Interviewer  Mm.
Kate  I think when it’s something as serious as your heart, then, then people would take that seriously as well, you know. Erm if that had been a problem I don’t think I would have let it rule, rule me, obviously you would, there perhaps would been certain things I would have to change=
Interviewer  Mm.
Kate  =were things, but I wouldn’t have let it change who I was so. Where as I’ve seen people do that, as in me mother-in-law, completely flummoxed her, you know. But she’d never been ill for 63 years she’s never been ill, so it came as big shock. I think
because I've always had things before, you cope
with it better.

Yeh, yeh. Okay. What does the term illness mean to
you?

It depends what sort of illness, if somebody's got
cancer that's an illness=

that even if you come out of it, it's rough treatment
and they're gonna go through a lot and, that, that to
me, and if you've got a heart condition and you've
got to have things done that's, that's what I call a
proper illness rather than the flu (laugh), when
you're poorly for a few days and things like that. I
think with things like my arthritis people, other
people don't look at that as an illness, they just think
it's something you've got. I don't know whether I
class it as an ill', I certainly didn't to begin with, I
didn't know what, what I'd got to face over the
years so.

How long ago were you diagnosed?

About 15 years ago.

Right, so initially you didn't think of it as an illness.

No, no it was you got rheumatoid arthritis, this is
your anti-inflammatory taken when you need them.

For four years that's just what I did and then went
downhill rapidly (laugh).

So no I'd, even though I'd, I'd, I like to find out
about things as well. When I was first diagnosed
with it, I sent for leaflets and things and read up on
it. So I knew how bad it could be but I think until
you reach that point you don't believe it, you don't
actually believe it, so.

Okay. How much do you think about your physical
health?

Actually quite a lot=

=quite a lot. Erm because I'm so restricted, erm
things like me weight, 'cause I've put on a lot of
weight over the last few years, I'm aware of the
dangers that that causes. But to do an awful lot about
it I'm really struggling.

So we do eat quite healthily, I'm not saying I never
have chips because I do (laugh). But certainly not to
excess and I've got high cholesterol. I've been on
tablets for that for years, which I can, but I
controlled it with diet for many years first. And it was only after a big dose of steroids that it went so bad, it wouldn’t come down, I’d to start on medication then, but the steroids had done it rather than me.

Interviewer: Yes.
Kate: So that, that, when you’ve got that it puts you in a way of eating quite healthily anyway so that just carries on.

Interviewer: Yes. Do you see yourself as being ill?
Kate: At the minute yes (laugh).

Interviewer: And that’s linked to?
Kate: The arthritis.

Interviewer: Yeh. So the chest pain isn’t-
Kate: No.

Interviewer: Doesn’t feature?
Kate: No.

Interviewer: Okay. I think you’ve probably already answered this, but on a day-to-day basis how do you deal with having the chest pain? Is there any strategies?
Kate: No, no because it (sigh), because it never worried me that much up until that one incident, so I don’t have strategies to deal with it because it never really worried me that much so it’s just another thing.

Interviewer: You were talking about, you’ve laid in bed with your chest pain, you just made sure you didn’t go to sleep until it went.
Kate: Yeh.

Interviewer: Are there any other times when you’ve had the chest pains around the house or whatever, what would you do?
Kate: Yeh there has been but I haven’t sort of thought, got to still down and stop, I’ve just carried on, so=

Interviewer: Okay.
Kate: =it’s only when you, because you’re in bed and you’re frightened to go to sleep, because you think I want to wake up, you know (laugh). I suppose when you’re in bed it’s, you always think about things more anyway so, when it’s day time it’s obviously easier to cope with, because you just carry on and ignore it to an extent so.

Interviewer: Okay, yeh. Well that’s really most of my questions over and done with. Is there anything else you’d like to sort of add about your health in general or erm any thoughts about chest pains that you have, that you’ve not said?
Kate: No not really I wouldn’t say I would ignore things in future because you don’t know do yer. If it was similar to what I had with, that took me in the hospital before, even now I’ve been to chest pain clinic, I would probably look at going again.

Interviewer: Right.

Kate: If, if through the GP I had further investigations and they found out it’s from something else, then I wouldn’t. But, or, or I would go perhaps to the line of the GP first, the doctors first, and say I’ve had this before, it wasn’t heart, you know I would perhaps push it more with the doctors, I don’t know, I don’t know. But that day that was, that was a bit worrying that day, so I may not be quite so lax about it, despite the fact that I know it’s been checked out.

Interviewer: Right. And when you say you wouldn’t be so lax, you’d, would you-

Kate: Well you know, I actually sat in the car that day thinking well do I carry on, and I nearly carried on, you know. If I’d have had somebody else with me, I probably would have done, I’d have probably gone this is nothing and carried on= Right.

=because I was on me own, =

Interviewer: Yes.

Kate: =then it it’s a little bit harder.

Interviewer: Mm, so if it, you’re saying is if it happened again what, what difference would it make do you think?

Kate: It depends when it was, I think it, if it was next week= Right.

Interviewer: Right.

Kate: =and that happened then I would have to chase it up with the doctor. If it was a Saturday afternoon and they said me you got to go hospital again, then I would go=

Interviewer: Right.

Kate: =even though I knew in the back of me mind I’ve had this, and I’ve had it checked out=

Interviewer: Yeh.

Kate: =I would go.

Interviewer: Right. Because?

Kate: Because you just never know what’s round the corner.

Interviewer: Mm, so it sounds like it’s changed the way you think about it because you’ve had one incident.

Kate: Yeh, yeh, as I say despite the relief when I came out of the clinic to be told no your hearts fine, was
bigger than I thought it would be, because I didn’t
think I was worried about it. So you when you feel
that relief you know don’t you that in the back of
your mind you have been (laugh) so you know, yeh.

Yeh. That’s great. Erm, I haven’t got any more
questions, that’s lovely, unless you’ve got anything
else to say then-

No, no I can’t think of anything

Okay, well I’ll turn this tape off then.

THE END
Josh
Okay just to start with erm Josh, can you tell me a brief history of your chest pain problems from when you first noticed the pain?

I first noticed the chest pains about six months ago I suppose.

Right.

But I didn’t really put any account to it. I just thought it was muscular or something like this. Yeh.

But then I started feeling a little bit unwell and then these chest pains seemed to come back, that’s when I decided I needed to get it checked.

You said unwell, what do you mean by unwell?

Just felt a bit out of sorts really and not much energy, erm I wouldn’t say lethargic, but not me usual self if you like. I not one of these people that would be going to the doctors every five minutes. I’m not.

No, but you, did you say when you were feeling unwell you went to the doctors?

Yeh, when you actually feel, with these chest pains that you have and you put it to back of your mind and say it’s nothing it’s indigestion or it’s this or it’s that. And then with this unwell feeling. I had this unwell feeling for about three month.

Erm, and then I started having chest pains again and I thought well, you know, put your mind at rest and there was a bit of nagging from the wife as well. I went to get it checked out.

And that’s when I came down to the access clinic to get it checked.

What did the GP say when you went to see him?

Erm, she asked the questions of what kind of pain it is, where do you get the pain, how long does it last for, which are quite awkward questions to, to answer when they ask you.

What kind of questions?

Well you try and say is it a sharp pain, is it this pain, is it that type pain, I say it’s a pain (laugh).

And you know where was the pain and questions like that really.

And was it hard because you don’t remember or is it just hard to put it into words?
I think it's hard to put into words really you know, they say you know sharp pain and they wait for you to say oh it was a real sharp pain and I couldn't really do anything and I was paralysed with it. Well I, well it's never been like that, it's been a pain that's there just doesn't come on at any certain time, just comes. Saying that since I've been to the access clinic I haven't really experienced much pain. Maybe it is in here (points to head) (laugh). (laugh)

You don't know do you?

No, no. I mean the one reason the research is being done is because there's not much known about it in that's=

Yeh, yeh.

= it's trying to find out a bit more information really. Erm can you explain your initial thoughts of what caused the chest pain, what did you initially think?

I thought it was may be strained something or pulled something. I'm always doing things, I'm either doing the gardening or DIY or =

I've been doing at lot of digging and all sorts of things, clearing things out. And the first thing you think of it's just a strain and that seemed to go away and then like you say this unwell feeling I had the chest pain came back, I thought I better go and get it checked.

Did you have any thoughts about what you thought it might mean?

I mean it passed through your mind is it something to do with your heart and this that and the other but, you only go by the things that you read or you see on TV don't you how people have heart attacks. They usually grab their arm or grab their chest or they're paralysed and this, I had none of that.

Right.

But still with the nagging from the wife I thought it would be worth checking.

What did she have to say?

Straight forward you better go to doctors and get it checked really. If you ignore these things and it is something you'd be sorry wouldn't you.

Yeh.

So I went to get it checked.
Interviewer

Okay. Have your thoughts changed about the cause now?

Josh

Changed about what?

Interviewer

What the cause is of your chest pain, has it changed in anyway?

Josh

I suppose they have really, with going to the access clinic and they give you all these different tests and they run through these things and they say well there’s nothing wrong with your heart, that goes out your head then doesn’t it, ’cause there’s nothing wrong with your heart. And it could be ’cause I was feeling unwell, maybe it was something, a virus or something.

Interviewer

Right and that’s-.

Josh

Yeh, like I say I’ve no pain since I’ve been there that I can say I’m having pain, so.

Interviewer

Okay. You said you had the pain and then it went away and came back, was the pain the same or was it different the second time around?

Josh

I would think it was the same, I would say it was the same.

Interviewer

Yeh.

Josh

But like the doctor asked me the first time it wasn’t a driving pain where you grabbed hold of your chest and I’ve had indigestion in the past like it wasn’t, it was nothing like really discomfort shall we say. It was just this pain that you got in your chest if you like and it was around this area and just thought what is it?

Interviewer

Was there any pattern to it, did it last a certain amount of time, did it happen a certain time of day or-

Josh

Not really no, it just, I’m fairly active anyway doing things, no there was no real pattern to it, that I can think or when it was just there if you like.

Interviewer

And how long did it normally last?

Josh

Might last for half an hour it might last for an hour, erm but it wasn’t that bad for you to stop work or doing what your doing, if you like.

Interviewer

Right.

Josh

You get into what you’re doing and you don’t recognise it if you like, just vanishes away. Like when you’re busy isn’t it.

Interviewer

Yeh well it can do.

Josh

Like if you go to work with a cold and you’re busy it’s better than sitting at home, with your lemsip and you feel totally worse not even saying stuff, so
your active and you move around, it feels better quicker doesn’t it.
Yeh, yes it can do, I suppose it depends whether you can push it to the back of your mind or not.
Okay.
I think if I was grabbing my chest and screaming in pain, it would be a different issues then.
Okay. Have your friends and family shared any thoughts about the cause of the chest pain, any of your family?
The only person I’ve discussed it with really is me wife.
Right.
And her concern was go to doctors (laugh).
She didn’t, she didn’t say, she didn’t elaborate on that, what she thought it might mean or-
No, no, she said it could have been stress ‘cause in work I’ve had quite a lot of stress lately with applying for different jobs. There’s a lot of upheaval in work as there is in colleges these days.
So you know, she was saying it most probably come on maybe it’s a bit of stress or, I looked at her and said what stress? ‘Cause if you don’t know you’ve had stress, you don’t know what stress is.
You know what I mean. You don’t know if you’re suffering from it. So she said it probably stress then. She could be right to a point, because between October I think I had to apply for three jobs and then beginning of January which was New Years Eve, I think it was, I got told me job was at risk, and you have to apply. So since October to now or to the end February I had to apply roughly for three jobs. So it could well be something to do with stress.
And when did the chest pains actually start?
Like I say roughly about six months ago so round about that time really, Novembery time, Decembery time really.
Right.
So it could well be something to do with stress.
And did your wife say any, has she got any ideas, since you’ve been to the chest pain clinic, I mean I know you’ve had an idea what you could put it down to, has she said anything?
No she’s happy that I’ve come home and says that and they’ve said there’s nothing wrong with me
heart, and that’s it really, get on with the wedding
plans (laugh).

(laugh) May be it’s the thought of spending money I don’t
know.

(laugh) Could be, could be weddings are expensive
aren’t they.

They are expensive.

Can you explain to me how you actually feel when
you are in pain?

It’s a nuisance more than anything else and then
you just, when it comes you ‘till I went to the clinic
you think what is it like. I suppose you get stressed
yourself just thinking about it, or you get worried
about it.

Yeh.

Erm but yeh I suppose you get a bit concerned with
yourself thinking well what is this. You start toying
with yourself is it the heart or is it not the heart and
all this type of thing.

Yeh, so sort of the thoughts you were having is it,
is there any emotions or any physical symptoms
related to it besides the chest pain?

No I wouldn’t say so no.

I say when I’ve had the chest pain I did feel, unwell
if that’s associated with it or if that’s totally
different.

Sorry, sorry say that again.

If it’s something totally different from, from the
chest pain and the not feeling well, then I don’t
honestly know.

Mm, oh I see, I really don’t know. But you didn’t
have lethargic feeling the first time you had the
chest pain, it came on later, did you say or-
I think it did come on later really, I think it, I think
in that period, like I say, I’m going back to October
time.

Mm.

You feel well then may be it was the start of stress
or something then you seem to have a bit of chest
pain and it could be a general stress, run down
whatever really.

Mm. Okay. Erm I know you said something of this
anyway, but just erm just to sort of elaborate a little
bit, how the chest pain has affected your daily life?

Don’t think is has at all really.
Interviewer: It's not affected your work or-
Josh: I haven't taken any days off with it.
Interviewer: No.
Josh: I haven't you know sat in the house wondering what the thing is. I've just carried on. So it hasn't really affected me life at all, just the thing in the back of your mind that you needed to get it checked.
Interviewer: It's not affected how you speak to your wife or anything or deal with the children or anything like that?
Josh: No, not talking to the wife, I might kick the dog a bit, you know, no not at all.
Interviewer: (laugh) Okay. Can you describe what the chest pain means to you, sort of what words spring to mind or images?
Josh: I thought when I first had the pain. The first thing is you think, there's something wrong with your heart, you're having stroke whatever, heart attack whatever really, first thing that comes into your mind. Erm other than that it was just a bit of a wondering well what is it like. So did something about it, get it checked.
Interviewer: Mm, okay. How would you describe yourself as a person?
Josh: Laid back.
Interviewer: Do you want to elaborate on that?
Josh: No I don't get, I don't get wild about anything. I am very laid back, very easy going. Erm but a bit more outspoken than I used to be.
Interviewer: Yeh okay. If you were asked about sort of like the important, your most important characteristics. Somebody asked you what sort of things would you say?
Josh: Important characteristics?
Interviewer: If somebody had to sum you up in sort of three words or something, what sort of things would you feel quite strongly?-
Josh: I think I would say I was quite personable, erm I relate to people quite easily, communicate quite well with them erm, and I suppose they might say I was a little bit quiet, but like I say that's changed a little bit over the last few years.
Interviewer: Okay, okay. Has the chest pain made a difference in how you see yourself?
Josh: No not at all.
Okay. What about the way that other people see you, it would only be your wife?

No I don’t think so, only me wife that knows about these things and that why I went to chest clinic really. I think I mentioned to me mum when I went to visit once after being to the clinic, but no she just told me to take it easy, as mums do.

Yes (laugh). Okay can you tell me what the term illness means to you?

Illness.

Mm.

Being bedridden, not being able to do what you want to do, housebound, that’s about it really, hospital if you like. I don’t think of illness as a cold, that not illness. When you say illness to me it’s something serious.

Something serious, which could mean, what do you mean by serious?

Well you’d have to go to hospital or you’d be signed off work for a long period of time, and you’d be on medication and you’d have to go to the doctors to get checked quite regularly.

Okay. How much do you think about your physical health?

I think about it quite a lot actually, think I’m quite aware me physical health. I like to think I’m fairly fit, may be that’s ‘cause I’m getting towards fifty.

Yeh I do think of my physical health and I try an’ keep myself quite healthy, and I try and eat properly and all that and physical health. Yeh I think I’m quite conscious of my physical health.

So you think about what you eat what else?

I think about it quite a lot actually, think I’m quite aware me physical health. I like to think I’m fairly fit, may be that’s ‘cause I’m getting towards fifty.

Yeh I do think of my physical health and I try an’ keep myself quite healthy, and I try and eat properly and all that and physical health. Yeh I think I’m quite conscious of my physical health.

So you think about what you eat what else?

Well like a say I try to take regular exercise up to about six or nine months ago, I used to squash and five-a-side football.

Oh right.

I stopped doing that ‘cause I banged me knee on the floor and then it came up like a balloon. I had to have it drained three times so since then I haven’t played in case I bang it again, and it happens again so that’s where you need medical help but you don’t want something more serious to happen.

No.

Saying that I still walk the dog a mile ‘n a half every day.

Yeh.

So yeh I keep meself quite mobile shall we say.
Okay. Do you see yourself as being ill?

No.

I thought it was probably a fairly straight forward answer from that one, ‘cause the way you’ve spoken about the chest pain and how it’s impacted. How do you, how do you deal on a day to day basis with having the chest pain, what would you do?

It doesn’t change my life what so ever, I’m still. When I experienced it the first time it never really stopped me doing what I wanted to do.

So you just-

Just carried on.

Carried on, okay.

It’s back to your other question I suppose really, if I had to stop because of it I’d think that I was ill.

Okay, yeh.

So I carry on so I’m not ill.

That’s actually all my questions.

That’s quick then wa’n’t it.

That’s very quick.

(laugh)

Is there anything else that you’d actually like to add about?

No nothing at all really, if it has to do with your research.

It’s erm, you’ve been very precise and clear about everything really.

That’s one of the things my wife says I am, very precise and clear.

Really.

Something else you can add to my personal qualities.

Yes, thank you that’s been great, unless there’s anything else you think is relevant that you’d like to add.

No nothing at all.

THE END