Matters of the Heart: Unravelling the Implications of Coronary Artery Disease on Post-Menopausal Women and their Partners

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A dissertation presented to the Department of Psychology, University of Malta

for the degree of

Master of Psychology in Health Psychology

May 2025

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L-Università ta' Malta

FACULTY/INSTITUTE/CENTRE/SCHOOL Faculty for Social Wellbeing

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Dedication

This research is dedicated to all post-menopausal women diagnosed with coronary artery disease and their partners.

Acknowledgements

I extend my deepest gratitude to my supervisor, Dr Pamela Portelli, for her invaluable support and guidance throughout this journey. Your expertise equipped me with the tools to address my research questions. It has been an honour working with you.

I am sincerely grateful to the post-menopausal women with coronary artery disease and their partners for trusting me with their experiences. Special thanks to the intermediaries who facilitated participant outreach and to Gozo General Hospital and Mater Dei Hospital for their support.

To my mother, father, and sister, your love and belief in me have been a constant source of strength. I owe much of my success to your support and sacrifices.

Lastly, I would like to thank my boyfriend for his support and ability to keep me grounded throughout this process.

Overall, I am grateful for the dear people in my life who have shaped the person I am today and supported me along the way.

Abstract

This study explored the biopsychosocial implications of coronary artery disease (CAD) on the quality of life of postmenopausal women and their partners. It focused on two sub-questions: (1) How does CAD affect postmenopausal women's life satisfaction and psychological wellbeing? and (2) What implications does CAD have on the partners of post-menopausal women? A qualitative design was used, with data analysed through *Reflective Thematic Analysis*. Ten participants (five post-menopausal women with CAD and their male partners) were recruited via purposive and snowball sampling, respectively. Data collection involved 20 Single Question Aimed at Inducing Narrative interviews, coded using NVivo, guided by the *Dynamic Biopsychosocial Model* and *Rolland's Family Systems Illness Model*. Eight themes emerged: (1) Physical Implications, (2) Psychological Wellbeing, (3) Identity Perplexity, (4) Echoes of Solitude, (5) Impact on Intimate Relationships, (6) Navigating the Emotional Terrain of Chronic Illness, (7) Balancing Act: Coping Mechanisms Amidst CAD Stressors, and (8) Post-Traumatic Growth. The findings highlighted CAD's complex nature, which evolves with disease progression and extends beyond the individual, affecting the dyadic system. Despite its negative biopsychosocial effects, positive outcomes also emerged, including stronger relational bonds and personal growth. The study recommended several policy and clinical changes, including gender-specific care guidelines for women with CAD and training for healthcare professionals on gender-related symptomatology. It also called for further research into the experiences of children caring for a parent with CAD and the condition's impact on same-sex couples, among others.

Keywords: Coronary Artery Disease, postmenopausal women, informal caregivers, Biopsychosocial impact, Reflective Thematic Analysis

Table of Contents

List of Tables

List of Figures

List of Abbreviations

Coronary Artery Disease..... CAD

Family System Illness..... FSI

Health-Related Quality of Life ..... HRQoL

Reflexive Thematic Analysis..... RTA

Single Question aimed at Inducing Narratives ..... SQUIN

Operational Definitions

This research employs the following foundational definitions:

Quality of Life: Quality of Life is a multidimensional concept that assesses the individuals' general well-being, happiness and life satisfaction (Iqbal, 2021).

Health-Related Quality of Life (HRQoL): HRQoL is a subjective, multidimensional measure of how disease impacts daily life and health management, shaped by perceived health, disease progression, and coping strategies (Belachew et al., 2023; Eilayyan et al., 2023).

Post-menopausal women: Menopause, typically occurs between 45 and 55 years, making most post-menopausal women over 55 years (Ali et al., 2023; Ambikairajah et al., 2022).

Partner: A romantic partner is a committed, monogamous individual who provides affection, emotional support, and intimacy (Hammond & Sibley, 2022; Zoppolat et al., 2020). This study focuses on male partners in heterosexual marriages and cohabiting relationships.

Eudaimonic (Psychological) Wellbeing: Eudaimonic or psychological well-being includes six key dimensions: self-acceptance, positive relationships, environmental mastery, autonomy, purpose in life, and personal growth (Krok, 2022; Whyne et al., 2023).

Life Satisfaction: Life satisfaction is a key well-being indicator, shaped by health, work, life circumstances, relationships, age, gender, personality, and leisure activities (Malvaso & Kand, 2022; Natt och Dag et al., 2022).

This study will solely focus on post-menopausal women with coronary artery disease and their male partners.

Chapter 1

Introduction

"The heart is truly a multidimensional organ, undoubtedly the beating engine of our life"

(Cirillo, 2018, p. 15)

Cardiovascular Diseases

Cardiovascular diseases, a 21st-century health epidemic, caused 20.5 million fatalities in 2021 (Di Cesare et al., 2024; World Heart Federation, 2023). They are the main contributor to death among women, responsible for a third of global deaths and an eighth of healthcare expenses (Liu et al., 2022). In Europe, cardiovascular diseases account for 55% of female and 44% of male deaths, largely due to coronary artery disease (CAD) and stroke (Magnussen et al., 2023; Möller-Leimkühler, 2022).

Coronary Artery Disease

CAD, often referred to as coronary or ischemic heart disease, is the most prevalent CVD and a major global health issue (Hajikhani et al., 2023). It surpasses diabetes in disability-adjusted life years, is highly prevalent among women in developed countries, and is responsible for 20% of overall fatalities in Europe, highlighting the need for targeted interventions (Daponte-Codina et al., 2022; Zhu et al., 2022). Post-menopausal women experience higher mortality and morbidity from CAD due to the loss of oestrogen's protective effect (Aryan et al., 2020). Daponte-Codina et al. (2022) conducted a quantitative study revealing that CAD accounts for 16% of premature mortality in women under 75.

The Impact of CAD on Patients and Caregiving Partners. The unpredictable course of CAD drastically alters individuals' health-related quality of life (HRQoL) (Bouchard et al., 2023a). Women with CAD often face reduced physical and social

functioning, greater mental health challenges, and higher rates of hospitalisation and cardiac death (Oreel et al., 2020; Ranasinghe et al., 2023). These impacts extend to partners who often assume caregiving roles, increasing their stress and vulnerability to health issues such as hypertension and depression, particularly when adequate support is lacking (Michalski et al., 2022; Regmi & Siccardi, 2023).

Purpose of the Study

CAD is the primary contributor to female mortality worldwide, yet its biopsychosocial impacts, especially in the local context, are often misunderstood (Daponte-Codina et al., 2022; Moscucci et al., 2023). Research on CAD's effects on caregiving partners is limited, and the perception that women are less at risk than men needs re-evaluation (Bosomworth & Khan, 2023; Ohbe & Yasunaga, 2021). Despite the significance of addressing sex and gender issues in health studies, gaps remain, including the neglect of gender-specific biopsychosocial factors and bias from historically male-dominated studies (Gauci et al., 2022; Nielsen et al., 2021). This study seeks to address these lacunae by exploring the local biopsychosocial effects of CAD on women and their partners, identifying their needs, and recommending service improvements.

Research Question and Aims of the Study

The overarching question for this research was the following: "What are the holistic biopsychosocial implications of coronary artery disease on the quality of life of postmenopausal women and their partners?"

This primary research question was then divided into two main sub-questions:

1. How does coronary artery disease affect postmenopausal women's life satisfaction and psychological well-being?

2. What implications does coronary artery disease have on the partners of post-menopausal women?

To address such research questions, the following objectives were identified:

- To explore the biopsychosocial repercussions of coronary artery disease in post-menopausal women.
- To explore the effects of coronary artery disease on partners of post-menopausal women.
- To explore how post-menopausal women with coronary artery disease and their partners cope with such a condition.
- To explore the participants' perception of services available and how these can be improved.

Conceptual Framework

Conceptual frameworks integrate established theories with emerging researcher insights, highlighting gaps, and evaluating the study's significance and contribution (Luft et al., 2022; Van Der Waldt, 2020).

Methodological Theoretical Underpinnings

Current research on CAD in women mainly uses quantitative methods to examine the biopsychosocial factors influencing HRQoL of patients with CAD and relationship quality in patient-spouse dyads (Bouchard et al., 2023b; Rohrbaugh et al., 2008; Yu & Zhang, 2020). These studies have shown that patients with CAD maintain good quality of life, while couples report better relationship quality and symptom relief over time, with relationship factors playing a key role in the overall well-being of older adults with CAD.

For this research, a qualitative methodology was selected for its ability to analyse complex human behavioural dynamics (Tenny et al., 2021). *Reflexive Thematic Analysis* (RTA), developed by Braun and Clarke (2022a), was selected for its comprehensive data analysis approach (Lyons & Coyle, 2021). This study employs a contextualist approach and uses *Single Question Aimed at Inducing Narrative* (SQUIN) interviews with five postmenopausal women with CAD and their male partners.

Theoretical Framework

Theoretical frameworks provide insight into phenomena through established theories (Garvey & Jones, 2021; Hiebert et al., 2022). While many theories address chronic illnesses, the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) and *Rolland's Family System Illness Model* (1994) were deemed most fitting for this study. The former explores the biopsychosocial impact of CAD on patient outcomes and HRQoL, while the latter examines how chronic illness influences family dynamics, crucial for understanding couples' coping and adaptation.

Personal Standpoint

Coming from a psychology background, I was always intrigued by how medical conditions affect individuals beyond their medical repercussions. My interest in CAD grew due to its prevalence in my family and the loss of my aunt to the condition. These personal experiences provided a deeply emotional and motivating context for my research pursuits. Observing my aunt's husband in trying to support my aunt and cope himself deepened my desire to explore the broader implications of CAD. This is especially important given the multifaceted biopsychosocial distress and lifestyle adjustments experienced by both patients and their partners.

Overview

Following the introduction, Chapter 2 will review pertinent studies. Chapter 3 will detail the methodology. The next chapter will present and analyse interview findings with existing literature. The final chapter will summarise key findings, strengths, limitations, and offer recommendations.

Chapter 2

Literature Review

This chapter reviews studies on the pathogenesis of CAD, gender intersectionality, CAD's biopsychosocial effects, relationship dynamics, and CAD within the local context. It concludes with the rationale for this research, its contributions to the field of psychology and the study's theoretical frameworks.

Pathogenesis of Coronary Artery Disease

CAD begins with endothelial dysfunction caused by traditional factors (e.g., smoking) and gender-specific influences (e.g., menopause), leading to inflammation and atherosclerosis (Cho et al., 2023; Gusev & Sarapultsev, 2023). This promotes the formation of early atherosclerotic lesions and subendothelial plaques, progressing to chronic coronary syndrome (Frąk et al., 2022; Shahjehan & Bhutta, 2024). Over time, plaques can obstruct blood flow, causing acute coronary events like angina (Xu et al., 2023a). Plaque destabilisation may result in serious consequences, including myocardial infarction, stroke, haemorrhage, heart failure, and death (Budzianowski et al., 2024; Qi et al., 2023).

Menopause and Atherosclerosis

Menopause, characterised by reduced oestrogen levels, significantly contributes to atherosclerosis and CAD (Aljumah et al., 2023). Oestrogen's cardioprotective effects include vasodilation, which lowers blood pressure and slows plaque formation through its antioxidant, anti-inflammatory, and antithrombotic actions (Gersh et al., 2024; Qian et al., 2024; Wu et al., 2024). However, reduced oestrogen increases arterial stiffening and cardiovascular risk.

Gender Intersectionality and Coronary Artery Disease

Gender, shaped by biopsychosocial differences, is a key health determinant (Vohra-Gupta et al., 2023; Caraducci et al., 2022). *Intersectionality,* as defined by Crenshaw (1998), highlights how interconnected social categories, like gender, create discrimination systems. In healthcare, it shows how multiple identities impact access to care, treatment, and health outcomes (Lee et al., 2023; van den Houdt et al., 2024). Women experience greater health disparities due to sociocultural, socioeconomic, and political factors (Lyell et al., 2022; Norris et al., 2023). The *Theory of Constrained Choices* (Rieker & Bird, 2005) suggests that work, family, and policy shape health decisions, creating barriers or opportunities (Winkler et al., 2020). Women, often balancing multiple roles, may prioritise others' needs over their health (Isiadinso et al., 2022).

Gender significantly affects CAD outcomes but is often overlooked in clinical practice, resulting in diagnostic and treatment disparities for women (Jäckel et al., 2021; Reynolds et al., 2022). Historically viewed as a male disease, CAD has caused unconscious gender bias among practitioners (Gauci et al., 2022; Goodarzynejad et al., 2023). Women often exhibit atypical symptoms before a CAD diagnosis, such as dyspnoea, weakness and nausea, which are less recognised than the classic chest pain seen in men (De Marvao et al., 2021; Montarello & Wai Ping, 2022). They also seek treatment later, averaging 3.2 hours compared to 2.4 hours for men, partly due to lower awareness and fewer targeted campaigns (Daponte-Codina et al., 2022). This bias leads to delayed diagnoses, less aggressive treatments, and higher mortality, a phenomenon known as *Yentl syndrome*, coined by Dr Bernadine Healy (1991) (Chrysohoou et al., 2020; Sawan et al., 2023).

Impact of Coronary Artery Disease on Women

> "Having a chronic illness means more than learning to live with it. It means struggling to maintain control over the defining images of self and over one's life" (Charmaz, 1997, p.5).

The onset of CAD presents multifaceted challenges impacting individuals on biopsychosocial levels (Swathi et al., 2023; Xu et al., 2023b).

Physical Implications

CAD causes serious health consequences, marked by a range of symptoms rather than a single indicator. Women with CAD often experience persistent symptoms, including angina, arrhythmia, and oedema, which negatively affect their HRQoL and cause physical distress (Jurgens et al., 2022; Rieckmann et al., 2020). The extent of these symptoms varies depending on the amount of arterial plaque and disease progression (Collet et al., 2022; Marzilla, 2023).

For post-menopausal women, staying active is essential due to menopause-related changes like increased abdominal fat, which limit physical activity and exacerbate CAD symptoms (Godoy-Izquierdo et al., 2024; Vincent et al., 2023). Chronic chest pain and discomfort can further impact daily activities and reduce exercise capacity, heightening the risk of diabetes and hypertension, which complicates CAD management (Spoletini et al., 2020).

CAD can also impair cognitive function due to reduced brain blood flow, contributing to cognitive decline and dementia (Brain et al., 2023; Olesen et al., 2024). Women with CAD face an increased vulnerability to developing chronic kidney disease and sleep apnoea (Cepoi et al., 2024; Helmer et al., 2023).

Patients with CAD are prescribed secondary prevention medications to manage symptoms and reduce complications (Khatib et al., 2019). Due to higher comorbidity rates and the need for preventative medications, women with CAD often experience polypharmacy (De Oliveira Laterza Ribeiro et al., 2023; Tran et al., 2022). This increases the risk of adverse effects, like tachycardia and liver dysfunction (Lee, 2023; Ruscica et al., 2023). Frequent medical care and diagnostic tests further add to their physical burden (Jayathilaka et al., 2020; Park & Nam, 2022).

Psychological Implications

CAD can cause *symptom distress* (McCorkle & Yeung, 1978) that worsens disease perception and increases cardiac episode risk (Onah et al., 2024; Wang & Song, 2023). CAD also leads to greater reliance on others, leading to feelings of hopelessness (Rubio et al., 2021; Soleimani et al., 2022). According to *Self-Determination Theory* (Deci & Ryan, 1985), reduced autonomy undermines motivation for health-promoting behaviours, making individuals less likely to engage in activities like exercise, which can worsen their health (Ntoumanis et al., 2021).

The incurable nature of CAD requires lifelong management and significant lifestyle adjustments, known as the *burden of treatment*, which can be mentally taxing (Luo et al., 2023; Stacherl & Sauzet, 2024). Patients must adopt heart-healthy habits, like reducing sodium intake, increasing exercise, stopping smoking, and staying consistent with their medication (Bansal & Hiwale, 2023; Sharifi-Rad et al., 2020). Regular monitoring is crucial, but limited healthcare access can exacerbate this burden (Becker et al., 2022). These demands can lead to frustration, particularly for women balancing health and daily life (Stacherl & Sauzet, 2024).

Self-efficacy and *internal locus of control* are crucial in managing CAD. *Self-efficacy* involves belief in one's ability to successfully carry out behaviours to achieve a goal (Waddington, 2023). *Internal locus of control*, a key concept in *Health Locus of Control Theory* (Wallston et al., 1976), reflects the belief that outcomes result from one's actions rather than external forces like fate or luck (Dogonchi et al., 2022; Luque et al., 2023). Together, these factors can strengthen an individual's capacity to handle the challenges of CAD management, promoting a sense of agency and reducing feelings of helplessness (Chen et al., 2023a; Ifeagwazi et al., 2023).

CAD can transform an individual's identity, shifting from a healthy self to an *illness identity* (Helgeson & Zajdel, 2017). This aligns with *Illness Perceptions Theory* (Leventhal et al., 1984), which suggests illnesses alter self-concept, health beliefs, and future expectations, creating uncertainty (Sheth et al., 2023; Singh & Rejeb, 2024). *Self-Regulatory Theory* (Baumeister & Vohs, 2007) highlights managing uncertainty through strategies like self-monitoring to maintain a coherent self-concept (Breland et al., 2020; Hagger & Orbell, 2022). For CAD patients, maintaining a coherent sense of self is essential for resilience and engagement in health-promoting behaviours. Additionally, women with CAD often struggle with low self-esteem, diminished personal worth, and body image issues (Adib-Hajbaghery et al., 2020; Siu et al., 2024).

Women with CAD face numerous stressors, including social role demands leading to *psychological distress* encompassing anxiety and depression (Conversano & Di Giuseppe, 2021; Kim, 2022; Soloveva et al., 2023). Anxiety affects between 20% and 50% of CAD patients, with women being disproportionately affected due to their heightened susceptibility to stress (Heshmati et al., 2021; Pushkarna, 2023). Moreover, elevated anxiety levels can

impair immune function, further complicating disease management (O'Keefe-McCarthy et al., 2023).

Depression affects 20–30% of CAD patients and is twice as common in women (Shiga, 2023; Rome et al., 2023). Rates are higher among hospitalised patients, reaching 41–51% (Askin et al., 2020). Depression is linked to poorer cardiovascular outcomes, including higher mortality, increased risk of myocardial infarction, and reduced quality of life (Giuliani et al., 2024; Krittanawong et al., 2023). Overall, psychological distress is significantly more prevalent in CAD patients than in healthy individuals (Vaillancourt et al., 2021).

Social Implications

CAD can limit mobility and participation in physically demanding activities, reducing social interactions (Iovino et al., 2023; Komalasari et al., 2019). This isolation can strain relationships and induce feelings of guilt (Chatzinikolaou et al., 2021; Tomás et al., 2023). Additionally, social gatherings can make patients feel self-conscious or pressured to eat certain foods to conform to social norms around eating which may conflict with their dietary restrictions (Wang et al., 2020). Changes like quitting smoking or reducing alcohol, which are essential for CAD management, can also alter social dynamics, leading to isolation or pressure to revert to old habits (Chobarunsitti & Prakobchai, 2021; Sugiharto et al., 2024).

Anxiety and depression from the diagnosis and treatment of CAD can further contribute to social withdrawal (Rezaee et al., 2024; Tiksnadi et al., 2023). *Kinesiophobia,* an intense fear of movement due to perceived pain or reinjury risks, is common among CAD patients, who worry that physical activity might trigger a cardiac event in public, further heightening social anxiety (Clarke et al., 2024; Deka et al., 2021; Keessen et al., 2020). Moreover, regular medical visits disrupt routines, limiting social interactions (Kodeboina et al., 2023).

Patients with CAD may also fear negative judgment worrying about being seen as a disease rather than an individual or as frail (Marini et al., 2023; Pham et al., 2021). The stigma surrounding CAD, often viewed because of poor lifestyle choices, intensifies these concerns and can lead to discrimination (Fekih-Romdhane et al., 2023; Nicoloro-SantaBarbara & Lobel, 2024). This aligns with *Goffman's Stigma Theory* (1963), which highlights how deviation from social norms can lead to labelling and isolation.

Medications for CAD, like diuretics, can significantly impact one's social life (Freak-Poli et al., 2023). Diuretics increase urine production, requiring frequent restroom visits which can limit spontaneity and participation in longer events (Kehrenberg & Bachmann, 2022; Surma et al., 2023). They can also cause nocturia, frequent urination at night, leading to fatigue and irritability that further affect temperament and social relations (Akasaki et al., 2021; Garrison et al., 2023; Rahman et al., 2021).

Financial Implications

CAD imposes a significant economic burden on individuals (Hu et al., 2022; Xiao et al., 2022). In 2021, CAD cost the European Union €77 billion, with 37% on medical services, 2% on social services, 24% on productivity losses, and 37% on informal care, averaging €173 per citizen (Luengo-Fernandez et al., 2023).

CAD treatment, including medications, rehabilitation and surgeries, can be costly, particularly for those with low to middle socioeconomic status (Kumar et al., 2023; Shukla et al., 2021). This financial burden, known as *financial toxicity*, can lead to debt and long-term insecurity, depleting retirement savings, especially among older adults (Ghazal et al., 2023; Maguire et al., 2021).

A diet rich in fruits, vegetables, fish, legumes, and nuts is essential for cardiovascular health (Karam et al., 2023; Mente et al., 2023). However, the cost of these healthy foods has

risen significantly over the past 30 years compared to unhealthy options, adding to the economic burden (Hoenink et al., 2024; Lewis et al., 2023).

CAD can impair work ability, especially the ability to partake in physically demanding jobs, leading to income loss and early retirement (Pahmeier et al., 2022; Siu et al., 2024). This burden may last for decades unless alternative employment is secured (Kamdar et al., 2020). Employed individuals often face increased absenteeism due to medical appointments and presenteeism where they are present but less productive due to their condition (Luengo-Fernandez et al., 2023).

Cardiac patients often face frequent re-hospitalisations, leading to substantial out-of-pocket costs and insurance expenses impeding care adherence (Loo et al., 2022; Nadash & Jansen, 2023). For individuals with low socioeconomic status, these financial burdens are exacerbated by additional stressors like job insecurity, resulting in cumulative disadvantage (Hardman et al., 2020). Medical expenses exceeding 40% of disposable income are particularly catastrophic, increasing the risk of poverty (Xu & Yang, 2022).

Implications of Coronary Artery Disease on Caregiving Partners

Sameroff's Transactional Model (1975) highlights that individuals constantly influence and are influenced by one another. This is also echoed in *Bronfenbrenner's Social-Ecological Model* (1977), which views an individual's social environment as interconnected contexts. In romantic partnerships, health experiences are interdependent, with each partner's behaviour affecting the other (Min et al., 2020; Weitkamp et al., 2021). During illness, this interdependence can become asymmetrical, with one partner relying more on the other (Abendschein et al., 2021).

Home care is often necessary after cardiovascular hospitalisations (Grubic et al., 2024). Romantic partners, viewed as “hidden patients,” frequently assume caregiving roles in

late adulthood, reflecting Maltese cultural norms (Chakraborty et al., 2023; Cutajar & Camilleri, 2023). While caregiving can be rewarding, it includes demanding tasks like care coordination, monitoring, advocacy, emotional support, and medication management, which can lead to caregiver burden (Kitko et al., 2020; Lee et al., 2020). This aligns with the *Stress Process Model* (Pearlin et al., 1981), suggesting caregiving is a significant stressor that negatively impacts caregiver well-being (Chen et al., 2023b). Stress levels vary based on care needs, recipient impairments, and care duration (George et al., 2020; Stathopoulou & Fragkiadakis, 2023). The *Caregiver Stress Model* (Pearlin et al., 1990) categorises stressors into primary (related to the care recipient's health) and secondary stressors (broader burdens like relationship strain and financial pressures), which can adversely affect caregivers' biopsychosocial and financial well-being (Burger et al., 2020; Freytes et al., 2021).

Physical Implications on Caregivers

Caregiving for a partner with CAD increases responsibilities, leading to physical strain (Huo & Kim, 2023; Turker et al., 2023). Moran et al. (2024) found that 67.8% of caregivers reported physical health issues, including chronic pain and musculoskeletal disorders. Psychological stress due to caregiving demands can trigger cardiovascular responses like hypertension, delay wound healing and compromise immune function (Crielaard et al., 2021; O'Connor et al., 2021). Strained caregivers also have higher mortality rates (King et al., 2021; Pristavec & Luth, 2020). Several models support these physical implications. The *Reactivity Hypothesis* (Krantz & Manuck, 1984) suggests that repeated stress leads to exaggerated cardiovascular reactivity and health issues. The *Diathesis-Stress Model* (Genis-Mendoza et al., 2022) explains disease development through predisposing vulnerabilities and stress. The *General Adaptation Syndrome* (Selye, 1950) describes how stress affects health through alarm, resistance, and exhaustion stages (Chu et al., 2022).

Partners of CAD patients, who are often older and may have their own health issues, experience additional strain (Eriksson et al., 2019; Ketcher et al., 2020). They frequently prioritise their partner's health over their own, which can worsen their health problems (Liu et al., 2024a; Thomson et al., 2020). Leykum et al. (2022) found that up to a third of caregivers rate their health as fair or poor, with deterioration over time.

Caring for a partner with CAD can increase the caregiver's own risk of developing CAD, a phenomenon known as *health concordance,* which is common in married and long-term couples (An et al., 2023; Subih et al., 2020). This aligns with the *Shared Resource Hypothesis* (Smith & Zick, 1994), which posits that shared environments and lifestyles lead to behavioural convergence and shared health risks (Lu & Shelley, 2019).

Psychological Implications on Caregivers

Witnessing a loved one with a life-threatening condition like CAD can cause significant distress, which can surpass that of the general population and sometimes even the patients themselves (Bouchard et al., 2023c; Goldfarb et al., 2022). This distress is particularly pronounced for those caring for partners or children, compared to caregivers of parents or siblings (Li & Lee, 2020; Singh Solorzano et al., 2021).

Anxiety over a partner's health can lead to burnout, marked by emotional exhaustion and depersonalisation (Liao et al., 2022; Min et al., 2020). Anxiety levels are particularly elevated during acute hospitalisations, with 25-30% of caregivers experiencing anxiety-related symptoms six months after their partner's cardiac event, and 25% still affected a year later (Laflamme et al., 2022).

Partners often also experience depression due to their loved one's health (Lacey et al., 2024; Loo et al., 2022). Around 19-38% of caregivers report depressive symptoms during

their partner's hospitalisation, with 14-38% still affected a year later (Laflamme et al., 2022). Depression may present as persistent sadness and concentration difficulties, complicating caregiving (American Psychiatric Association, 2022; Lespine et al., 2023). Caregivers' mental health often worsens with their partner's health, and prolonged distress can result in severe mental health issues, such as major depressive disorder (Bom et al., 2019; Pushkarna, 2023). Depression and anxiety also elevate the risk of developing CAD (Noetel et al., 2024; Zhang et al., 2023).

Caregivers often worry about future care if their partner outlives them (Diaz et al., 2022). Managing complex care needs can lead to cognitive overload (Falzarano & Siedlecki, 2021; Kang et al., 2020). Combined with secondary trauma from medical emergencies, this can impair cognitive functioning and trigger Post-Traumatic Stress Disorder symptoms, like nightmares and hyperarousal (Forkey et al., 2023; Koller et al., 2022).

Women, being more emotionally expressive, often require continuous emotional support, leading male caregivers to experience *compassion fatigue,* as described in *Figley's Compassion Fatigue Process Model* (Figley, 2002). This can cause emotional disconnection, straining social and intimate relationships (Feng & Ivanov, 2023; Monroe et al., 2021). While women traditionally filled caregiving roles, this is changing (LaManna & Loerzel, 2024). Men taking on these roles may feel overwhelmed and unprepared due to the challenges of adapting to new responsibilities (Choi et al., 2024).

Social Implications on Caregivers

Informal caregiving is often regarded as an unanticipated role transition that often disrupts daily life and leads to social withdrawal (Boamah et al., 2024; Hajek et al., 2021). The time-intensive nature of caregiving leaves little room for self-care or leisure, negatively impacting caregivers' psychological and physical health (Loo et al., 2022).

Physical and mental exhaustion elicited from caregiving may cause caregivers to isolate themselves (Niño de Guzmán Quispe et al., 2021). Feelings of guilt about leaving their partner alone or participating in activities without them can lead to declined social invitations (Costa-Font & Vilaplana-Prieto, 2022; Gemito et al., 2024; Howard et al., 2023).

Social isolation is exacerbated when friends, family, and colleagues fail to understand the demands of caregiving, leading to strained relationships, challenges with boundary-setting, and communication difficulties (Blom et al., 2023; Remeshbabu et al., 2023). This often weakens their social support networks (Le & Ibuka, 2023).

Financial Implications on Caregivers

Caring for a significant other with CAD imposes varying economic burdens (Marinho et al., 2022; Turker et al., 2023). In the United States, nearly 4 in 10 (38%) informal caregivers endure moderate to severe financial stress, with 45% facing debt and difficulties affording essentials (Reinhard & Feinberg, 2020). Male caregivers report greater financial strain compared to female caregivers (Willert & Minnotte, 2021).

Caregiving often limits caregivers' ability to maintain paid employment, causing significant financial strain (Lambrias et al., 2023). This may lead to adjustments in work hours or career changes, impacting family income to meet caregiving demands (Le & Ibuka, 2023). In some cases, caregivers may increase work hours to offset a partner's reduced income, leading to guilt over reduced presence (Fransoo, 2018). In advanced cases of CAD, caregivers may need to significantly reduce working hours due to extensive care demands (Lambrias et al., 2023; Liu et al., 2024b). This reflects *Becker's Theory of Opportunity Costs and Time Allocation* (1965), which links the time spent on caregiving to reduced availability for paid work.

Caregivers often face significant distractions and reduced productivity at work due to caregiving-related stress (Wang et al., 2022). They may need to alter their career paths or decline job opportunities if these involve additional responsibilities or relocation (Chen et al., 2023b; Cheng et al., 2023). To cope, some may hire additional help, which increases their financial burden (McHorney et al., 2021).

The Impact of CAD on Romantic Relationships and Caregiving

Well-functioning romantic relationships are essential for well-being but often overlooked in health discussions (Smith, 2022; South, 2023). While having an intimate partner is linked to better CAD management, CAD can destabilise couple dynamics (Dhindsa et al., 2020; Shrout, 2021; Sorber et al., 2022). This strain can triple the risk of myocardial infarction within five years and is associated with more severe atherosclerosis, poorer prognosis, increased risk of recurrent events, and reduced survival rates among CAD patients (Heidari et al., 2020; Smith et al., 2021).

CAD affects couples' connectivity by altering daily routines (Shin et al., 2021; Zhang et al., 2024a). These changes can disrupt shared activities and couple rituals, impacting emotional connections and bonding dynamics (Niedling & Hämel, 2023).

Sexuality is crucial for life satisfaction in adulthood and can impact physical and mental health (Markhus et al., 2023). CAD-related physical and psychological challenges often disrupt sexual health and intimacy, affecting relationship dynamics and marital satisfaction (Niño de Guzmán Quispe et al., 2021; Zhang et al., 2024a). Women with CAD often experience sexual dysfunctions like orgasm disorders, painful intercourse, vaginismus, and decreased lubrication, leading to lower sexual interest and satisfaction (Da Silva et al., 2022; Markhus et al., 2023). These issues can lead to tension in relationships. For men, sexual loneliness can trigger anger, aligning with the *Aggression-Frustration Theory* (Dollard

et al., 1939), which posits that frustration often triggers aggressive behaviour like verbal outbursts or physical aggression (Räsänen, 2023).

CAD undermines relationship quality and positive attitudes towards partners (Bouchard et al., 2021, 2023a). In satisfying relationships, care is often provided out of love, while in strained ones, it may stem from obligation, affecting intimacy, support, and partner roles (Eriksson et al., 2019). Bouchard et al. (2023b) found that relationship quality significantly predicts the quality of life for both patients and partners' post-cardiac event. Similarly, Yu and Zhang (2020) reported that poor relationship quality worsens patients' functional limitations at two-year and four-year follow-ups.

Local Context

In 2020, 2021, and 2023, cardiovascular diseases caused 2,400, 1,230, and 1,168 deaths, respectively (Farrugia, 2025; TVM News, 2023; Zammit, 2022). Locally, CAD is the primary cause of mortality, with 1 in 5 people succumbing to this condition (Cuschieri et al., 2021; Malta Heart Foundation, 2020a). It accounts for 41% of deaths in women and 35% in men locally (Xuereb, 2020). In 2022 alone, CAD caused 1,211 deaths (Balzan, 2024; Farrugia, 2024). This high prevalence is partly due to Malta's leading rates of overweight and obesity in the European Union (European Commission, 2023). CAD rates remain a significant concern, as local death rates are well above the European Union's average (Debono, 2022).

The demographic dynamics of life expectancy in Malta have important implications for gender-specific health management, particularly regarding CAD. Maltese women live 4.1 years longer than men, a gap smaller than the European Union's average of 5.4 years, meaning that women manage CAD symptoms and consequences longer (European Commission, 2023).

Malta offers a robust public healthcare system, providing free healthcare services, including cardiac services, operations and medications to all Maltese citizens, residents and Maltese migrants, financed through general taxation (Briffa & Baldacchino, 2020; Directorate for Pharmaceutical Affairs, 2024).

Cardiac Services for Patients

Locally, cardiac services include the Cardiac Rehabilitation Unit, Sports Cardiology Clinic, and Rapid Access Chest Pain Clinic at Mater Dei Hospital. Additional services are provided by the Cardiac Rehabilitation Service at Gozo General Hospital and Hospice Malta.

Cardiac Rehabilitation Unit. The Cardiac Rehabilitation Unit provides a multidisciplinary program for CAD prevention and rehabilitation, focusing on lifestyle education and risk management. Led by a specialised team, it includes exercise and supports patients recovering from heart attacks, heart failure, stent placements, or implantable cardioverter defibrillators (Government of Malta, 2021a).

Sports Cardiology Clinic. The Sports Cardiology Clinic provides cardiovascular care for athletes with cardiac symptoms, abnormal electrocardiograms, significant family histories, or suspected heart disease (Government of Malta, 2021b). It provides evaluations using echocardiography, Holter monitoring, and cardiopulmonary exercise testing (Government of Malta, 2021b).

Rapid Access Chest Pain Clinic. The Rapid Access Chest Pain Clinic aids CAD diagnosis and management by treating patients with anginal chest pain, offering comprehensive evaluations, diagnostic tests, and management plans (Sultana & Sciberras, 2022).

Cardiac Rehabilitation Service. Gozo General Hospital offers an 8-week cardiac rehabilitation program for patients recovering from heart attacks, stent insertions, bypass or

valve surgeries, and heart failure. It includes a pre-assessment with CAD education and risk evaluation, a tailored exercise regimen, and a post-assessment to address ongoing concerns.

Hospice. Hospice, a non-governmental organisation, provides palliative care for patients with end-of-life conditions, including cancer, motor neuron disease, and end-stage cardiac, respiratory, renal, and liver diseases, along with family support (Azzopardi, 2020; Hospice, 2024). Their multidisciplinary team offers palliative and home care, day therapy, hydrotherapy, respite care, transport, equipment loans, after-hours support, psychological services, and bereavement support (Hospice, 2024).

Rationale for Conducting this Study and Expected Contribution to the Field of Psychology

Despite longer life expectancy, women face rising CAD prevalence with age (Liu et al., 2022). Additionally, women remain underrepresented in clinical trials despite higher mortality (Poitras et al., 2021; Tobb et al., 2022). This has led to CAD being under-researched, underdiagnosed, and undertreated in women (Reza et al., 2022; Wu et al., 2023). Moreover, local research in the past four years has primarily focused on medical aspects, diagnostics and treatment of CAD (Bezzina, 2021; Montebello, 2022; Tewma, 2021), with limited attention to its biopsychosocial impact on women (Felice, 2014; Xuereb et al., 2016). HRQoL research in women with CAD is sparse but essential, as enhancing the HRQoL is as important as prolonging survival (Dou et al., 2022; Hutchens et al., 2022).

This research addresses these gaps by examining CAD’s impact on women's HRQoL through a biopsychosocial lens. Furthermore, the impact of CAD on caregivers' health and relationship dynamics has been underexplored (Smith, 2022; Tulloch et al., 2020). This research will offer insights into how CAD affects caregivers' biopsychosocial aspects and relationships.

Theoretical Frameworks

In line with the study's aims and objectives, this research draws on two theoretical frameworks: the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) and *Rolland's Family System Illness Model* (1994).

Dynamic Biopsychosocial Model

The *Dynamic Biopsychosocial Model* (Lehman et al., 2017) integrates *Engel's Biopsychosocial Model* (1980), *Bronfenbrenner's Ecological Theory* (1979), and *Sameroff's Transactional Model* (1975), providing a comprehensive framework for understanding CAD in postmenopausal women and their partners (Singh & Dhanoa, 2022). It conceptualises CAD as the evolving interaction of biological, psychological, and interpersonal factors (Pattnaik et al., 2023).

Biological dynamics involve physiological processes like inflammation and vascular function, contributing to atherosclerosis and CAD's physical impact (Achim et al., 2023; Portelli, 2021; Roberts, 2023). These factors fluctuate over time, affecting management and outcomes.

Psychological dynamics encompass mental, affective, drive-related, and action-oriented processes influencing health (Vroegindeweij et al., 2023). This dimension explores illness perception, stress management, and mental health, with factors like depressive symptoms, stress appraisal, illness schemas, and self-concept, which significantly influence health management and adherence (Hussain et al., 2021). CAD can also lead to evolving psychological challenges, affecting coping strategies.

Interpersonal dynamics reflect the impact of social interactions on health outcomes (Lehman et al., 2017). According to *Bronfenbrenner's Typology* (1979, 1986), this includes

direct interactions and the broader consequences of others' behaviours. Positive social interactions can enhance emotional well-being and provide crucial support during health crises, while social isolation and strained relationships can increase stress and hinder recovery (Syed et al., 2020). Understanding these dynamics is essential for understanding how CAD impacts postmenopausal women, their partners, and intimate relationships (Akyirem et al., 2022; Tomás et al., 2023).

Rolland's Family System Illness Model

CAD, requires lifelong management, becoming central to family identity (Larsen, 2009). The *Rolland Family Systems Illness* (FSI) *Model* (1994) integrates family systems theory and medical perspectives, using a biopsychosocial lens to explore the evolving interplay between illness, individual and family dynamics (Rolland, 2005).

The *FSI Model* (Rolland, 1994) focuses on three key aspects: 1) psychosocial types of illness and disability, 2) significant stages in the illness progression, and 3) critical family system factors (Rolland, 2020).

Illnesses are categorised by onset (abrupt or incremental), course (constant, progressive, or intermittent), and outcome (lethal or life-limiting), influencing their impact on the family (Rolland, 1999). The *FSI Model* (Rolland, 1994) outlines three phases of illness experience: crisis phase (initial diagnosis and shock), chronic phase (long-term adaptation and uncertainty), and terminal phase (end-of-life issues) (Rolland, 2020). CAD features an incremental onset, progressive course, potentially lethal outcome, and is disabling, presenting unique psychosocial challenges in each phase.

The *FSI Model* (Rolland, 1994) examines how developmental stages and cultural, spiritual, and gender-related beliefs affect illness perception and caregiving (Rolland, 2018).

It also acknowledges key family system variables, including family structure, communication, and individual roles that influence coping (Rolland, 2005).

Conclusion

This chapter covered the pathogenesis of CAD and gender intersectionality, and the biopsychosocial impacts on patients and caregiver partners, including intimate relationships. It reviewed local statistics, available services for CAD patients, the study's rationale and its anticipated contributions to psychology and theoretical frameworks. The subsequent chapter will outline the study's methodology and research instruments.

Chapter 3

Methodology

This chapter details the study's methodology, including research questions and aims, design, tools, participant recruitment, piloting, and data analysis. It concludes with ethical considerations and measures for ensuring trustworthiness, credibility and reflexivity.

Research Questions and Aims

This research is being presented because, at the time of writing, and to the author's current knowledge, there are limited local studies addressing the impact of CAD on the quality of life of post-menopausal women diagnosed with the condition and their partners. Therefore, this study endeavours to bridge the identified gap within the local context.

The research question guiding this study was: "What are the holistic biopsychosocial implications of coronary artery disease on the quality of life of postmenopausal women and their partners?"

The main research question was subsequently broken down into two core sub-questions:

1. How does coronary artery disease affect postmenopausal women's life satisfaction and psychological well-being?
2. What implications does coronary artery disease have on the partners of post-menopausal women?

To address these questions, the research examined the biopsychosocial impacts of CAD on post-menopausal women and their partners, focusing on their coping strategies, perceptions of services, and potential improvements from the service users' perspective.

Research Design

"If there were only one truth, you couldn't paint a hundred canvases on the same theme" (Picasso, 1966, p. 5).

Over the past fifteen years, qualitative research has grown in psychology (LaMarre & Chamberlain, 2022; Levitt et al., 2021). Defined as "the study of natural phenomena" (Busetto et al., 2020, p. 1), it provides a holistic view of human dynamics (Mwita, 2022a; Tümen-Akyıldız & Ahmed, 2021). This approach explores individuals' experiences through open-ended questions, focusing on the "how," "what," and "why," unlike quantitative research, which focuses on "what" or "how often" (Oranga & Matere, 2023; Xiong, 2022). It captures rich data critical for understanding CAD's nuanced impacts (Bazen et al., 2021; Muzari et al., 2022). Moving from post-positivist to interpretive and constructivist paradigms, qualitative research prioritises subjectivity and interpretation (Mattimoe et al., 2021). Given the aims of this research, a qualitative approach was deemed most suitable for this research.

Thematic Analysis

Thematic Analysis is defined as "a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). It can be approached in two ways: *small q* and *Big Q*. *Small q* follows a positivistic framework with pre-existing themes and coding reliability, while *Big Q* adopts a constructivist, interpretative approach, allowing flexible coding and theme construction shaped by the researcher's reflexivity (Braun & Clarke, 2024a).

Philosophical Underpinnings

The researcher's epistemological stance influences Thematic Analysis's effectiveness and research quality (Ozuem et al., 2022). Key epistemologies in qualitative research include (post)positivism, contextualism, and constructionism (Braun & Clarke, 2019, 2022a). This

study adopted a contextualist approach aligned with *Big Q* Thematic Analysis to explore CAD's biopsychosocial impacts on post-menopausal women and their partners, enabling diverse interpretations shaped by societal factors (Braun & Clarke, 2022b).

Reflexive Thematic Analysis. Braun and Clarke revised their 2006 framework, clarifying that Thematic Analysis is an umbrella term rather than a single method (Braun & Clarke, 2021a, 2021b). They identified three approaches: codebook analysis, coding reliability, and *reflexive thematic analysis* (RTA) (Wiltshire & Ronkainen, 2021). *RTA* identifies themes as patterns of meaning, emphasising researcher reflexivity and interpretative coding, aligning with *Big Q* qualitative research (Finlay, 2021). This approach was chosen for its compatibility with the researcher's contextualist stance and the study's nature.

Rationale for Reflexive Thematic Analysis. *RTA* is extensively used in psychology for exploring recurring themes and interrelating subjective concepts across datasets (Squires, 2023). It helps uncover underlying notions generating rich insights into complex, under-researched topics, making it well-suited for this study (Campbell et al., 2021; Lochmiller, 2021).

Research Tools

Qualitative researchers see reality as subjective, shaped by individual experiences and cultural contexts (Naz et al., 2022). Interviews, commonly used in social sciences, enable in-depth exploration of these interpretations (Dursun, 2023; Mwita, 2022b).

Single Question aimed at Inducing Narratives

The *Single Question aimed at Inducing Narratives* (SQUIN) interviews were chosen for data collection from post-menopausal women and their partners (Appendix A & B).

SQUIN, developed by Wengraf and Chamberlayne, effectively explores complex life experiences (Kutsyuruba & Mendes, 2023). It uses one open-ended question to elicit detailed responses, with the researcher remaining silent (Peta et al., 2022). Up to two additional interviews may be conducted for clarification and probing (Moran et al., 2022). In this study, two interviews were conducted with each participant on separate days due to the intensive nature of the information disclosed, allowing time for reflection and further clarification.

Rationale for using SQUIN. Interviewer interjections can disrupt holistic narratives, but the *SQUIN* method preserves this by using open-ended responses to reveal individuals' experiences (Wengraf & Chamberlayne, 2007). *SQUIN* encourages researchers to relinquish control and practice active listening, facilitating participant-led interviews (Mooney, 2020). Unlike structured interviews, *SQUIN* empowers participants, avoids emotional triggers, and enhances the study's quality (Wengraf, 2001). The author chose *SQUIN* as it aligns with her role as a health psychology trainee and supports a participant-focused approach.

Sampling Strategy

This study employed purposive sampling to recruit post-menopausal women with CAD who met specific criteria, ensuring the research question was addressed and enhancing the findings' credibility and trustworthiness (Nyimbili & Nyimbili, 2024).

Tulloch et al. (2020) emphasised triangulation for a comprehensive perspective when conducting qualitative research. This insight prompted the decision to include the male partners of interviewed post-menopausal women. To access hard-to-reach participants, Gierczyk et al. (2023) and Pasikowski (2023) recommend snowball sampling. Thus, this method was used to contact the male partners, with the women sharing the researcher's contact information. Permission was obtained from both parties before the interviews; if a

partner declined, the corresponding interview with the woman was not conducted and vice versa.

While there is no universally ideal sample size for *RTA*, qualitative studies often use small samples for depth (Bekele & Ago, 2022). In this study, five post-menopausal women with CAD and their partners were interviewed, amounting to a total of 20 interviews. Two interviews were conducted online, while the rest were face-to-face. All participants were English-speaking.

Participant Recruitment

Following ethical clearance from the University of Malta's Faculty Research Ethics Committee, the researcher contacted Gozo General Hospital and Mater Dei Hospital. At Gozo General Hospital, the Chief Executive Officer connected the researcher with a Practice Nurse as an intermediary, while at Mater Dei Hospital, the Deputy Clinical Chairperson designated a Senior Staff Nurse. Approvals are detailed in Appendix C. Intermediaries received information letters, and consent forms in Maltese and English for distribution (Appendix D & E). At Gozo General Hospital, participants contacted the researcher directly, while at Mater Dei Hospital, communication was managed through the intermediary per hospital policy.

Inclusion Criteria. Inclusion criteria are crucial for methodological rigour and must align with the study's research question and objectives (Benbow et al., 2022). Clearly defining and justifying these criteria ensures transparency (Balla & Dimitropoulos, 2022; Knott et al., 2022).

Participants had to meet specific inclusion criteria. Women diagnosed with CAD were selected, as CAD is a leading cause of death among women but remains under-researched

(Babahajiani et al., 2023). Post-menopausal women needed to be between 55–70 years due to the increased CAD risk associated with declining oestrogen levels, providing a high-risk sample (Aïdoud et al., 2023; Ryczkowska et al., 2023). For male partners, the inclusion criterion specified being male to explore gender differences, as men are often perceived as less emotional and more analytical and are often key supporters during symptom onset and diagnosis (Agung & Putri, 2023). Their involvement offers insights into CAD's progression and aids triangulation (Ahmed, 2024; Kowalski et al., 2023). Both groups needed to provide informed consent, agree to audio recordings, and be capable of answering interview questions, ensuring methodological rigour and data accuracy (Hill et al., 2022).

Piloting

Pilot studies are crucial for assessing the feasibility of research design and methodology (Shakir & ur Rahman, 2022). They help identify issues, refine tools, and ensure question clarity, enhancing the study's credibility (Morin, 2023; Ullah et al., 2023). This study conducted a pilot with a post-menopausal woman with CAD and her partner. Feedback confirmed that the *SQUIN* approach elicited in-depth responses. No changes were made to the interview guide, as it was effective for gathering rich, relevant data. The pilot interviews were included in the results with participants' consent.

Data Analysis

> "Data analysis is conceptualised as an art not a science where creativity is central to the process, within a framework of rigour" (Braun & Clarke, 2022b, p. 7).

Data analysis is crucial in qualitative research (Dierckx de Casterlé et al., 2021). *RTA* requires choosing between constructionist and experiential orientations (Bryne, 2022). This study employed an experiential approach to interpret participants' experiences within their

social contexts, aligning with a contextualism-experiential perspective (Braun & Clarke, 2012, 2024b).

This study utilised Braun and Clarke's (2022a) framework for its systematic and widely recognised method, facilitating data understanding and research rigour (Naeem et al., 2023). The six phases are recursive and iterative, allowing movement between stages as needed (Braun & Clarke, 2021a). The phases outlined by Braun and Clarke (2022a) are as follows:

Data Familiarisation

The researcher manually transcribed interviews verbatim, facilitating familiarisation (Ayton, 2023a). Transcripts were cross-checked with audio recordings for accuracy (Cristou, 2023) in line with Braun and Clarke's (2006) Thematic Analysis criteria (Appendix F). Familiarisation involved multiple readings of transcripts and noting initial ideas (Cernasev & Axon, 2023). While Braun and Clarke (2006) recommend reading transcripts once before coding, each was read three times for a thorough analysis.

Coding

The researcher began coding to summarise dense text, identify patterns, and uncover underlying ideas (Byrne, 2022). Naeem et al.'s (2023) six R's coding strategy (robust, reflective, resplendent, relevant, radical and righteous) was used to ensure comprehensive data coverage (Appendix G), aligning with Braun and Clarke's (2006) Thematic Analysis criteria (Appendix F). This step was crucial for identifying elements relevant to the research questions (Naeem et al., 2023). An inductive coding approach, consistent with the *Big Q* qualitative paradigm, was employed to provide a contextually grounded understanding of CAD's biopsychosocial impacts, given limited local research (Bingham, 2023).

An iterative coding approach, involving multiple readings for accuracy, was used to enhance trustworthiness (Kraiwanit et al., 2023). The dataset was reviewed three times for accuracy. Coding was guided by the research questions, a contextualism-experiential approach, and dataset interpretations, conducted solely by the researcher, as per standard *RTA* practice (Braun & Clarke, 2022b).

Coding was performed using NVivo, with transcripts prepared as Word documents and uploaded into the software (Ronzani et al., 2020). NVivo (Version 14) was chosen for its user-friendly interface and efficient data management, making it ideal for analysing extensive interview data such as in this case (Fitkov-Norris & Kocheva, 2023). It facilitates information retrieval, reduces data loss, and enhances research rigour, though it cannot replace the researcher's role in meaning assignment (Paulus, 2023).

Generating Initial Themes

The researcher compiled codes and searched for themes reflecting key data insights. To ensure coherence with research aims, the 4Rs of theming (reciprocal, recognisable, responsive, and resourceful) were applied (Naeem et al., 2023) (Appendix H). Themes in *RTA* can be semantic or latent, deductive or inductive (Proudfoot, 2023). A latent-level, inductive approach was used to uncover underlying ideas beyond surface meanings, allowing the data to shape the themes in a bottom-up, data-driven manner (Bihu, 2024; Braun & Clarke, 2020). The themes emerged through the researcher's active involvement with the data, guided by her values (Braun & Clarke, 2022b). This is effective for exploring novel phenomena (Clarke & Braun, 2017) and aligns with criterion 15 of Braun & Clarke's (2006) Thematic Analysis checklist (Appendix F).

Developing and Reviewing Themes

After developing initial themes, the researcher refined them in two stages: reviewing themes within individual transcripts and across the entire dataset (Dawadi, 2021). This ensured internal homogeneity within themes and external heterogeneity across themes, meeting criterion six of Braun and Clarke's (2006) Thematic Analysis checklist (Appendix F) (Cernasev & Axon, 2023). The researcher re-read and cross-referenced the themes to ensure they represented the dataset's overall narrative (Braun & Clarke, 2006). A thematic map was created to show relationships between codes and themes, with ongoing revision due to the organic coding process (Christou, 2023).

Refining, Defining and Naming Themes

The researcher reviewed, refined, and defined themes to capture their essence and enhance the findings' credibility (Braun & Clarke, 2006). Hierarchical structures within themes were assessed to ensure an organised narrative, aligning with criterion nine of Braun and Clarke's (2006) Thematic Analysis checklist (Appendix F) (Kiger & Varpio, 2020). Extracts were selected to illustrate each theme's concept (Byrne, 2022). A short excerpt from an analysed transcript can be found in Appendix I.

Writing up

The researcher began the analysis and discussion phase, described by Freeman & Sullivan (2019, p. 180) as bringing "the analysis to life for the reader." This chapter presented a coherent narrative, supported by extracts demonstrating thematic cohesion (Ayton, 2023a). It outlined the process from identifying patterns to deriving broader implications, addressing research questions and summarising participants' experiences (Jowsey et al., 2021). The stages were used to cross-analyse interviews with post-menopausal women with CAD and their partners, forming basic, organising, and global themes (see Figure 1, Chapter 4). The

Dynamic Biopsychosocial Model (Lehman et al., 2017) and *Rolland's Family System Illness Model* (1994) guided data collection and analysis.

Ethical Considerations

Ethical approval is crucial for studies involving human participants and must be obtained before participant contact (Sadeghi & Smith, 2024). Adhering to ethical practices ensures credibility and integrity (Wa-Mbaleka, 2019). This study received approval from the University of Malta's Faculty Research Ethics Committee (Appendix J). Before the interviews, the researcher reviewed the information sheet and obtained written consent, a "cornerstone of research ethics" (Xu et al., 2020, p.1). The consent form outlined the research purpose, participant criteria, and involvement (Zhang et al., 2024b).

Protecting participants' rights is essential in qualitative research (Putra, 2023). The researcher adhered to the Malta Psychology Profession Board's Code of Ethics and General Data Protection Regulations to minimise risks. Participants were notified of their voluntary involvement and right to withdraw (Potthoff et al., 2023a).

The researcher also involved participants in decision-making, mainly interview logistics and feedback on the interview guide highlighting the importance of research partnership (Potthoff et al., 2023b). Confidentiality was maintained through pseudonyms and unidentifiable quotes (Tolich & Tumilty, 2020). Participants were grounded after the interview and provided with information on support services if needed (Appendix K).

Participants had the option to receive transcripts via email or registered mail and had four weeks to review and amend them, ensuring data accuracy (Carcary, 2020). Finalised transcripts led to the permanent deletion of encrypted recordings from the researcher's password-protected computer accessible only by the researcher. Consent forms were stored in

a locked cabinet and disposed of after the study's completion. Throughout interactions, the researcher ensured empathy, respect, and cultural sensitivity (Muthanna & Alduais, 2023).

Credibility and Trustworthiness

Trustworthiness is crucial in qualitative research to ensure credibility and preserve the phenomenon's complexity (Vella, 2024). Frameworks by Lincoln and Guba (1985) and Yardley (2000) enhanced the study's rigour and credibility. Yardley (2000) identified four dimensions of research quality: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Lincoln and Guba (1985) outlined five strategies for establishing trustworthiness: credibility, transferability, dependability, confirmability, and authenticity.

Sensitivity to context, as per Yardley's criteria (2000), aligns with Lincoln and Guba's (1985) authenticity. This was addressed by using recent literature and considering the local context of Maltese participants' perspectives, with the researcher's psychology background aiding in crafting questions.

Yardley's criterion of commitment and rigour, aligned with Lincoln and Guba's (1985) credibility, was achieved through triangulation and member checking (Ayton, 2023b). Member checking, where participants verified transcript accuracy, ensured findings reflected their perspectives (McKim, 2023). Denzin (1978) identifies four types: researcher, theoretical, methodological, and data (Coleman, 2022). This study used data triangulation, incorporating themes from both partners to provide diverse perspectives, identify patterns and ensure a comprehensive understanding of CAD's biopsychosocial implications (Vivek et al., 2023).

Yardley's (2000) criterion of transparency and coherence aligns with Lincoln and Guba's (1985) dependability and confirmability. Dependability and transparency were achieved by detailing procedures and decisions throughout data collection and analysis (Adler, 2022). Coherence was ensured through consistent research questions, aims, and frameworks. Confirmability, ensuring findings reflect participants' experiences, was achieved by including direct quotes and implementing reflexivity, discussed further in the next section (Armour & Williams, 2023).

Yardley's (2000) principle of impact and importance aligns with Lincoln and Guba's (1985) principle of transferability, ensuring findings are relevant to similar contexts. This study achieved transferability by providing contextual participant data (Kakar et al., 2023). To enhance impact and importance, participant feedback was used to identify service improvements, increasing the practical relevance of the findings (Yardley, 2000).

Reflexivity

In *RTA*, reflexivity is critical, especially during coding, theme development, and data interpretation (Bright et al., 2023; Morgan, 2022). To ensure reflexivity, I kept a reflexive journal to deepen engagement (Enworo, 2023; Lee-Johnson et al., 2023), following the guidance of Guba and Lincoln (1982), Karcher et al. (2024), and Braun and Clarke (2022a).

The journal enhanced creative data engagement and streamlined analysis, enabling a critical review of my assumptions and deepening data understanding (Jamieson et al., 2023; Kimberley, 2021). This helped prevent interpretations from being overly influenced by pre-existing views, crucial in *Big Q* research (Braun & Clarke, 2024b; Naeem et al., 2023). Reflective journaling, a quality-enhancing strategy in *Big Q*, aligns with *RTA*'s perspective of researcher subjectivity as an important asset (Braun & Clarke, 2023).

I engaged in structured reflection throughout the research, categorising it into key domains (Olmos-Vega et al., 2023; Summers et al., 2024). First, personal reflections focused on my motivations for choosing the topic, my values, and how my background could influence my perspective. I examined my assumptions, biases, and emotional responses, allowing for ongoing evaluation of how my context shaped my understanding and analysis (Ahmed, 2024; Sirris, 2022).

In the second domain, interpersonal reflections, I focused on the dynamic relationship between myself and the participants. I explored how my role, interactions, and the social context of our encounters might have influenced the participants' responses and generated data. This helped me identify and address any power imbalances that could affect the authenticity of their narratives (Aguilar-Solano, 2020; Ayton, 2023b). To mitigate this, I built rapport, adopted a non-hierarchical, non-judgemental and empathetic approach, and used open-ended questions to encourage authentic self-expression while allowing participants to guide the discussion's pace and direction.

Methodological reflections focused on my decisions regarding research design and data collection. I critically assessed how choices, like selecting specific methods and frameworks, influenced the research outcomes and what implications these decisions had on the findings' validity and interpretation (Busetto et al., 2020).

Lastly, contextual reflections accounted for societal, cultural, and environmental factors influencing both participants and the research. Recognising these external influences helped me understand how gender norms, cultural expectations, and health system limitations may have shaped participants' narratives and the overall study (Johnson et al., 2020).

Conclusion

This chapter outlined the research design, tools, sampling, recruitment and piloting, data analysis, ethical considerations, credibility, trustworthiness and reflexivity. The next chapter will present the interview findings, comparing the perspectives of post-menopausal women with CAD and their partners with existing literature.

Chapter 4

Findings and Discussion

This chapter details the findings for the primary research question: “What are the holistic biopsychosocial implications of coronary artery disease (CAD) on the quality of life of postmenopausal women and their partners?” This question was further divided into two specific inquiries: “How does coronary artery disease affect postmenopausal women's life satisfaction and psychological well-being?” and “What implications does coronary artery disease have for the partners of postmenopausal women?” This chapter analyses themes from the interviews, relating them to existing literature.

Demographic Characteristics

This section outlines the demographic and background information of postmenopausal women with CAD and their partners, who also served as primary caregivers. The study included 20 interviews with five women aged 55–68 and their partners aged 57–67. Table 1 presents a summary of their demographic details.

Table 1

Profiles of Post-Menopausal Women With Coronary Artery Disease and Their Partners

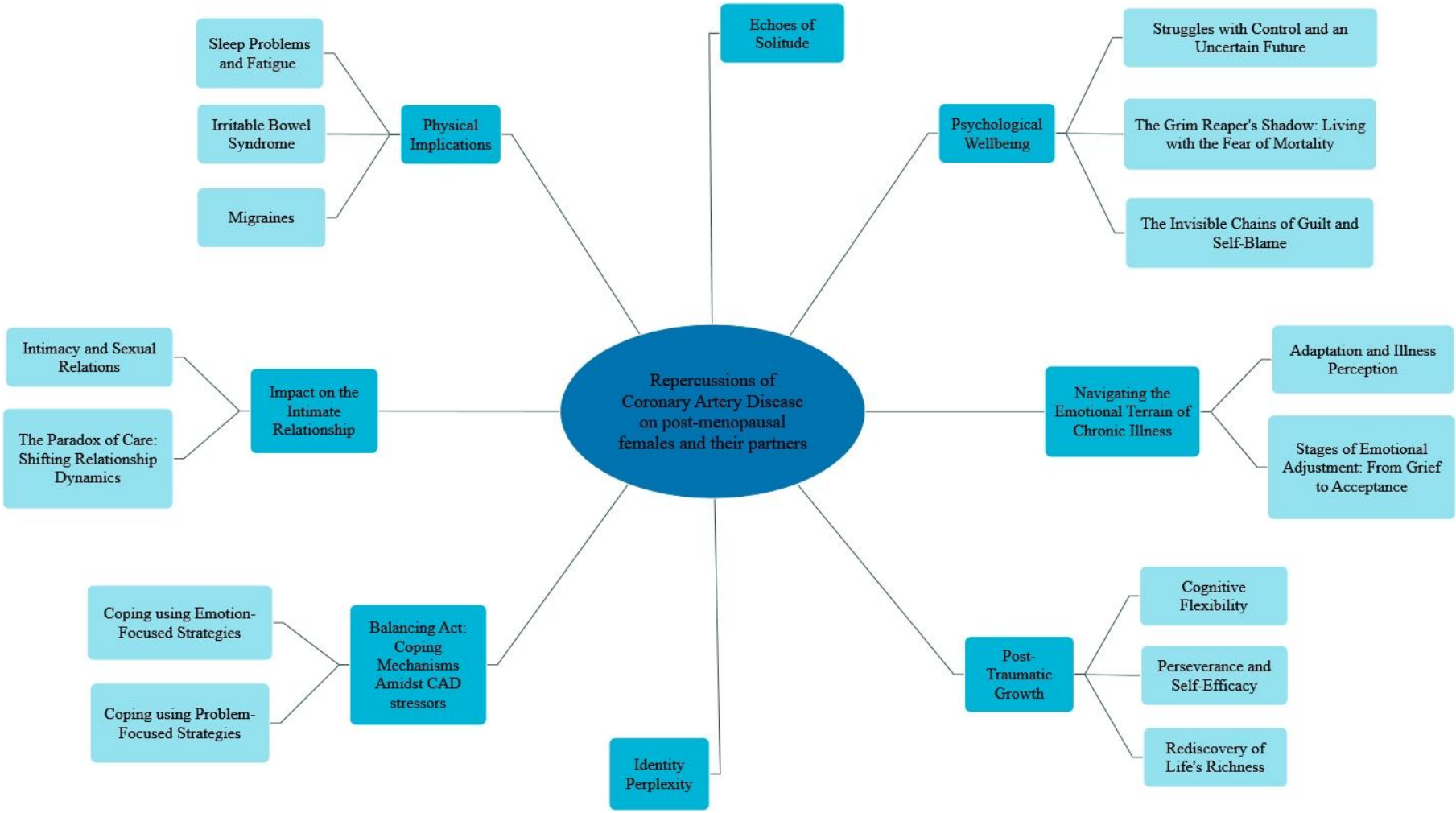
Pseudonym	Age	Brief Background Overview	Pseudonym	Age	Brief Background Overview
Clara	55	She was diagnosed with CAD two years ago after sudden leg weakness, blackouts, and indigestion.	Thomas	57	A construction worker who has been married to Clara for 20 years.
Olivia	59	She was diagnosed with CAD two years ago after back pain she attributed to lifting. Fearing job loss, she delayed seeking help. She also has type 1 diabetes, hypothyroidism, osteoporosis, and hypercholesterolemia.	Henry	60	A maritime worker married to Olivia for 25 years.
Josephine	62	She was diagnosed with CAD three years ago after persistent fatigue and dizziness, initially	Edward	65	A lawyer who has been with Josephine for 40 years.

		mistaking them for the flu. She also has hypertension and battles obesity.			
Elizabeth	65	She was diagnosed with CAD four years ago after experiencing dizziness and vomiting. Fearing a fate like her father's, who died of a myocardial infarction, she delayed seeking help.	Jack	63	He works in healthcare and has been married to Elizabeth for 30 years.
Diana	68	She was diagnosed with CAD five years ago after an echocardiogram due to her family history of heart disease. Recently underwent angioplasty for a critical blockage. She has asthma, hypothyroidism and hypertension.	Albert	67	He runs a family business and has been with Diana for 43 years.

Figure 1 illustrates the thematic map, showing the global, organising, and basic themes identified in the analysis. These themes, reflecting the shared experiences of postmenopausal women with CAD and their partners, will be explored in depth in the sections that follow.

Figure 1

Thematic Map of the Global, Organising and Basic Themes



Physical Implications

As highlighted in the literature review, CAD leads to significant stress for both patients and caregivers (Gill et al., 2023; Moazzami et al., 2023). The *Hypothalamus-Pituitary-Adrenal axis* and sympathetic nervous system are crucial for stress management (Simmons et al., 2024). *Allostatic Load Theory* (McEwen & Stellar, 1993) links chronic stress to cortisol and adrenaline surges, leading to physiological damage (James et al., 2023; Juster & Misiak, 2023). Participants identified three physical issues related to CAD-induced stress: 1) Sleep Problems and Fatigue; 2) Irritable Bowel Syndrome and 3) Migraines.

Sleep Problems and Fatigue

Sleep is vital for health (Badri et al., 2023; Kudrnáčová & Kudrnáč, 2023). Sleep also regulates functions like the circadian rhythm (Baranwal et al., 2023; Feingold & Smiley, 2022). Disruptions can cause circadian misalignment and insomnia (Honma et al., 2020; Poza et al., 2022).

Insomnia affects 36% to 45% of CAD patients, often due to anxiety (Al Maqbali et al., 2022; Frøjd et al., 2023). Consistent with research, CAD patients and partners reported insomnia characterised by disruptions in sleep onset, sleep continuity or experiencing poor-quality sleep (Cooper et al., 2022; Sugawara et al., 2023). Women described their nights as “torture” (Diana), “a nightmare” (Elizabeth), and “a test of endurance” (Josephine). Partners saw the bed as “a place of despair” (Albert), “a prison” (Edward), and “a battleground” (Jack). Insomnia causes severe fatigue, impairing daily functioning (Chatzinikolaou et al., 2021; Kang et al., 2020). Olivia said, “it feels like I’m missing out on life,” Diana called her fatigue “debilitating and a constant battle,” and Josephine felt “drained all the time … a struggle to keep up with daily life.” Clara said, “I can’t find the energy to do anything,” and Elizabeth described being “exhausted all the time.” Diana recounted cutting her hand while

washing a blender due to fatigue. Fatigue is considered a major burden in CAD (Goërtz et al., 2021).

Fatigue also affected interviewed partners and increased the risk of injury, particularly in physically demanding jobs (Cunningham et al., 2022). “I almost fell from a construction site” (Thomas), “I slept and realised I was steering my boat into a rock” (Henry) and “I almost fell off a ladder at work” (Albert).

The metaphorical descriptions, like nights as torture, reveal how insomnia erodes the comfort of rest. For patients and caregivers, the impact goes beyond discomfort, affecting daily life and increasing safety risks, as fatigue impairs attention and coordination. Fatigue deepens the burden of CAD, undermining well-being and independence. These insights stress the need to prioritise sleep interventions for both patients and partners. Health psychologists can help by providing evidence-based interventions, such as sleep hygiene education and stress reduction techniques, to improve sleep and quality of life.

Irritable Bowel Syndrome

Stress from CAD can disrupt the *Gut-Brain Axis*, affecting the autonomic nervous system, the *Hypothalamus-Pituitary-Adrenal* axis, and the gastrointestinal network (Alzubide & Alhalafi, 2024; Toader et al., 2024). *Hypothalamus-Pituitary-Adrenal* axis activation triggers pro-inflammatory cytokines, weakening the intestinal barrier and increasing inflammation (Mayer et al., 2022; Ye et al., 2024). This chronic inflammation can alter gut microbiota, contributing to Irritable Bowel Syndrome (Ancona et al., 2021; Peppas et al., 2021). Consistent with existing research Olivia, Clara, and Diana reported symptoms commonly presented with Irritable Bowel Syndrome, such as “abdominal pain,” “bloating and constipation,” and “diarrhoea” respectively (Bhinder et al., 2023; Snijkers et al., 2024).

Caregiver distress can contribute to Irritable Bowel Syndrome (Zand et al., 2020). “Since becoming a caregiver, I’ve struggled with frequent digestive problems” (Jack), “Worrying about Olivia’s health triggers stomach pains that intensify with stress” (Henry), “I've developed stomach symptoms I never had before” (Albert), “The more stressed I am about caregiving, the worse my digestive issues become” (Thomas) and “Since becoming a caregiver, my gut health has changed in ways I never expected, despite my high-stress career” (Edward).

Beyond physical discomfort, digestive symptoms drastically influence everyday activities and quality of life (Goodoory et al., 2022). Participants shared how unpredictable issues disrupted routines, limiting work and socialising. “I tend to stay at home fearing that I might need to use the bathroom if I go out” (Olivia), “I can’t go out for long periods because I’m afraid of not being near a bathroom” (Diana) “I feel embarrassed when I have to ask shopkeepers if I can use their bathroom” (Clara), “My digestive issues make it hard to focus at work” (Jack), “I hate when my stomach acts up… being out on the boat means I can’t just run to a bathroom” (Henry), “because of my stomach issues it's hard to fall asleep,” (Albert) and “I want to sleep but have to get up at night to use the bathroom, leaving me with little energy for work in the morning” (Thomas).

Participants’ struggles with digestive issues highlight how stress manifests physically and increases helplessness. The unpredictability of gut symptoms intensifies distress, creating a cycle where stress and discomfort reinforce each other. These experiences emphasise the physical, psychological, and social toll of stress-induced gastrointestinal issues, stressing the importance of comprehensive approaches that tackle both symptoms and their impact on daily life.

Migraines

Migraines, associated with CAD-related distress and caregiver burden, are intense headaches that persist from 4 to 72 hours, often followed by queasiness, vomiting, and light sensitivity (Fernández-Bermejo et al., 2023; Kalkman et al., 2023). Women are three to four times more likely to experience them than men (Edelstein, 2022; Pirthiraj & Bhagwan, 2023). In this study, two women with CAD reported migraines: Diana described "throbbing that wouldn't subside … like a van ran over me," while Elizabeth expressed "When I get migraines, certain smells make me feel nauseous."

Conversely, all partners of CAD patients reported migraines, supporting the *Psychosomatic Theory*, which links psychological stress to physical symptoms (Okumura et al., 2020; Taylor, 2022). "About a month after my wife's diagnosis I began to experience severe headaches" (Thomas), "Stress causes intense headaches which impair my vision" (Henry), "The added responsibilities affected me more than I care to admit… I thought I was having a stroke when the migraine occurred" (Albert), "Thinking about everything I need to do makes my head feel like it's about to explode" (Edward) and Jack recalled, "Struggled to avoid vomiting, especially while working around chemicals."

Migraines are highly debilitating and a leading cause of workplace absenteeism (Battista et al., 2023; Kwon et al., 2023). "I took numerous sick days and rescheduled appointments during severe episodes" (Jack). Thomas said, "I stay home for my wife because I can't bear to think of what might happen if I get hurt." Missing work brings financial strain, increasing stress and making it harder to meet obligations. This financial pressure exacerbates their sense of instability, further affecting their overall well-being.

Despite the severity, three partners continued working. "I need to go to work no matter what because I don't have a guarantee the weather will be good when they [migraines]

pass" (Henry), "It's not always possible to reschedule my clients due to court, so I pushed through the discomfort" (Edward) and "Although I have the flexibility to stay home, everything depends on me at the shop" (Albert).

Notwithstanding the debilitating nature of migraines, some caregivers continued prioritising their responsibilities over their health, raising concerns about the hidden costs of caregiving. At what point does resilience turn into self-neglect? This highlights the need for better awareness and support to address the health consequences caregivers face, ensuring they are not left to suffer in silence.

Psychological Wellbeing

The literature review, alongside the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) and *Rolland's Family System Illness Model* (1994), highlights that CAD significantly impacts the psychological well-being of both patients and caregivers (Huang et al., 2023; Sugiharto et al., 2024). The interviews revealed three primary themes: 1) Struggles with Control and an Uncertain Future; 2) The Grim Reaper's Shadow: Living with the Fear of Mortality; and 3) The Invisible Chains of Guilt and Self-Blame.

Struggles with Control and an Uncertain Future

CAD often results in a perceived loss of control (Priorello & Arbona, 2024; Raz et al., 2023). "My condition makes me feel like I am a passenger in my own body … like I'm no longer in control" (Clara), "My body is betraying me and I'm powerless against it" (Josephine), "I used to make my own decisions, but now it feels like the disease controls me" (Diana) and "Due to the unpredictable nature of my condition, I feel like I lost control over myself" (Olivia). This loss of control was also prevalent in the partners. "It feels like everything is dictated by the disease; I no longer make the decisions" (Edward), "The illness has taken charge; every decision we make is now shaped by what it requires" (Jack), "My

plans and priorities take a backseat to its [CAD] needs" (Albert). These experiences show that CAD fosters a constant state of reaction, where plans and desires are subordinated to the disease's needs (Van Wilder et al., 2021). This aligns with the *Deterioration Model* (Ensel & Lin, 1991), which suggests that progressive illness depletes psychological resources, including the sense of control, vital for psychological well-being. Additionally, this sense of powerlessness reflects *Learned Helplessness Theory* (Seligman, 1975), which posits that a perceived lack of control can lead to helplessness, intensifying emotional distress and diminishing motivation for adaptive coping.

Day-to-day living typically relies on certainty, but CAD introduces ongoing unpredictability, requiring constant planning, vigilance, and emotional endurance (Becker, 2022; Brown et al., 2020). This disruption fosters chronic stress and anxiety, as even simple tasks become sources of concern (Cruijsen et al., 2024; Mozaffarian et al., 2024). Statements like "I need to think twice before doing something" (Olivia), "It's hard constantly making sure I exercise, take medication, and plan healthy meals" (Josephine), and "I bring my blood pressure machine everywhere… it brings a lot of anxiety" (Elizabeth) illustrate the toll of sustained self-monitoring. Partners echoed similar burdens: "Now I need to keep track of much more… It does get tiring" (Jack), "I feel like I'm in charge of so much more now… everything needs planning" (Henry), and "I'm always thinking, What will we eat? Where can we go that's safe for her health?" (Thomas). These experiences align with *Mishel's Uncertainty in Illness Theory* (1990), which highlights how illness disrupts individuals' ability to predict future outcomes, leading to persistent emotional distress.

For those living with CAD and their caregivers, uncertainty is a constant source of emotional exhaustion, complicating condition management. The need to anticipate and manage the unknown disrupts daily life and increases vulnerability (Ma, 2023; Murphy et al.,

2022). Recognising the role of uncertainty in chronic illness can inform interventions that address both the physical and emotional challenges of CAD.

The Grim Reaper's Shadow: Living with the Fear of Mortality

CAD can trigger deep existential anxiety, stemming from fears of death and bodily decline (Hamdy Mahmoud Mtawea et al., 2023; Kazim et al., 2023). These concerns negatively affect psychological well-being and Health-Related Quality of Life (HRQoL) (Ma, 2023). For postmenopausal women, who may already be reflecting on aging, CAD heightens mortality awareness (DeAngelis, 2023; Genazzani et al., 2024). Yalom (1980, p.8) identified four core existential concerns; death, freedom, isolation, and meaninglessness, activated by "boundary situations" like chronic illness (Soleimani et al., 2020).

"The tension between the awareness of the inevitability of death and the wish to continue to be" (Yalom, 1980, p.8) was evident among the participants. "I feel like I'm living on borrowed time... I want to see my grandchildren grow up, but my disease might prevent it" (Josephine), "The fear of my heart giving out is always on my mind" (Clara), "My condition has made me very aware of my mortality... I struggle with not being young anymore" (Elizabeth) and "I planned a whole life with Albert, but death is a constant thought" (Diana). CAD appears to have shattered female participants' hopes and dreams about the future, forcing them to confront the fragility of life and the unavoidable reality of death. This awareness creates profound existential tension, where the desire to continue living clashes with the fear of time running out. Ultimately, CAD not only threatens longevity but also challenges one's sense of meaning and connection to life.

Caregivers, witnessing a loved one's health decline, may experience heightened fears about their mortality (McAndrew et al., 2024; Tarbi et al., 2023). "Watching Clara's health decline daily, I can't help but think on how delicate life is, … she's so young. It makes me

wonder what will happen to me." (Thomas), "It was when Elizabeth was diagnosed that I started to confront my mortality, despite working in healthcare" (Jack) and "Diana's condition makes me question how long I have left" (Albert). These statements align with *Terror Management Theory* (Routledge & Vess, 2018), which suggests that mortality salience, or heightened awareness of death, triggers fear and anxiety.

Perspectives on life and death are shaped by various factors. Age may influence acceptance, with older individuals often having had more time to reflect (Officer et al., 2024). Psychological factors like resilience, anxiety, and depression, as well as cultural and religious beliefs, can either offer comfort or deepen existential struggles. These influences are further explored in the theme of coping mechanisms. Family dynamics, especially relationships with children or grandchildren, can heighten feelings of responsibility and the desire to stay alive. Understanding these factors is crucial for comprehending how individuals navigate the tension between life and death.

The Invisible Chains of Guilt and Self-Blame

Patients with CAD often feel they are adding to their caregivers' stress, leading to *self-perceived burden* (Kuharic et al., 2023, 2024). This can result in feelings of inadequacy and worthlessness (Stewart et al., 2023). "I can't do the things I used to do for myself or my family, and it makes me feel like I'm just in the way" (Diana), "I know he's already dealing with so much, and the last thing I want to do is be another burden to him" (Elizabeth), "I've failed because I can't do even simple things without relying on others" (Josephine). Olivia echoed these feelings, saying, "Sometimes I feel like I'm nothing more than a headache for my husband." This guilt takes a toll on their mental well-being.

Caregivers often internalise responsibility for their partner's condition, leading to self-blame (Lognon et al., 2022; Loureiro et al., 2023). Reflecting Luck and Luck-Sikorski's

(2022) findings, Thomas, Henry, Jack, and Edward expressed guilt over perceived caregiving inadequacies. This self-blame erodes self-worth and adds to their emotional burden (Harrison et al., 2022; Jacobsen & Petersen, 2023). They described themselves as “a failure” (Albert), “useless” (Henry), “good for nothing” (Thomas), and “insignificant” (Edward). Combined with the ongoing uncertainty of CAD, this persistent guilt exacerbates anxiety and depression (Jaeckle et al., 2023; Massazza et al., 2023). These reactions align with the *Emotion in Relationships Model* (Berscheid, 1983) and *Affective Contagion Theory* (Berscheid, 1985), which posits that emotions and stress are shared and amplified between partners (Weber & Hueluer, 2021).

Consistent with the *Interpersonal Theory of Suicide* (Joiner, 2005) and the *Self-Esteem Model of Suicide* (Williams, 1997), perceived burdensomeness is a major risk factor for suicidal ideation (Teismann et al., 2024). Diana said, “I didn’t want to add more problems for him… I thought about not existing when I received the diagnosis.” Josephine reflected, “I initially thought I was a problem for my husband… I wanted God to take me.” Elizabeth similarly noted, “There were times when I thought my husband would be better off without me.” Additionally, extreme self-blame can lead to suicidal ideation (Reddy, 2023; Suh et al., 2021). “I often feel guilty, like I’m not doing enough … Not the first time thoughts about ending my life passed through my mind” (Thomas), “… ‘Could I have prevented this? ... sometimes I just want to end it” (Albert). Edward shared, “I sometimes think that somehow my wife’s condition is my fault … I do wonder why I should keep living sometimes.”

Individuals with CAD and their caregivers face significant psychological challenges, with emotional needs often unmet. Tailored psychological support is needed to address these emotional strains. Health psychologists can aid by improving emotional regulation, easing perceived burdens, and reducing suicide risk through early intervention. As patients and

caregivers navigate these challenges, they often undergo an identity transformation reshaping their sense of self.

Identity Perplexity

CAD can profoundly disrupt an individual's sense of self (April et al., 2022; Shneider et al., 2024). As Becker (1997, p.39) notes, "an illness is a major disruption to one's biography… One must reconstitute the sense of wholeness to regain a sense of continuity." Consistent with literature, participants with CAD reported mourning their former selves (Murphy et al., 2022; O'Keeffe-McCarthy et al., 2023). "I changed into someone I barely recognise" (Josephine), "feeling hollow… I could feel that something was missing" (Diana), "asking who am I?... the person I used to be seems like a distant memory," (Clara) and Elizabeth felt "a ghost of my former self… disconnected from the person I once was." These experiences align with Oris et al.'s (2018) concept of *Illness Identity*, which emphasises the role of illness in reshaping one's sense of self.

Supporting previous findings, women diagnosed with CAD reported a shift from viewing themselves as healthy to seeing themselves as sick (Rapelli et al., 2021). "no longer feel like a force of nature... I had to accept my vulnerabilities" (Clara), "I used to see myself as someone who could handle anything, but now I'm no longer strong" (Olivia), "I once felt invincible, but now I'm weak" (Josephine). This aligns with Brewer and Gardner's (1996) *Concept of Personal Identity*, where the "sick" identity becomes central, overshadowing other aspects of self-perception.

Interviewed partners reported significant shifts in their identity due to caregiving, reflecting its transformative impact. *Caregiver Identity Theory* (Montgomery & Kosloski, 2009) highlight caregiving as a dynamic process that reshapes the caregiver's identity (Bidwell et al., 2023; Bierman et al., 2023). Both Cooper (2021) and the current study

highlight that caregiving can lead to role engulfment and a diminished sense of self. Partners expressed that caregiving had “taken part of my identity” (Edward), “stolen who I was. At times I don’t recognise myself anymore” (Henry). Jack shared that his wife’s condition had “made me question who I am... sometimes, I feel just a shell of what I once was.” As identity shifts occur, many caregivers and patients experience social isolation, which profoundly impacts their well-being.

Echoes of Solitude

The Humanistic perspective highlights the intrinsic need to belong as essential for well-being (Kahl et al., 2023; Lim et al., 2023). CAD can disrupt this connection, leading to social disconnectedness (Babić et al., 2024). Reflecting this, participants described feelings of loneliness, a distressing emotional state stemming from the discrepancy between desired and actual social interactions (Akhter-Khan et al., 2023; Kandola et al., 2023).

Weiss’s (1973) *Social Deficit Approach to Loneliness Model* distinguishes between *social loneliness*, lack of broad social networks, and *emotional loneliness*, unmet emotional needs despite contact (Lewis et al., 2024; Yuldasheva & Samindjonova, 2023). Both forms of loneliness were evident in this study.

Consistent with previous research, participants declined social invitations due to CAD-related symptoms (Gecaite-Stoneciene et al., 2021; Nicoloro-SantaBarbara & Lobel, 2024). “I turn down invitations because I fear I won't have the energy … but it feels lonely” (Elizabeth), “Although I tell my friends I won’t attend due to fatigue, I still feel excluded” (Olivia), “It's easier to stay home due to symptoms, but I wonder if they notice I'm missing” (Diana), “I fear my symptoms will show, so I say no, but it makes me feel more distant” (Clara), “I turn down invites because I can't keep up, and the more I pull back, the less I hear

from them" (Josephine). These narratives illustrate the *Social Loneliness* component of Weiss's (1973) *Social Deficit Approach to Loneliness Model*.

Consistent with existing literature, caregivers in this study reduced social engagement due to the physical and emotional strain of caregiving (Bonin-Guillaume et al., 2022; Stephanou, 2023), aligning with the *Caregiver Stress Model* (Pearlin et al., 1990). "I do want to go out but at the end of the day, all I want is sleep" (Jack), "Housework is demanding and leaves me exhausted. I often wonder what my friends are up to, but then I tell myself that even if I go, I won't have much to contribute to the conversation" (Edward), and Henry added, "I would be tempted to accept meeting my friends but … My work is hard, and caring for my wife makes it even harder. … Going out is the last thing on my mind".

An interesting paradox emerged: participants withdrew from social interactions to manage CAD symptoms or caregiver demands yet felt deeply isolated. While this withdrawal served as a protective strategy, the resulting loneliness was often unexpected and difficult to accept. Their narratives revealed a tension between valuing rest and yearning for connection, leading to feelings of abandonment. This underscores the complexity of illness-related social withdrawal, where efforts to protect health can unintentionally intensify emotional distress. It also highlights how social loneliness stems not only from physical absence but from the perception of being forgotten.

Emotional Loneliness, a component of Weiss's (1973) *Social Deficit Approach Model* was evident in the following quotations. "Surrounded by others still makes me feel lonely" (Diana), "Alone or with friends I still feel the same" (Elizabeth), "Even surrounded by others, I still feel alone" (Clara) and Olivia added, "Even with my family, I sometimes feel alone." These experiences reveal a perceived divide between 'us' who are unwell and 'them', the external world that remains unaware of their suffering (Iovino et al., 2023). Similarly,

caregivers expressed similar feelings. “Occasionally, I do meet up with my friends but I still feel alone” (Thomas), “I’m with people all day, but no one ever really asks how I am. It feels like I’m invisible” (Jack) and “Whenever my family asks me how I’m doing and I reply they always tell me that it’s expected of me to take care of my wife and that I shouldn’t complain” (Edward).

The time-consuming nature of caregiving limits the engagement of caregivers in social activities and hobbies (Liang et al., 2024; Oyegbile, 2024). “I used to love photography, but I had to stop” (Edward), “I had to stop fishing,” (Thomas) and Albert added, “I used to build model ships, but now I don’t have time” (Albert), “He [Albert] used to spend hours building model boats but with everything he has to juggle, he had to stop”, “The gym for Jack was his sanctuary, but when I got sick, he reduced a lot from going” (Elizabeth) and “He [Henry] used to enjoy seeing the fishermen when they brought in their catch, but unfortunately, he stopped going as much” (Olivia). These accounts reflect the personal sacrifices caregivers make, often at the expense of their well-being and personal interests. The loss of restorative activities can lead to emotional exhaustion and strain relationships, highlighting the need for support that helps caregivers reconnect with their own lives.

Impact on the Intimate Relationship

CAD develops within an interpersonal context, affecting couple relationships through ongoing daily challenges and shifting dynamics (Carberry et al., 2024; Shrout et al., 2024). Interdependence within intimate partnerships further influences these relational shifts (Abendschein et al., 2021). Two key sub-themes emerged: 1) Intimacy and Sexual Relations, and 2) The Paradox of Care: Shifting Relationship Dynamics.

Intimacy and Sexual Relations

Sexuality and intimacy are crucial for life satisfaction and successful ageing (Boyacıoğlu et al., 2023; Soysal & Smith, 2022). The caregiving dynamic can disrupt intimacy, eroding a fundamental relationship pillar (Niedling & Hämel, 2023). Few couples discussed this topic, with women often providing more detailed accounts.

Echoing Sorber et al.'s (2022) findings, some women with CAD described their partners as caregivers rather than companions, using terms like “nurse” (Diana) and “parent-child relationship” (Olivia). “It felt that he [Edward] was no longer my partner, he was someone that took care of me” (Josephine), “Seeing Albert as my caregiver lessened my interest in intimacy” (Diana) and Clara remarked, “For me, intimacy is important. But not when I see him [Thomas] as my brother.” These reflections reveal how caregiving roles can blur relational boundaries and diminish sexual desire, as women longed to be seen as partners not patients. Caregivers themselves echoed this emotional distancing. “I miss being her husband …not just the one who brings her medications” (Edward), “Sometimes I feel more like a support worker than a husband” (Jack) and “I stopped seeing Josephine as my wife but more as someone I cared for” (Albert).

Reflecting prior research, participants feared that sexual activity might trigger a myocardial infarction, worsen CAD, or even lead to death (Swan et al., 2023; Zhang et al., 2024a). “I sometimes imagine my heart giving out mid-way … it terrifies me” (Clara). “Even when I feel the desire, fear takes over. … What if I don’t survive it?” (Olivia), “It’s hard to feel close when I worry if my heart can handle it [sexual intercourse]” (Elizabeth). Partners expressed similar fears. “I thought that it [sexual activity] might cause additional harm” (Edward), “Whenever we try, I always worry that something might happen to her” (Henry) and “I’d rather avoid it [sexual intercourse] than risk my wife’s life” (Thomas).

These fears, though understandable, are often based on misconceptions. When CAD is properly managed, sexual activity poses minimal risk (Piegza et al., 2025). Incorporating psychoeducation and cognitive restructuring into cardiac rehabilitation can help couples challenge catastrophic thinking. Health psychologists can support them in reframing fears, through behavioural strategies and stress management techniques to restore intimacy safely and confidently.

Intimacy can also be sustained through non-sexual physical closeness (Jolink et al., 2022; Markhus et al., 2023). “Hugs became our new way to be intimate” (Josephine), “I always thought intimacy was only achieved through sex, but cuddling made me feel the same connection” (Clara). Diana added, “Although our sexual life is almost non-existent, kisses still make me feel wanted.” Caregivers also found comfort in these small gestures of closeness. “Sometimes holding hands in silence feels more intimate than anything else” (Edward). “When I brush her hair, it’s my way of staying close to her” (Henry) and “Touch has become our way of saying ‘I’m here,’ even when words fail” (Albert). These insights highlight how redefining intimacy can help couples sustain emotional closeness despite health-related changes.

The Paradox of Care: Shifting Relationship Dynamics

Reflecting broader research, interviewed partners often coped with anxiety and fear of loss through overprotection (Rapelli et al., 2021; Türker et al., 2023). “I was attentive about Josephine's exercise … I cannot lose her” (Edward), “Unhealthy foods were banned from the house … I need to keep her safe” (Henry), “I need to prepare all her food to make sure every ingredient is healthy … It [overprotection] makes me feel like I am in control of something” (Jack), “Whenever my wife had chest pain, I’d insist on a hospital visit” (Albert). These accounts show how protective behaviours can reflect deeper emotional vulnerabilities.

Some women with CAD felt that overprotection trapped them and stripped their agency. Olivia felt “suffocated… like I couldn’t breathe … He [Henry] wants to keep me inside a bubble”, Elizabeth shared, “I’m treated like a porcelain doll… I know that he [Jack] feels the need to take care of me, but I’m not disabled.” Diana described feeling “in a cage… You cannot do this… You cannot do that.” Similarly, Josephine felt “treated like a child. Not trusted to make decisions for myself.” Though rooted in care, partners’ hypervigilance often caused emotional strain, leaving women feeling smothered and deprived of autonomy. This emotional confinement can unintentionally erode trust and intimacy, as protective actions may be perceived as controlling rather than supportive.

Research shows that overprotection gradually shifts relationship dynamics (Meyer et al., 2023; Mozafari & Xu, 2020). Bouldin et al. (2019) identified four dyadic patterns: collaborative, avoidant, distant, and antagonistic. “Initially, my husband was very close. But after I was diagnosed, he retracted into himself” (Diana), “I try to talk to him [Henry], but he brushes it off, saying we’ll address it later. We weren’t like this before” (Olivia). These changes reflect a shift from collaborative to avoidant dynamics, often driven by distress or caregiver burnout (Çakmak & Arıkan, 2024; Janshen et al., 2024).

However, some partners viewed withdrawal as a defence mechanism, aligning with the *Analytical Rumination Hypothesis of Depression* (Andrews & Thomson Jr, 2009), which suggests that withdrawal can be protective (Hupferberg & Hasler, 2023). “I was not raised to talk about my feelings” (Edward), “I think it’s a male thing … we shut down until we’ve had time to process it” (Jack). Thomas added, “Sometimes, staying quiet feels like the only way to cope.” These reflections illuminate how societal norms around masculinity may shape men’s coping strategies, reinforcing silence and withdrawal as expected responses to distress.

The biopsychosocial impacts of CAD and added responsibilities can trigger tension in intimate relationships (Singh & Dhanoa, 2022; Smith, 2022). “Sometimes I snap at Elizabeth, and I know it's not really about her, but more about everything I’m dealing with" (Jack), “I occasionally raise my voice with Olivia, when I’m stressed, even though I know it's not fair to her" (Henry), “At times, Jack seems a bit more impatient with me, but I understand it’s because he feels overwhelmed” (Elizabeth), and “Every so often, my husband [Henry] raises his voice, but I know it’s because he feels helpless against my condition” (Olivia). These behaviours align with the *Psychoanalytic Theory*, particularly Freud’s concept of displacement (Freud, 1990), which explains how emotional reactions are redirected toward less threatening targets (Di Giuseppe & Perry, 2021). These statements reflect how frustration and stress related to CAD are misdirected at partners, though the individuals recognise the inappropriateness of their responses. Their difficulty addressing the root causes of their distress contributes to relationship tensions and negative emotional impacts.

Conversely, some partners reported positive changes. “We are closer now. We’ve been talking much more since she [Clara] was diagnosed" (Thomas), "Through this experience, we’ve learned to include each other more in decisions" (Edward). These reflections suggest a shift towards a more collaborative dynamic, with CAD fostering increased closeness and engagement (Huo & Kim, 2023; Mishra et al., 2023). While these positive changes are significant, they also signal the start of a deeper emotional journey for post-menopausal women with CAD and their partners, as they navigate the complex emotional terrain chronic illness brings.

Navigating the Emotional Terrain of Chronic Illness

Echoing the study conducted by Niño de Guzmán Quispe et al. (2021), participants described their experiences as “a storm where everything felt chaotic, overwhelming, and suffocating” (Henry), “a maze with dead ends” (Jack), and “a rollercoaster of highs and lows,

never knowing what was coming next" (Clara), illustrating the complexity of adaptation. Two sub-themes emerged: 1) Adaptation and Illness Perceptions, and 2) Stages of Emotional Adjustment: From Grief to Acceptance.

Adaptation and Illness Perceptions

Research highlights the importance of adaptation in managing CAD, as poor adjustment affects both patients and caregivers (Aslan et al., 2021; Karademas & Thomadakis, 2020). Adaptation entails cognitive, emotional, and behavioural efforts, including acceptance and lifestyle changes (Krahn et al., 2021; Sturmberg, 2021). It extends beyond physical symptom management to how patients and caregivers perceive the illness (Różycka, 2021; Singh & Rejeb, 2024). *Leventhal's Common-Sense Model of Self-Regulation* (Leventhal et al., 2016) highlights how illness perceptions shape adaptation, particularly by placing an emphasis on coping strategies, which will be explored later.

Illness perceptions are shaped by sociocultural backgrounds, past experiences, and symptoms (Faraci & Bottaro, 2022; O'Connor et al., 2023). Oliva and Diana, having witnessed CAD in relatives, described it as "not a death sentence" and "manageable but requiring some adaptations," respectively, reflecting personal strength. "The chest pain used to frighten me, but now I see it as a signal to take a step back and rest" (Clara), "A friend of mine had a heart condition and still managed… It's a challenge, but life doesn't end because of it" (Henry). Josephine noted, "I don't see it [CAD] too negatively, yes, the symptoms are there, but they are manageable."

Conversely, Edward referred to CAD as "a destroyer of families, bringing nothing but sorrow." Jack described it as "the death reaper bringing sorrow and pain." Elizabeth portrayed it as "a silent intruder, robbing us of our former life." Albert described CAD as "a thief trying to steal Diana from me."

Illness perceptions are shaped not only by personal experience but also by access to information and understanding (Gosak & Stiglic, 2024; Xu et al., 2022). “Before, I didn’t know much, and it felt like an unknown threat… but learning about it made me see the condition in a more positive light” (Henry), “Reading about others’ experiences helped me realise it [CAD] wasn’t the end of the world” (Thomas), “When they [healthcare professionals] broke it [CAD] down they gave me a whole new way of looking at it” (Albert), while Clara stated, “When the doctor explained it [CAD] clearly, it stopped feeling like this big, terrifying thing”. Improved understanding and access to information are essential for strengthening individuals' *internal locus of control*, easing emotional adjustment to CAD and caregiving.

This study’s wide range of perceptions shows that how individuals make sense of CAD depends not only on physical effects but also on the personal and emotional meaning they assign to it. Some focused on adapting and living with the condition, while others felt deep loss and disruption. This variability highlights illness perception as a dynamic, multifaceted process evolving over time, shaped by individuals’ experiences, beliefs, access to information, and the broader social context in which they live.

Stages of Emotional Adjustment: From Grief to Acceptance

In this study, as observed in existing literature, the emotional burden faced by participants adjusting to living with CAD and caring for a loved one with CAD was compared to a grieving process (O’Keeffe-McCarthy et al., 2023). This aligns with the *Model of Chronic Illness Adjustment* (Moss-Morris, 2013), which suggests that individuals may achieve successful psychological adaptation or face ongoing difficulties (Stacherl & Sauzet, 2024).

Interviewed participants reported experiencing emotional stages resembling the *Kübler-Ross Grief Model* (1969), which, though originally for bereavement, is relevant to CAD due to the significant sense of loss involved (Ismail et al., 2023; Peña-Vargas et al., 2021). The five stages, denial, anger, bargaining, depression, and acceptance, were central to participants' experiences (Kübler-Ross & Kessler, 2014; Winardi & Subianto, 2023).

Modern revisions of the *Kübler-Ross Grief Model* highlight that stages are not always linear and can occur in any order (Duffy & Wild, 2023; Tyrrell et al., 2023). Clara first felt anger, "I always took care of my health, but then to have this diagnosis that is typically linked to obesity" then moved to bargaining "I prayed that if God took this [CAD] away, I'd go to church more" and eventually reached acceptance: "I just accepted it… I can only manage it." Thomas shared a similar path, from anger "Initially, I found myself shouting at doctors, at family … at anyone" to acceptance: "I realised I had to accept it." Diana echoed this, "I was angry at my own body … how could it betray me like this?" before reaching acceptance: "It took time, but I realised I couldn't keep denying the reality of the situation."

Most participants, except Clara, Diana, and Thomas, who still feel significant anger despite acceptance, regaining emotional stability over time. "At first, I thought I'd never feel 'normal' again, but then, I found a new rhythm. It's not perfect, but I'm back to feeling like myself" (Olivia), "After the initial shock, I feel like I'm back on track" (Elizabeth), "Once I learnt to love the new me, a huge rock lifted from my chest ... I was able to feel happiness again" (Josephine), "Although our lives changed a bit, we've found a way to make it work" (Henry), "It took a lot of adjusting, but now my wife and I are living our life much like before, just with some changes" (Jack), Edward said, "Things are better now, and I can see my wife getting back to her old self, which has helped me return to my old self." These statements reflect successful adaptation, supporting the *Theory of Hedonic Adaptation*

(Diener et al., 2006), which suggests that people generally return to a stable level of happiness after major life changes (Stacherl & Sauzet, 2023).

However, not everyone reaches a state of happiness and acceptance. In such cases, Acceptance and Commitment Therapy can help by promoting psychological flexibility and reducing rigid thought patterns (Grant & Cassidy, 2022; Li et al., 2022). This will be further discussed in the theme of *Cognitive Flexibility*, where adapting thinking to face challenges will be explored. This approach encourages acceptance of difficult emotions and taking value-driven actions, helping those stuck in negativity or helplessness engage more meaningfully with reality (Liu et al., 2023). It has also been shown to assist individuals with chronic illness and caregiving by improving distress management and adaptation (Dindo et al., 2023; Konstantinou et al., 2023).

Acceptance marks a key turning point in adjustment, but sustaining emotional well-being demands ongoing effort and effective coping strategies. This is essential for understanding how individuals manage and mitigate the stressors of living with CAD.

Balancing Act: Coping Mechanisms Amidst CAD Stressors

Lazarus and Folkman (1984) define coping as a dynamic process of managing overwhelming demands through mental, psychological, and behavioural efforts. Interviews in this study revealed that participants primarily used both emotion-focused and problem-focused strategies, aligning with *Lazarus and Folkman's (1984) Transactional Model of Stress and Coping*.

While research suggests gender differences in coping, with men often favouring problem-focused strategies and women tending towards emotion-focused ones, this study challenges these patterns, as participants used both strategies based on the demands of CAD (Cholankeril et al., 2023; Laghari et al., 2023).

Coping using Emotion-Focused Strategies

Emotion-focused coping involves strategies to alleviate the emotional burden of stressors, which is vital for CAD patients and caregivers due to its impact on life satisfaction and well-being (Meyer et al., 2023; O'Keeffe-McCarthy et al., 2023).

A key emotion-focused coping strategy identified was seeking social support, with many women with CAD turning to their partners for emotional reassurance, which helped reduce anxiety and improve psychological well-being (Gutiérrez-Sanchez et al., 2023; Xiao et al., 2022). This aligns with *Bodenmann's Concept of Dyadic Coping* (1997), which suggests that sharing stress with a partner enables couples to respond to stress through either supportive or detrimental actions (Bodenmann, 2005). The interviews underscored the vital role of social support. "My husband's embrace is my safe place" (Clara), "I couldn't have gotten through it [CAD] without my husband." (Josephine), "My husband always managed to calm me down" (Diana), "My husband makes my stress lessen" (Olivia). Social support was also mentioned by two partners. "My friend is always there offering support" (Henry) and "Talking to my brother helps me get through it" (Thomas). These experiences resonate with the *Stress Process Model* (Pearlin et al., 1981) and the *Stress-Buffering Hypothesis* (Cohen & Wills, 1985), which highlight how social support can mitigate stress.

Humour emerged as another emotion-focused coping strategy, buffering emotional distress related to CAD (Chakravarty & Joshi, 2024; Dionigi et al., 2023). "Laughter makes my wife happier, which makes me happier" (Thomas), "Humour gives me a temporary escape from stress" (Henry) and Albert said, "Humour helps me get rid of negative feelings". Although research shows that humour is predominantly used by men, women also engage in this coping strategy (Evans, 2023; Younas et al., 2024). "I try to find something funny to make the situation less heavy" (Elizabeth), "Humour helps me feel lighter during tough times" (Olivia), "A good laugh helps me feel a bit more in control" (Josephine).

Spirituality emerged as a key emotion-focused coping strategy, particularly in Maltese culture, where Catholicism is deeply integrated into daily life (Buhagiar et al., 2022; D'Amico, 2022; Saliba, 2023). *Rolland's Family System Illness Model* (1994) emphasises how spiritual beliefs shape illness perceptions and provide meaning during tough times (Rolland, 2018). Spiritual practices enhance well-being by reducing stress, depression, and anxiety, while also protecting against harmful health behaviours (De Eston Armond et al., 2022; Shukla et al., 2021). Clara shared, "praying made me feel at peace", "God was always there for me" (Diana), "Talking to God helps me. I know that at the end of this there will be some light" (Albert), and "I find comfort in praying, knowing there's a higher power watching over me" (Henry).

Consistent with prior studies, participants used self-distraction to manage stress and avoid directly engaging with the problem (Rodrigues et al., 2023; Sheth et al., 2023). "I used to take more time than the task required because I believed that if my mind was occupied, then there was no condition to deal with" (Jack), "I bury myself in books to keep my mind off things" (Edward), "I watch movies to forget about the stress" (Albert), "I go for long walks to clear my head" (Olivia), "I lose myself in cooking, it's a way to disconnect" (Josephine), "I immerse myself in knitting, (Diana)", "Reading helps me take my mind off the stress (Elizabeth)". While self-distraction offers temporary relief, excessive use may impede long-term problem-solving and emotional processing, delaying confrontation with the underlying reality.

Coping using Problem-Focused Strategies

In contrast to emotion-focused coping, problem-focused coping involves action-oriented behaviours to address stressors (Lazarus & Folkman, 1984). For CAD patients, lifestyle changes like a heart-healthy diet, increased physical activity, quitting smoking, and stress management are crucial (Gaudel et al., 2022; Krittanawong et al., 2024; van Trier et al.,

2022). These changes help manage symptoms and improve cardiovascular health (Kolanu et al., 2024; Vooturi et al., 2023). However, as per the *Self-Determination Theory* (Deci & Ryan, 1985), interviewed patients expressed that these lifestyle changes were “challenging to initiate” (Elizabeth), “difficult to sustain over time” (Josephine), “overwhelming at times” (Diana) and “frustrating to maintain” (Clara).

Consistent with existing studies, this research found that partners of CAD patients also made lifestyle changes to support adherence, reflecting concordance in health-related behaviours (Silverman-Retana et al., 2021), as outlined in the *Interdependence Theory* (Kelley & Thibaut, 1978). “I started eating healthy meals, to help Diana continue making these changes” (Albert), “I started walking with Clara to make it easier for her” (Thomas) and “I changed my diet to meet Elizabeth’s to support her” (Jack). These behaviours reflect a desire to gain control over an uncontrollable situation.

In line with present research, the findings showed that joint lifestyle changes reduced psychological distress and boosted energy (An et al., 2023; Verweij et al., 2021). “Seeing my wife eat healthy and exercise helped me feel more relaxed” (Henry), “Doing this with my wife helped me cope better with the condition” (Thomas), “These changes are helping me feel more energetic and productive” (Edward), “Walking with my husband helps me feel calmer, like we’re in this together.” (Olivia), and “I’m more motivated to stick to my routine knowing Albert is doing it with me” (Diana). Joint changes can help foster shared purpose and connection, challenging the idea of caregiving as one-sided and highlighting it as a partnership where both individuals grow.

Participants reported breaking objectives into smaller, manageable goals, reflecting the *SMART* (Specific, Measurable, Achievable, Relevant, Time-bound) *Model of Goal-Setting* (Doran, 1981). This improved their competence, efficacy, and reduced anxiety. "Dividing

things into small tasks lessened my anxiety" (Elizabeth), "Having a pill organiser made managing medications easier" (Josephine), "Allocating achievable times prevented me from feeling disappointed in myself" (Clara), "Doing the garden one day and the bathrooms another helped lessen the stress of managing everything at once" (Albert), "Realistic planning make me feel more in control of my tasks" (Edward). Jack stated, "I set deadlines for tasks to stay motivated and on schedule." Coping mechanisms can help individuals manage chronic illness and pave the way for *Post-Traumatic Growth*, resilience and a renewed sense of purpose.

Post-Traumatic Growth

Women with CAD and their caregivers reported experiencing personal growth, reflecting *Post-Traumatic Growth*, a positive psychological transformation arising from confronting and adapting to adversity (Henson et al., 2021; Jayawickreme et al., 2021). *Tedeschi and Calhoun's* (1995) *Post-Traumatic Growth Model* identifies key domains: personal strength and growth, enhanced relationships, shifts in life philosophy, and spiritual development (Dell' Osso et al., 2022; Taku et al., 2021). *Rolland's Family System Illness Model* (1994) suggests that chronic illness can challenge and strengthen families, fostering resilience (Rolland, 1994). Participants reported *Post-Traumatic Growth* mainly through cognitive flexibility, an element of personal strength; perseverance and self-efficacy, central to personal growth; and a rediscovery of life's richness, indicative of shifts in life philosophy.

Cognitive Flexibility

Participants reported increased *Cognitive Flexibility*, the ability to consider and choose among various responses to a condition (Buechner et al., 2023; Haim-Nachum & Levy-Gigi, 2021). "Every day presents a new challenge, but I try to see the opportunity in it" (Diana), "I could be angry at the condition or grateful for still being alive… I chose gratitude"

(Elizabeth), "No matter what life throws at me, I try to see the bright side" (Olivia), "I've learned to manage my condition, and while it's not easy, I'm determined to make the most of each moment" (Josephine) and "I've learned to embrace each day, despite challenges. There's always something to be grateful for" (Clara).

The cognitive shift was also evident among partners. "My wife's condition opened my mind to things I never considered before" (Thomas), "Caregiving helped me to think twice about things rather than rush" (Henry), "Taking a step back allowed me to approach challenges more thoughtfully" (Edward) and Jack stated he "developed a new skill of looking at issues from different perspectives rather than rushing into things like before". These observations reflect problem-solving, a key aspect of the *Cognitive Model of Resilience* (Parsons et al., 2016), which helps individuals confront difficulties and adjust their strategies.

From a Positive Psychology perspective, this cognitive shift reflects key resilience constructs, mainly strength utilisation and optimism (Phan et al., 2020; Siu et al., 2024). Participants emphasised how leveraging their strengths, such as Thomas, Edward and Henry's problem-solving skills, alongside Jack's ability to view challenges from different perspectives, played a crucial role in supporting their coping strategies. This strength utilisation aids in stress management and future success. Optimism was also significant, with Olivia, Elizabeth, Clara, Diana, and Josephine stressing the importance of maintaining hope despite challenges. Research links optimism to a 35% reduction in future cardiac events, better psychological well-being, and a 14% decrease in mortality risk (Krittanawong et al., 2022; Parra-Gaete & Hermosa-Bosano, 2023).

Perseverance and Self-Efficacy

Despite the challenges of managing CAD, patients and caregivers emphasised perseverance, as noted in Van Wilder et al.'s (2021) qualitative study. "I have no intention of

giving up now" (Olivia), "It [CAD] will not make me its slave" (Clara) and Elizabeth reflected, “Although at times I feel like I’m drowning, I know that every step I take is helping me somehow.” Partners also demonstrated determination. “I will face it head-on" (Henry), “I won’t give up, no matter how difficult it gets" (Jack) and Albert added, “We've faced tough times before and will get through this one too”.

Research supports that the resilience and determination of interviewed patients and caregivers not only helped manage CAD’s psychosocial challenges but also enhanced their self-efficacy, which is essential for effective CAD management (Nuraeni et al., 2023; Shahpanah et al., 2022). “I trust in my skills to provide the best care for Clara, no matter what happens” (Thomas). “I’ve learned a lot, and I’m confident I can keep supporting her in the way she needs” (Henry). “I’ve been doing this for a while now, and I’m confident I’m doing my best to help her through it" (Albert). “I know I have the strength to get through this, even on my hardest days” (Elizabeth). "I may struggle sometimes, but I know I can handle it and get back on my feet" (Clara). "I take it one day at a time, but I believe I’m capable of handling whatever comes my way" (Josephine). These sentiments align with *Bandura's Social Cognitive Theory* (1998), suggesting that confidence in one's abilities improves the management of challenging circumstances (Chan, 2021; Melin et al., 2023).

However, Edward and Diana experienced low self-efficacy. Edward said, "No matter what I do, I will never make a difference," while Diana lamented, "There are times when I feel that I am not capable of doing it anymore." The level of resilience and self-efficacy is influenced by personality traits, with perseverance and emotional regulation enhancing resilience, while pessimism or self-doubt may hinder it. In this context, psychologists play a vital role. Using techniques like cognitive restructuring and motivational interviewing, they can help individuals like Edward and Diana challenge negative thought patterns, shifting their perspective from helplessness to empowerment. This process can improve emotional

regulation and self-efficacy, supporting better coping with CAD's psychosocial challenges and enhancing well-being.

Rediscovery of Life's Richness

Patients reported a heightened sense of meaning and purpose post-diagnosis. "Before my heart condition, I used to go through life wearing a blindfold. It made me realise that life is much more than existing … it is about living" (Clara), "I learnt to appreciate little things in life ever since I was diagnosed" (Olivia) and Josephine added, "My condition made me reconsider my life, and now I am doing things that truly matter." These reflections align with meaning-making, central to *Cognitive Adaptation Theory* (Taylor, 1983), which suggests that although threatening life events disrupt stability, individuals strive to restore order by reinterpreting their lives in a more optimistic light (Czajkowska, 2020). Meaning-making supports post-traumatic growth, helping individuals reclaim mastery amid chronic illness (Purc-Stephenson & Edwards, 2024). By reinterpreting their experiences, they gain perspectives that foster healing and resilience. Meaning-making is both a psychological mechanism and essential to healing.

Consistent with previous literature, caregivers reported feelings of "enrichment" (Jack), "satisfaction" (Albert), "fullness" (Henry), and "happiness" (Thomas) (Hall et al., 2024; Ryan et al., 2024). "Making a difference in my wife's life helps me feel happy and complete" (Thomas), "There is something rewarding in taking care of the people you love" (Henry), "My wife's condition made me appreciate life more" (Jack) and Albert added, "I realised how valuable life is." This sense of purpose aligns with *Frankl's Concept of Self-Transcendence* (1969), where individuals find meaning by rising above personal hardship (Llanos & Martínez Verduzco, 2022; Worth & Smith, 2021). Caregivers' fulfilment highlights how responsibility can foster connection, purpose, and growth. Their experiences show that

meaning can arise not despite suffering, but because of it, emphasising the need to view caregiving as burdensome and rewarding.

Conclusion

This chapter analysed interview findings from post-menopausal women with CAD and their partners, integrating them with existing literature to highlight the condition's biopsychosocial impact from diagnosis to acceptance. For local relevance, it focused on Maltese participants. The next chapter will summarise key findings, critique the study's strengths and limitations, and offer recommendations for policy, practice, and future research.

Chapter 5

Conclusion

> The true burden of coronary artery disease isn't just the condition but watching the person you love slowly fade … the quiet loss of their strength, the diminishing spark in their eyes, and the helplessness as they slip further away each day. (Edward, a participant)

This chapter comprehensively summarises the key findings, evaluates the research's strengths and limitations, and presents recommendations for policy, practice, and future research.

Key findings

This study examined the biopsychosocial impact of coronary artery disease (CAD) on postmenopausal women and their partners, focusing on life satisfaction, psychological well-being, coping strategies, and their perceptions of healthcare services. Using *Reflexive Thematic Analysis*, findings were interpreted through the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) and *Rolland's Family Systems Illness Model* (1994). Results highlighted CAD's broad impact across biopsychosocial domains, affecting both individuals and their relational systems.

Triangulation and analysis of 20 *SQUIN* interviews conducted with five postmenopausal women and their partners yielded eight global themes. *Physical Implications* captured psychosomatic effects, mainly sleep issues, fatigue, irritable bowel syndrome and migraines. *Psychological Wellbeing* showcased loss of control, fear of death, guilt, and self-blame. *Identity Perplexity* reflected shifts in self-image and role changes. *Echoes of Solitude* described isolation from unmet needs and caregiving strain. *Impact on the Intimate Relationship* revealed disrupted intimacy and relationship dynamics. *Navigating the*

Emotional Terrain of Chronic Illness showed emotional adaptation through stages like denial, anger, bargaining, and depression, with some reaching acceptance. *Balancing Act: Coping Mechanisms Amidst CAD Stressors* detailed emotion- and problem-focused coping. Lastly, *Post-Traumatic Growth* captured how facing CAD fostered resilience, cognitive flexibility, and a renewed sense of purpose.

Strengths and Limitations of the Study

As with all research conducted, several strengths and limitations were identified. This study's primary strength lies in being the first local qualitative research to examine the biopsychosocial implications of CAD in postmenopausal women and their partners, moving beyond the medical model to explore personal experiences, coping, and relational dynamics.

Triangulating data from women and partners enhanced credibility and provided a nuanced understanding of CAD's multi-dimensional effects (Sharma et al., 2023; Zelčāne & Pipere, 2023). The study also offered participants a platform to share their stories, yielding rich insights into the challenges of coping with CAD.

Although participants were treated respectfully, social desirability bias, the tendency to give socially acceptable responses, may have influenced their answers, particularly around sensitive topics like intimacy (Teh et al., 2023). The use of audio-only recordings also limited access to non-verbal cues, which could have enriched the analysis. While the participants' age range (55 to 68 years) was not large, it may have influenced their experiences, as individuals within this range may differ in terms of physical health, psychological adjustment to ageing and perceptions of vulnerability or resilience. These life stage variations can shape how CAD is experienced and managed individually and within the couple dynamic.

To meet the primary research objective, participants were required to have a CAD diagnosis for homogeneity. However, variation in disease severity emerged as a limitation. While most postmenopausal women had mild blockage, one underwent angioplasty for critical stenosis. This disparity may have influenced their experiences, as those with more severe CAD likely faced different challenges or benefits compared to those with milder forms.

Recommendations

Drawing from the study's findings and participant interviews, several key recommendations for policy, practice, and future research on CAD have emerged.

Recommendations for Policy

Globally, despite growing sex-specific cardiovascular research, gender-specific care guidelines remain lacking (Montarello & Cahn, 2022). Locally, the *Non-Communicable Diseases Prevention Framework* (Ministry of Health and Active Ageing, 2024), set for implementation from 2025 to 2035, adopts a broad approach to cardiovascular health but overlooks women's unique risks and atypical CAD presentations. This gap may continue to lead to delayed diagnoses and suboptimal care, underscoring the need for tailored strategies to ensure equity (Montarello & Cahn, 2022).

Large-scale CAD risk screening is vital for prevention (Yang et al., 2023). Currently, local government screenings mainly focus on cancer (Government of Malta, 2023). The sole cardiovascular screening targets abdominal aortic aneurysms in men aged 65 and older (Ministry of Health and Active Ageing, 2024). Introducing screenings like Coronary Artery Calcium Scoring for high-risk groups like postmenopausal women, could improve early intervention, enhance prevention, and reduce long-term healthcare costs.

Recommendations for Practice

Most recommendations made in this section were identified by participants, drawing from their experiences. This study reveals a significant gap in CAD awareness among postmenopausal women and their partners. All participants were unaware of their condition before diagnosis due to atypical symptoms, consistent with research (Kim, 2024; Joseph et al., 2021). Partners also failed to recognise these signs, with most resources encountered being male-oriented. To address this, non-governmental organisations and public health bodies could implement targeted awareness campaigns on gender-specific CAD symptoms. Health psychologists can design these campaigns using behaviour change frameworks like the *Health Belief Model* (Rosenstock, 1974) to correct misconceptions (e.g., CAD as a "man's disease") and encourage proactive healthcare-seeking behaviours (Sharma, 2022, p.1).

Campaigns can include community workshops, conferences, and digital outreach. Internationally, several initiatives address cardiac health. The HER Disease Campaign (Heart Research UK, 2023) educates the public and healthcare professionals on how heart disease presents in women, while the Wear It. Beat It campaign (Penningtons Manches Cooper, 2018) promotes community engagement and fundraising for heart health research and awareness.

Locally, the Marigold Foundation runs an annual Cardiac Awareness Campaign with the Malta Cardiac Society (Malta Daily, 2022; TVM News, 2022). Although the Malta Heart Foundation and the Health Promotion and Disease Prevention Directorate also conduct awareness efforts, these are not held regularly. Increasing the frequency of such campaigns could strengthen public health outcomes, as health education is key to an early identification and reduction of chronic diseases (Maccido, 2024).

Technology has greatly improved access to health information, aiding chronic disease management. Over 350,000 health applications are available, with nearly half focusing on

mental health, diabetes, and cardiovascular disease (Hewage et al., 2025; IQVIA, 2021). Evidence-based apps like *MyHeart Counts*, *Love My Heart For Women* and *Qardio* support education, self-management, and heart health tracking (Hershman et al., 2019; Meddar et al., 2022). Incorporating them into public health campaigns could strengthen education and support for postmenopausal women and their partners.

Participants reported that healthcare professionals initially failed to recognise their condition when they first presented with the symptoms, reflecting a gap in identifying gender-specific symptoms which aligns with research (Bosomworth & Khan, 2023; Wang et al., 2024). Targeted education and ongoing professional development are needed to address this.

Participants recommended that routine healthcare visits should include proactive CAD assessments for women. Incorporating female-specific risk assessments into standard care could support earlier detection even when CAD is not suspected. Evidence suggests cardiac risk evaluations should be conducted at every routine visit for women aged 40–75 (Arnett et al., 2019; NHS, 2023).

Participants highlighted long waiting times as a major challenge, despite early follow-ups being key for adherence, lifestyle changes, and well-being (Huang et al., 2024). Timely care also lowers mortality, healthcare costs, and hospital readmissions (Romero-Farina & Aguadé-Bruix, 2021; Saxena et al., 2022), but global staff shortages hinder this (Michaeli et al., 2024; Sipos et al., 2024). Policymakers and healthcare institutions could benefit from investing in workforce recruitment and retention to alleviate staff pressures and improve service delivery.

This study and existing literature highlight social isolation as a major challenge for patients and caregivers (Boamah et al., 2024; Kalandari et al., 2023). Echoing Tough et al.'s

(2022) findings, participants expressed a strong desire for greater social connection to reduce isolation. Social support has been shown to reduce caregiver burden and enhance well-being, making structured support groups a valuable intervention (Bongelli et al., 2024; Makhtar et al., 2023). While in-person groups offer richer interaction, virtual options may be more accessible considering caregivers' and patients' schedules (Carroll et al., 2019).

Several international support groups cater to caregivers and patients with CAD, such as Mended Hearts (Mended Hearts of Orlando, 2025) and The American Heart Association Support Network (American Heart Association, n.d.). The Coronary Artery Disease Support Group on Facebook also provides a virtual space for those affected. Locally, support groups exist for various conditions like breast cancer (Europa Donna Malta, 2025) and Huntington's disease (Caritas Malta, n.d.), but no groups were found for women with CAD or their caregivers. This highlights the need for targeted support networks to address their unique challenges.

Recommendations for Future Research

As highlighted by *Rolland's Family System Illness Model* (1994) and echoed by participants, CAD affected both individuals and their relationships as couples. While this study included data from post-menopausal women and their partners, incorporating children's perspectives could further enrich understanding of family dynamics.

This study focused on postmenopausal women due to the higher prevalence of CAD in this group, highlighting the need for targeted management strategies where the burden is greatest (Tayal et al., 2024; van den Houdt et al., 2024). Although CAD is less common in younger women, its prevalence is rising (Minissian et al., 2023). Future research should explore women under 54 years, as recent studies suggest a growing trend, offering insights

into early disease progression and prevention strategies for early-onset CAD (Pintos-Rodríguez et al., 2025; Wang et al., 2024).

Investigating how CAD affects same-sex couples would be valuable, as they may face unique healthcare challenges and relational dynamics when compared to heterosexual couples. Exploring these factors could deepen understanding of how social and relational contexts influence this population's disease management, support systems, and health outcomes.

Drawing from the *Dynamic Biopsychosocial Model* (Lehman et al., 2017), further research could explore how environmental stressors, personality traits, attachment styles, and protective factors interact with biopsychosocial influences on CAD outcomes. Understanding these interactions could provide valuable insights into individual differences in disease progression, treatment adherence, and coping mechanisms.

Concluding Comments

This study explored the biopsychosocial impact of CAD on the quality of life of postmenopausal women and their partners. The insights gained aspire to inform future interventions and policies to better support these individuals. This research also seeks to raise awareness on the often-overlooked biopsychosocial burden of CAD on postmenopausal women and their partners, populations frequently underrepresented in research and healthcare discussions.

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Appendices

Appendix A

Interview Guide for post-menopausal women with CAD (English version)

1. “Could you tell me your experience when you were diagnosed with coronary artery disease? Start wherever you like. Please take the time you need. I'll listen first I won't interrupt, I'll just take some notes for afterwards”.
2. “What measures would you recommend to lessen the impact CAD has on the wellbeing of individuals?”

Interview Guide for post-menopausal women with CAD (Maltese version)

1. “Tista’ tgħidli l-esperjenza tiegħek meta ġejt dijanjostikat b’mard tal-arterji koronarji? Ibda fejn tixtieq. Jekk jogħġbok ħu l-ħin li għandek bżonn. L-ewwel nisma’ mhux se ninterrompi, nieħu ftit noti għal wara”.
2. "X'miżuri tirrakkomanda biex jitnaqqas l-impatt li għandu CAD fuq il-benessri tal-individwi?"

Appendix B

Interview guide for male partners of post-menopausal women with CAD (English version)

1. “Could you tell me your experience when your significant other was diagnosed with coronary artery disease? Start wherever you like. Please take the time you need. I'll listen first I won't interrupt, I'll just take some notes for afterwards”.
2. “What are your perceptions of the available services and how can these be improved?”

Potential prompts

1. Can you please tell me a bit about yourself and your relationship with your partner?
2. How did you first learn about your partner's diagnosis of CAD (coronary artery disease)?
    a. Can you describe the initial emotions and thoughts you experienced upon hearing about the diagnosis?
    b. What was your partner's reaction to the diagnosis, and how did you support them during this time?
    c. Did you have any prior knowledge or concerns about CAD before your partner's diagnosis?
3. How has the diagnosis of CAD affected your relationship with your partner?
    a. Have there been any changes in communication, intimacy, or daily routines since the diagnosis? If so, how?

b. Can you share any challenges or adjustments you've had to make as a couple due to CAD?

4. How do you perceive CAD has impacted your partner's overall well-being and quality of life?

   a. In what ways have you observed changes in your partner's physical and emotional health since the diagnosis?
   b. How do you support your partner in managing their CAD and associated symptoms?

5. Can you describe how coronary artery disease (CAD) has affected you emotionally and mentally when seeing your partner navigate through this condition?

   a. What emotions do you experience when witnessing your spouse's journey with CAD?
   b. How do you cope with the stress or anxiety that may arise from seeing your spouse dealing with CAD?
   c. Have you noticed any changes in your own mental health or well-being since your spouse was diagnosed with CAD? If so, how
   d. Can you describe any specific instances or moments that have been particularly challenging for you as you support your spouse through their CAD diagnosis?
   e. How do you balance your own emotions and needs with those of your partner who has CAD?
   f. Are there any support systems or resources that you have found helpful in navigating your own emotional journey alongside your spouse's CAD diagnosis?

6. What resources or support services have you utilised since your partner's diagnosis?

   a. Can you share your thoughts on the adequacy and accessibility of support services available for partners of individuals with CAD?
   b. Are there any specific support needs or services you feel are lacking or could be improved?

7. Is there anything else you would like to share about your experience as a partner of a post-menopausal woman diagnosed with CAD?
8. Do you have any additional questions or concerns you would like to address before we conclude?

Interview guide for male partners of post-menopausal women with CAD (Maltese version)

1. “Tista’ tgħidli l-esperjenza tiegħek meta ta’ meta s-sieħba tiegħek ġejiet dijanjostikata b’mard tal-arterji koronarji? Ibda fejn tixtieq. Jekk jogħġbok ħu l-ħin li għandek bżonn. L-ewwel nisma’ mhux se ninterrompi, nieħu ftit noti għal wara”.
2. "X'inhuma l-perċezzjonijiet tiegħek tas-servizzi disponibbli u dawn kif jistgħu jittejbu?"

Mistoqsijiet li jistħu jintużaw għal- iktar informazzjoni

1. Tista' jekk jogħġbok tgħidli ftit dwarek innifsek u dwar ir-relazzjoni tiegħek mas-sieħba tiegħek?
2. Kif tgħallimt l-ewwel dwar id-dijanjosi tal-mard tal-qalb tas-sieħba tiegħek?
    a. Tista’ tiddeskrivi l-emozzjonijiet u l-ħsibijiet inizjali li esperjenzajt meta smajt dwar id-dijanjosi?
    b. X'kienet ir-reazzjoni tas-sieħba tiegħek għad-dijanjosi, u kif appoġġajtha matul dan iż-żmien?
    c. Kellek xi għarfien minn qabel jew ħassib dwar il-mard tal-qalbi koronarji qabel id-dijanjosi tas-sieħba tiegħek?
3. Id-dijanjożi medica għamel impatt fuq ir-relazzjoni tagħkhom?
    a. Kien hemm xi bidliet fil-komunikazzjoni, intimita, jew rutini tagħkom d-dar wara d-dijanjozi? Jekk iva, kif?
    b. Tista' taqsam xi sfidi jew tibdiliet li għamiltu minħabba l-kundizzjoni?
4. Kif taħseb li mard tal-arterji koronarji affetwat il-benesser u l-kwalità tal-ħajja tas-sieħba tiegħek?
    a. F'liema modi ta' tibdiliet observajt fil-benesser fiziku u emozzjonali tal-partner tiegħek mill-diġinostika?

   b. Kif tappoġġja l-partner tiegħek u s-sintomi associjati?

5. Kif taħseb li l-marda tal-arterji koronarji affetwatek emozzjonalment u mentalment meta tara s-sieħba tiegħek għaddejja minnha?
   a. X’ emozzjonijiet tħoss meta tara s-sieħba tiegħek għaddejja min din il-kundizzjoni?
   b. Kif tkampa mal- stress jew anzjeta li jistgħu jitilfu milli tara s-sieħba tiegħek għadejja mil-marda tal-arterji koronarji?
   c. Kien hemm xi tibdiliet fis-saħħa mentali jew fil-benesser tiegħek stess minn meta s-sieħba tiegħek ġiet iddijanzozata? Jekk iva kif?
   d. Tista' tiddeskrivi xi każijiet jew momenti speċifiċi li kienu partikolarment diffiċli għalik waqt li tagħti l-appoġġ lis-sieħba tiegħek meta rċiviet di-dijonjożi?
   e. Kif tibbilanċja l-emozzjonijiet u l-ħtiġijiet tiegħek ma’ dawk tas-sieħba tiegħek?
   f. Hemm xi sistemi ta' appoġġ jew risorsi li inti sibt utli waqt il-kont għaddej/ja minn din l-esperjenza mas-sieħba tiegħek?
6. Hemm xi riżorsi jew servizzi ta' appoġġ li użajt minn meta s-sieħba tieħek irċiviet d-dijanjożi?
   a. Tista' taqsam l-ħsibijiet tiegħek fuq l-adekwatezza u l-aċċessibilità ta' servizzi ta' appoġġ disponibbli għal-partners tal-individwi bil-mard tal-qalb?
   b. Hemm xi bżonnijiet speċifiċi ta' appoġġ jew servizzi li tħoss li jistgħu jitjiebu?
7. Hemm xi ħaġa oħra trid tixtieq taqsam dwar l-esperjenza tiegħek bħala partner ta' mara li għaddiet mill- menopawza u ġiet dijonjożata bil-mard tal-qalb?
8. Għandek xi mistoqsijiet addizzjonali li trid issaqsi qabel ma ntemmu?

Appendix C

Approvals from Mater Dei Hospital and Gozo General Hospital

Approval from Data Protection Officer at Mater Dei

RE: Enquiry for the possibility that Mater Dei could act as a gatekeeper

Data Protection at MHA - MDH <datapro.mdh@gov.mt>
Tue 25/06/24 10:26

To:'Christine Gauci' <christine.gauci.16@um.edu.mt>
Cc:Young Sharon at MHA - MDH <sharon.young@gov.mt>;Data Protection Approval Form at MHA - MDH <dpaform.mdh@gov.mt>

Dear Ms Gauci

On the basis of the documentation you submitted, from the MDH data protection point of view you have been cleared to proceed with your study titled ***Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners*** provided that you obtain approval from MDH CEO (ceo.mdh@gov.mt - please provide the relevant documents including Dr Tiziana Felice's approval and this email).

- Your intermediary to approach potential participants on your behalf is *Ms Marilyn Gauci – Staff Nurse who works at the Cardiac Rehab Unit within the Cardiology Department, MDH*
- Your potential participants to attend your interviews are *adult patients between the age of 55 years to 70 years diagnosed with Coronary Artery Disease who are receiving a service at the Cardiology Department, MDH*

All data stored must be anonymized and in no way should you retain any personal details you obtain from your research and these should be destroyed at the end of your study and /or if any of your participants decides to withdraw. Remember that participants reserve the right to be forgotten.

Anonymisation and Data minimisation

Participant consent forms must be separated from the interview answers at source, meaning that there will be no correlation between one and the other that will indicate how participants replied.

ALL data presented to your supervisors / tutors or examiners or any other personnel from UOM or anyone else must be already anonymized; meaning that you must not divulge to anyone the identity of your participants and / or how they replied. There shall not be any exceptional circumstances allowing the supervisors, examiners or anyone else to access personal identifiable data.

Consent Criteria

This clearance does not allow viewing of medical records nor access to Health Information Systems.

All your participants must be reached and approached for invitation when physically at the Cardiology Department, MDH grounds (through Ms Marilyn Gauci) and NOT via postal services, email, telephone or any other means. You cannot be handed any contact details of potential participants, otherwise consent would be bypassed.

Potential participants must be approached by Ms Marilyn Gauci for invitation and not directly by you. You can approach only after the participants will consent.

Personal identifiable data such as signed consent forms or pseudonym lists are not to be sent via email (not even relayed to yourself), replicated and/or uploaded to any server, cloud storage, site or any other media given that participants will not consent any service provider to store their personal identifiable data.

Audio recordings must be strictly accessed and listened only by you (not even by your tutors, supervisors or any personnel from UOM/ FHS) and that all data (including transcripts) presented to UOM / FHS must be completely anonymised. Such recordings are not to be sent via email, replicated and/or uploaded to any server, cloud storage, site or any other media. Audio recordings must be destroyed after the conversation will be transcribed or if a participant decides to withdraw from your study.

If a transcription software will be used, it is in your responsibility to ensure that this is not connected online to any cloud service or server and that such software operates in an offline mode. All cashed data and any other personal identifiable data should be immediately wiped out after the transcript is produced and anonymised.

Video recordings and photography are not allowed for this research.

Clarifications

This clearance does not cover ethical approval.

All documents presented to your participants must include UOM's logo.

This clearance does not allow verbal consent.

This clearance is valid for your report to be included with your dissertation only and not in medical journals or elsewhere given that you are not obtaining approval from MDH legal office.

Your submitted documentation must remain unchanged.

What was declared during this clearance process is what you will abide to.

You must abide with all the articles of the GDPR (EU) 2016 / 679 throughout the data collection process and thereafter.

You are requested to submit a copy of your findings to this office at the end of your study.

This clearance covers your research to be carried out only at the Cardiology Department, MDH and not in any other department / institution such as Primary Healthcare, GGH, KGH, MHS, SVPR, DHIR or any other institution / department that doesn't form part of MDH Data Controller.

Please communicate with Ms Marilyn Gauci to present this clearance email.

To sign the data protection form, please contact Ms Graziella Aquilina through dpaform.mdh@gov.mt to provide the following:

1. *This clearance email in PDF – to provide in PDF*
2. *MDH CEO's approval in PDF - pending*
3. *The name of the Chairperson who approved your research – Dr Tiziana Felice*
4. *The period of data collection – July 2024 (after you sign the DP form) – October 2024*
5. *Title of your research - Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners*
6. *Your ID number:- pending*

NB: you must sign this form before starting. You will receive an email from adobe sign to sign electronically.

In summary – next step

1. Obtain approval from MDH CEO through ceo.mdh@gov.mt
2. Sign the Data Protection form at Ms Graziella Aquilina through dpaform.mdh@gov.mt (please provide the above six points)

Regards

Simon Caruana
Senior Manager (Compliance)
Health Informatics Directorate
Health-Mater Dei Hospital

MINISTRY FOR HEALTH AND ACTIVE AGEING
Mater Dei Hospital, Triq Id-Donaturi Tad-Demm,

Msida, Malta

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 25 June 2024 09:40 AM
To: Data Protection at MHA - MDH <datapro.mdh@gov.mt>
Cc: Young Sharon at MHA - MDH <sharon.young@gov.mt>
Subject: Re: Enquiry for the possibility that Mater Dei could act as a gatekeeper

Dear Mr Caruana,

Good morning. I hope this email finds you well. Below kindly find the answered questions in a different colour as instructed. Additionally, I am also sending the approval email from Dr Felice, a document signed by the intermediary, a copy of the information sheet and consent forms (in Maltese and English), a copy of the interview guide (Maltese and English) and the declaration concerning audio recordings.

Should you require any other documentation, kindly let me know.

Kind regards,
Christine Gauci

From: Caruana Simon at MHA - MDH <simon.caruana@gov.mt> on behalf of Data Protection at MHA - MDH <datapro.mdh@gov.mt>
Sent: Wednesday, June 5, 2024 11:25 AM
To: 'Christine Gauci' <christine.gauci.16@um.edu.mt>
Cc: Young Sharon at MHA - MDH <sharon.young@gov.mt>
Subject: RE: Enquiry for the possibility that Mater Dei could act as a gatekeeper

Dear Ms Gauci

Please provide us an approval from Dr Tiziana Felice and the following information (you can annotate below each line with a different colour):

NB: please include the title and the relative data processing in the request that you will send to Dr Felice and eventually provide to us with the included approval

1. Study title

Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners

2. How are subjects recruited?

Participants are recruited through the intermediary who will access the data system and contact individuals fitting the criteria for the study, informing them about the study and provide my email address to them so that they contact me.

Alternatively, the intermediary can also provide the information sheet to clients fitting the criteria should they come to the hospital for their appointment and then they can contact me through the email address on the paper if they are interested in participating.

When interviewing post-menopausal women with coronary artery disease, Single Question aimed at Inducing Narratives (SQUIN) interviews lasting between 60 – 90 minutes will be utilised. They will be selected through the use of purposive sampling since a particular phenomenon is being addressed. The inclusion criteria for this study are as follows: post-menopausal women (between the ages of 55 - 70 years), diagnosed with coronary artery disease. Additionally, participants who would like to partake in this study need to consent for the interview to be audio recorded. The exclusion criteria would be women with coronary artery disease younger than 55 years and older than 70 years, and participants who would not like their interview to be audio recorded.

3. What do subjects do, or what is done to them, or what information is gathered?

Prior to the interview, the participants will be given a consent form with regards to their rights as well as an introduction letter providing an overview of the study. These documents will be both in Maltese and English and given to the participants in the language they prefer. Prior to conducting the interview, a synopsis of the consent form and introduction letter will be carried out by myself. They will be also reminded that all the data collected is for research purposes. Moreover, I will remind them that the data will be collected, stored and analysed as per the Data Protection Act.

When interviewing post-menopausal women with coronary artery disease I will ask an open-ended question mainly on the following lines either in English or Maltese according to the participant's preferred language: "Could you tell me your experience when you were diagnosed with coronary artery disease. Start wherever you like. Please take the time you need. I'll listen first I won't interrupt, I'll just take some notes for afterwards'. Subsequently, I will carry out probing questions based on the material that arose from the SQUIN.

4. How information is gathered, where it is stored and for how long?

Information is gathered through Single Question aimed at Inducing Narratives (SQUIN) interviews lasting between 60 – 90 minutes. SQUIN interviews are going to be used as it allows flexibility where the participants can disclose relevant information that they are comfortable with thus avoid any potential triggers.

The audio recording of the interview will be saved with their pseudonym. The audio recordings of the interviews will then be transcribed as soon as possible in a verbatim manner. Once the interview is completed, I will ask the participant how they would like to receive the transcript e.g. email or registered mail, and they will be informed that they have 4 weeks to amend as needed thus ensuring accuracy, credibility and audit trail.

All participants will also be informed that once they are satisfied with the details within the transcript, the audio recordings will be destroyed, thus eliminating the possibility of them being recognised. The soft copies of the transcripts will be stored using the chosen pseudonym on my private computer which is solely utilised by myself. In addition, both devices are password-protected. Additionally, transcripts will be stored in an encrypted file on my personal computer. With regards to the filled-in consent form, these will be stored in a filing cabinet under lock and key which is only accessible by myself. Documents containing information disclosed by the participants (ie. consent forms, transcripts etc) will be shredded and/or deleted on 30.05.2025.

5.

6. Who will have access for the data gathered?

I will only have access to the data gathered. Supervisor, examiners and/or other parties will not have access to the participants' personal data. However, participants will be informed that snippets consisting of unidentifiable information within their transcripts will be used in the results and discussion chapter within the dissertation.

6. State the period of the study.

July 2024 – May 2025

7. State the data collection period.

July 2024 – September 2024

8. Who will carry out this study? Please include any research assistants.

I am the sole researcher in this study and will not be using any research assistants.

9. How long will participation take?

Each interview will last 60 - 90 minutes. Ideally, the interview with each participant will be conducted on one day however should I see that the session was heavy, I will be conducting the probing questions on a separate day. The SQUIN approach allows the researcher to conduct a maximum of two other [sub-sessions] interview sessions with each participant (the initial meeting and 2 other sessions).

10. If direct participation takes place, the following needs to be provided (with UOM's logo):

- The interview guide in Maltese and English
- Participant consent form in Maltese and English
- Participant information letter in Maltese and English

The info letter must be specific and detailed but in layman's terms; including a confirmation that only your good self will access personal data and that in no instance you will provide access to anyone else (to personal data) including the signed consent forms)) to your supervisors or examiners or anyone else

11. If you are conducting audio recordings, provide us a declaration:

- that audio recordings will be accessed and listened only by you
- where the audio recordings are being stored
- that the audio recordings will not be sent via email, replicated and/or uploaded to any server, cloud storage, site or any other media
- that the audio recordings will be destroyed after the conversation will be transcribed

- that the audio recordings will be destroyed immediately if the participant decides to withdraw from the study
- whether a transcription software will be used and that this operates offline

11. Confirm that video recordings or photography will not take place.

No video recordings will take place.

12. Provide us a signed declaration from an employee who will act as your intermediary to approach potential participants for the invitation to your interview; the declaration must include:
    i. The gov email address of the employee
    ii. A statement that s/he is already in contact with potential participants as part of his / her duties
    iii. That the invitation will take place when physically at MDH

Regards

Simon Caruana
Senior Manager (Compliance)
Health Informatics Directorate
Health-Mater Dei Hospital

MINISTRY FOR HEALTH AND ACTIVE AGEING
Mater Dei Hospital, Triq Id-Donaturi Tad-Demm,
Msida, Malta

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 03 June 2024 11:26 AM
To: Data Protection at MHA - MDH <datapro.mdh@gov.mt>
Subject: Enquiry for the possibility that Mater Dei could act as a gatekeeper

To whom it may concern,

Good morning. I hope this email finds you well. I am reading for a Masters of Psychology in Health Psychology at the University of Malta. My research is entitled "Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners" and intends to explore the holistic consequences of coronary artery disease on post-menopausal women and their partners, under the supervision of Dr Pamela Portelli. I will be employing interviews with post-menopausal women diagnosed with coronary artery disease and their partners. These will be audio-recorded, transcribed and analysed. Moreover, pseudonyms will be used thus safeguarding the participants' identity. Participants for this study need to have the following criteria:

Post-menopausal women

- Between the ages of 55 - 70 years

- Diagnosed with coronary artery disease.

Their partners

- Male

- They have been in a relationship when their partner experienced the symptoms and got diagnosed.

All participants who which to partake in this study need to consent to have the interview audio recorded.

This proposal has been submitted to FREC (Faculty Ethics Research Committee) who provided ethical clearance. Hence, I am writing to enquire if you would have any objection to forwarding my request to your clients. Should you consent, I will send a detailed information letter and consent forms accordingly whilst attaching your reply as an appendix within my study.

Kind regards,

Christine Gauci (115998M).

Approval from the Head of the Cardiology Department within Mater Dei Hospital

Re: Approval to conduct the study in the cardiology department

Felice Tiziana at MHA - MDH <tiziana.felice@gov.mt>
Tue 18/06/24 18:10
To:Christine Gauci <christine.gauci.16@um.edu.mt>

Dear Christine,

You have my approval to conduct the study: Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners" .

I would recommend Dr Mark Abela (mark.c.abela@gov.mt) as an intermediary but ideally you need to ask him for his availability.

I hope this is helpful.

Dr Tiziana Felice M.D.(Melit.) MRCP UK M.Sc.(Melit.)
Consultant Cardiologist with special interest in inherited cardiomyopathies
Deputy Clinical Chairperson Department of Cardiology

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 17 June 2024 07:15:45
To: Felice Tiziana at MHA - MDH
Subject: Approval to conduct the study in the cardiology department

CAUTION: This email originated from OUTSIDE the Government Email Infrastructure. DO NOT CLICK LINKS or OPEN attachments unless you recognise the sender and know the content is safe.

Dear Dr Felice,

Good morning. I hope this email finds you well. I am writing as I approached the data protection officer at Mater Dei who informed me that to commence the clearing process I need to obtain your approval since you are the head of the cardiology department.

Additionally, the data protection officer also mentioned that I need an intermediary to reach out to the participants for me. Could you kindly let me know who is willing to help me please? Upon being informed who will be willing to assist me I will be sending them a document stating their role in the recruitment process to fill it in and re-send it back to the data protection officer.

Thank you in advance,
Kind regards,
Christine

Approval from the intermediary working within Mater Dei Hospital

Re: Enquiry regarding possibility to act as my intermediary

Gauci Marilyn A at MHA - MDH <marilyn.a.gauci@gov.mt>

Mon 24/06/24 12:12

To:Christine Gauci <christine.gauci.16@um.edu.mt>
Cc:Abela Mark at MHA - MDH <mark.c.abela@gov.mt>

Dear Ms. Gauci,

sure no problem, I will act as the intermediary for your research project.

kindly when will the study commence?

kind regards

Marilyn Gauci
Senior Staff Nurse

T +356 25454236
E marilyn.a.gauci@gov.mt

Mater Dei Hospital, Triq id-Donaturi tad-Demm, l-Imsida, Malta MSD 2090 | Tel +356 2545 0000 |
https://deputyprimeminister.gov.mt/en/MDH/Pages/Home.aspx | https://www.facebook.com/materdeihospital/

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 24 June 2024 11:58:15
To: Gauci Marilyn A at MHA - MDH
Cc: Abela Mark at MHA - MDH
Subject: Re: Enquiry regarding possibility to act as my intermediary

Dear Ms Gauci,

Good afternoon. I hope this email finds you well. I am reading for a Masters of Psychology in Health Psychology at the University of Malta. My research is entitled “Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners” and intends to explore the holistic consequences of coronary artery disease on post-menopausal women and their partners, under the supervision of Dr Pamela Portelli. I will be employing interviews with post-menopausal women diagnosed with coronary artery disease. These will be audio-recorded, transcribed and analysed.

I am sending you this email to enquire if you would be interested in acting as my intermediary to contact participants with the following criteria:

Post-menopausal women

- Between the ages of 55 - 70 years

- diagnosed with coronary artery disease.

- - currently or in the past made use of the services provided by the cardiology department

I have received ethical clearance from the University to conduct this study. Moreover, I have received approval from Dr Felice to conduct my study within the Cardiology department.

Should you accept to act as my intermediary, I will be sending you a document stating your role in the recruitment process to fill it in and re-send it back to the data protection officer since this is requested to commence the clearing process of MDH. Additionally, I will also be sending you the information sheet on my study to distribute to interested participants so that they can contact me should they want to participate.

Should you require any other information about my study, feel free to contact me.

Thank you very much in advance,

Kind regards,

Christine Gauci (115998M).

From: Gauci Marilyn A at MHA - MDH <marilyn.a.gauci@gov.mt>
Sent: Monday, June 24, 2024 11:46 AM
To: Abela Mark at MHA - MDH <mark.c.abela@gov.mt>; Christine Gauci <christine.gauci.16@um.edu.mt>
Subject: Re: Enquiry regarding possibility to act as my intermediary

Dear Ms. Gauci,

How can I help in your study?

regards

Marilyn Gauci
Senior Staff Nurse

T +356 25454236
E marilyn.a.gauci@gov.mt

Mater Dei Hospital, Triq id-Donaturi tad-Demm, l-Imsida, Malta MSD 2090 | Tel +356 2545 0000 |
https://deputyprimeminister.gov.mt/en/MDH/Pages/Home.aspx | https://www.facebook.com/materdeihospital/

From: Abela Mark at MHA - MDH
Sent: 24 June 2024 11:33:59

To: Christine Gauci; Gauci Marilyn A at MHA - MDH
Subject: Re: Enquiry regarding possibility to act as my intermediary

Mar, can you help with this?

Surgeon Lieutenant (VRF) Dr Mark Abela MD (Melit) MRCP (London) MSc Internal Medicine (Edinburgh) MSc Sports Cardiology (London) FESC
Cardiology Resident Specialist
Special interest in Sports Cardiology and Inherited Cardiac Conditions
Nucleus Member of the Sports Cardiology and Exercise Section of the EAPC
Armed Forces of Malta Cardiologist
Honorary Senior Lecturer in the Cardiovascular and Genomics Research Institute at St George's, University of London
EAPC National Cardiovascular Disease Prevention Coordinator
Clinical lead for Sports Cardiology / Inherited Arrhythmias / Cardiac Rehabilitation at Mater Dei Hospital
Pager: 3560138 (79847989)

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 24 June 2024 11:33:30
To: Abela Mark at MHA - MDH
Subject: Re: Enquiry regarding possibility to act as my intermediary

Could you kindly provide me a contact number and email address where I can reach them please.

Thank you in advance for your help.

Kind regards,
Christine Gauci

From: Abela Mark at MHA - MDH <mark.c.abela@gov.mt>
Sent: Monday, June 24, 2024 11:31 AM
To: Christine Gauci <christine.gauci.16@um.edu.mt>
Subject: Re: Enquiry regarding possibility to act as my intermediary

Then may I advise getting in touch with the cardiac rehabilitation nurses. They see 10 patients daily post acute coronary syndrome admissions. Most would fulfill your inclusion criteria. Patients will be collected prospectively.

Surgeon Lieutenant (VRF) Dr Mark Abela MD (Melit) MRCP (London) MSc Internal Medicine (Edinburgh) MSc Sports Cardiology (London) FESC
Cardiology Resident Specialist
Special interest in Sports Cardiology and Inherited Cardiac Conditions
Nucleus Member of the Sports Cardiology and Exercise Section of the EAPC
Armed Forces of Malta Cardiologist
Honorary Senior Lecturer in the Cardiovascular and Genomics Research Institute at St George's, University of London
EAPC National Cardiovascular Disease Prevention Coordinator
Clinical lead for Sports Cardiology / Inherited Arrhythmias / Cardiac Rehabilitation at Mater Dei Hospital
Pager: 3560138 (79847989)

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 24 June 2024 11:29:22
To: Abela Mark at MHA - MDH
Subject: Re: Enquiry regarding possibility to act as my intermediary

Dear Dr Abela,

This is my first time using a hospital for participant recruitment however when I used other institutions in the past, the organisation would access the data record system, contact the individuals who satisfy the criteria for the study and would provide them with my email address and they contact me should they would like to participate.

Kind regards,
Christine Gauci

From: Abela Mark at MHA - MDH <mark.c.abela@gov.mt>
Sent: Monday, June 24, 2024 11:22 AM
To: Christine Gauci <christine.gauci.16@um.edu.mt>
Subject: Re: Enquiry regarding possibility to act as my intermediary

How am I going to reach out?

Surgeon Lieutenant (VRF) Dr Mark Abela MD (Melit) MRCP (London) MSc Internal Medicine (Edinburgh) MSc Sports Cardiology (London) FESC
Cardiology Resident Specialist
Special interest in Sports Cardiology and Inherited Cardiac Conditions
Nucleus Member of the Sports Cardiology and Exercise Section of the EAPC
Armed Forces of Malta Cardiologist
Honorary Senior Lecturer in the Cardiovascular and Genomics Research Institute at St George's, University of London
EAPC National Cardiovascular Disease Prevention Coordinator
Clinical lead for Sports Cardiology / Inherited Arrhythmias / Cardiac Rehabilitation at Mater Dei Hospital
Pager: 3560138 (79847989)

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 24 June 2024 11:18:28
To: Abela Mark at MHA - MDH
Subject: Re: Enquiry regarding possibility to act as my intermediary

Dear Dr Abela,

Thank you for your response. Your assistance in this study should you accept would consist of reaching out to around 10 postmenopausal women between the ages of (55-70 years) diagnosed with coronary artery disease who utilised or are currently making use of the services provided by the cardiology department.

Kind regards,
Christine Gauci

From: Abela Mark at MHA - MDH <mark.c.abela@gov.mt>
Sent: Monday, June 24, 2024 11:11 AM
To: Christine Gauci <christine.gauci.16@um.edu.mt>
Subject: Re: Enquiry regarding possibility to act as my intermediary

Before taking on this, I need to know what my commitment will have to include. I am inundated with clinical and academic commitments, so I am afraid I cannot allocate a lot of time for this task.

Surgeon Lieutenant (VRF) Dr Mark Abela MD (Melit) MRCP (London) MSc Internal Medicine (Edinburgh) MSc Sports Cardiology (London) FESC
Cardiology Resident Specialist
Special interest in Sports Cardiology and Inherited Cardiac Conditions
Nucleus Member of the Sports Cardiology and Exercise Section of the EAPC
Armed Forces of Malta Cardiologist
Honorary Senior Lecturer in the Cardiovascular and Genomics Research Institute at St George's, University of London
EAPC National Cardiovascular Disease Prevention Coordinator
Clinical lead for Sports Cardiology / Inherited Arrhythmias / Cardiac Rehabilitation at Mater Dei Hospital
Pager: 3560138 (79847989)

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 24 June 2024 07:50:11
To: Abela Mark at MHA - MDH
Subject: Re: Enquiry regarding possibility to act as my intermediary

Dear Dr Abela,

Good morning. I hope this email finds you well. I am writing as a gentle reminder on the below email please.

Thank you very much in advance,
Kind regards,
Christine Gauci

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: Tuesday, June 18, 2024 6:52 PM
To: mark.c.abela@gov.mt <mark.c.abela@gov.mt>
Subject: Enquiry regarding possibility to act as my intermediary

Dear Dr Abela,

Good afternoon. I hope this email finds you well. I am reading for a Masters of Psychology in Health Psychology at the University of Malta. My research is entitled "Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners" and intends to explore the holistic consequences of coronary artery disease on post-menopausal women and their partners, under the supervision of Dr Pamela Portelli. I will be employing interviews with post-menopausal women diagnosed with coronary artery disease and their partners. These will be audio-recorded, transcribed and analysed.

I have received approval from Dr Felice to conduct my study within the Cardiology department. I am sending you this email to enquire if you would be interested in acting as my intermediary to recruit participants with the following criteria:

Post-menopausal women

- Between the ages of 55 - 70 years

- diagnosed with coronary artery disease.

This proposal has been submitted to FREC (Faculty Ethics Research Committee) who provided ethical clearance. Should you accept to act as my intermediary, I will be sending you a document stating your role in the recruitment process to fill it in and re-send it back to the data protection officer since this is requested to commence the clearing process of MDH.

Should you require any other information about my study, feel free to contact me.

Thank you very much in advance,

Kind regards,

Christine Gauci (115998M).

Approval from Mater Dei Chief Executive Officer

RE: Approval to carry out a study within MDH

Fenech Carol 1 at MHA - MDH <carol.fenech.1@gov.mt>
Tue 16/07/24 10:59
To:Christine Gauci <christine.gauci.16@um.edu.mt>
Cc:Gatt Cherise at MHA- Contractors <cherise.gatt@contractors.gov.mt>;Magri Caroline Jane at MHA - MDH <caroline-jane.magri@gov.mt>

Dear Ms Gauci,

On behalf of Ing. Keith Attard, CEO, Mater Dei Hospital, your study titled ***"Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners"*** is hereby approved.

Kindly keep to the guidelines provided and as ethical clearance is sought.

Best regards,

Carol Fenech
Assistant Director and Coordinator for European Reference Networks
Admin- Office Of The CEO
MHA-Mater Dei Hospital

t: 25454102 **e:** carol.fenech.1@gov.mt
https://health.gov.mt

MINISTRY FOR HEALTH AND ACTIVE AGEING
Mater Dei Hospital, Triq Id-Donaturi Tad-Demm,
Msida, Malta

From: Magri Caroline Jane at MHA - MDH <caroline-jane.magri@gov.mt>
Sent: Thursday, July 11, 2024 11:51 AM
To: Christine Gauci <christine.gauci.16@um.edu.mt>; Fenech Carol 1 at MHA - MDH <carol.fenech.1@gov.mt>
Subject: Re: Approval to carry out a study within MDH

Dear Christine,

Thanks for the info provided. Approved from my end.

Regards,

Caroline

Dr. Caroline J. Magri
MD, MRCP (UK), FEFIM, MPhil (Melit), M. Int. Cardiol. (UniSR), MSc (Brighton), PhD (Melit), FESC, PG Cert EBM, MSc Healthcare Management & Leadership, FRCP (Edin)
Consultant Cardiologist
Research Support Lead, Office of the Medical Director, Mater Dei Hospital
Lead Clinician in Research in Cardiology, Mater Dei Hospital
Visiting Senior Lecturer University of Malta
Reader in Cardiology, Queen Mary University of London Malta Campus

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: 11 July 2024 10:26:47
To: Magri Caroline Jane at MHA - MDH
Subject: Fw: Approval to carry out a study within MDH

Dear Dr Magri,

Good morning. I hope this email finds you well. I am writing as a gentle reminder on the below email please.

I hope you have a nice day ahead.
Kind regards,
Christine

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: Friday, July 5, 2024 1:12 PM
To: Magri Caroline Jane at MHA - MDH <caroline-jane.magri@gov.mt>; CEO at MHA - MDH <ceo.mdh@gov.mt>
Cc: Fenech Carol 1 at MHA - MDH <carol.fenech.1@gov.mt>
Subject: Re: Approval to carry out a study within MDH

Dear Dr Magri,

Good afternoon. Thank you for your reply. Attached kindly find a document with an overview of the study, the approval email from Dr Felice, clearance from the data protection officer, a document signed by the intermediary, a copy of the information sheet and consent forms (in Maltese and English), a copy of the interview guide (Maltese and English) and the declaration concerning audio recordings.

Should you require any other document kindly let me know.

Thank you in advance,
Kind regards,
Christine

From: Magri Caroline Jane at MHA - MDH <caroline-jane.magri@gov.mt>
Sent: Thursday, July 4, 2024 9:36 PM
To: CEO at MHA - MDH <ceo.mdh@gov.mt>; 'Christine Gauci' <christine.gauci.16@um.edu.mt>
Cc: Fenech Carol 1 at MHA - MDH <carol.fenech.1@gov.mt>
Subject: RE: Approval to carry out a study within MDH

Dear Christine,

Kindly forward me all attached documents in relation to your study, especially the study protocol and interview guide so that I can proceed with approval of the study.

Regards,
Caroline

Dr. Caroline J. Magri
MD, MRCP (UK), FEFIM, MPhil (Melit), M. Int. Cardiol. (UniSR), MSc (Brighton), PhD (Melit), FESC, PG Cert EBM, MSc Healthcare Management & Leadership, FRCP (Edin)
Consultant Cardiologist
Research Support Lead, Office of the Medical Director, Mater Dei Hospital
Lead Clinician in Research in Cardiology, Mater Dei Hospital
Visiting Senior Lecturer University of Malta
Reader in Cardiology, Queen Mary University of London, Malta Campus

From: Fenech Carol 1 at MHA - MDH <carol.fenech.1@gov.mt> **On Behalf Of** CEO at MHA - MDH
Sent: Wednesday, 03 July 2024 11:16
To: 'Christine Gauci' <christine.gauci.16@um.edu.mt>; CEO at MHA - MDH <ceo.mdh@gov.mt>
Cc: Magri Caroline Jane at MHA - MDH <caroline-jane.magri@gov.mt>
Subject: RE: Approval to carry out a study within MDH

Dear Ms Gauci

Thank you for your email. You have MDH DPO related approvals. I am keeping in copy Dr Caroline Jane Magri who vets the actual research proposal. Once I have Dr Magri's approval I can proceed with issuing approval on behalf of CEO. Please keep the name of the study in the subject of the email for related future correspondence .

Kind regards,

Carol

Carol Fenech
Assistant Director and Coordinator for European Reference Networks
Admin- Office Of The CEO
MHA-Mater Dei Hospital

t: 25454102 **e:** carol.fenech.1@gov.mt
https://health.gov.mt

MINISTRY FOR HEALTH AND ACTIVE AGEING
Mater Dei Hospital, Triq Id-Donaturi Tad-Demm,
Msida, Malta

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: Monday, July 1, 2024 8:40 AM
To: CEO at MHA - MDH <ceo.mdh@gov.mt>
Subject: Fw: Approval to carry out a study within MDH

To whom it may concern,

Good morning. I hope this email finds you well. I am writing as a gentle reminder concerning the below email please.

Thank you in advance,
Kind regards,
Christine Gauci

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: Tuesday, June 25, 2024 10:41 AM
To: ceo.mdh@gov.mt <ceo.mdh@gov.mt>
Subject: Approval to carry out a study within MDH

To whom it may concern,

Good morning. I hope this email finds you well. I am reading for a Masters of Psychology in Health Psychology at the University of Malta. My research is entitled "Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners" and intends to explore the holistic consequences of coronary artery disease on post-menopausal women and their partners, under the supervision of Dr Pamela Portelli. I will be employing interviews with post-

menopausal women diagnosed with coronary artery disease. These will be audio-recorded, transcribed and analysed.

I have received ethical clearance from the data protection officer (email attached) and also I have received approval of Dr Felice to conduct the study within the cardiology department (email attached). Attached kindly find my information sheet, consent forms, interview guide, declaration of audio recordings and declaration of my intermediary.

I am writing to enquire if you would kindly provide your approval to carry out this study within Mater Dei Hospital.

I hope you have a nice day.

Thank you very much in advance,
Kind regards,
Christine Gauci

Approval from the Director General Health Informatics

FW: Data Protection Approval Form - Christine Gauci between Mater Dei Hospital and Ms Christine Gauci is Signed and Filed!

Data Protection Approval Form at MHA - MDH <dpaform.mdh@gov.mt>
Thu 18/07/24 07:54
To:'Christine Gauci' <christine.gauci.16@um.edu.mt>

1 attachments (229 KB)
Data Protection Approval Form - Christine Gauci - signed.pdf;

Good Morning

Form received. You may now proceed.

Regards,

Graziella Aquilina
Personal Assistant to Director General Health Informatics (C109 298)

Health Informatics Directorate
Health-Mater Dei Hospital

t: +356 25455334 **e:** graziella.aquilina@gov.mt
www.gov.mt

MINISTRY FOR HEALTH AND ACTIVE AGEING
Mater Dei Hospital, Triq Id-Donaturi Tad-Demm,
Msida, Malta

From: Adobe Sign <adobesign@adobesign.com>
Sent: Wednesday, July 17, 2024 9:28 AM
To: Ms Christine Gauci <christine.gauci.16@um.edu.mt>; Data Protection Approval Form at MHA - MDH <dpaform.mdh@gov.mt>
Subject: Data Protection Approval Form - Christine Gauci between Mater Dei Hospital and Ms Christine Gauci is Signed and Filed!

Data Protection Clearance Declaration Form

Data Protection Clearance Declaration Form

REF: 131/2024

I hereby declare that I will respect the confidentiality and privacy of any personal data or information that I will come across at Mater Dei and will in no circumstance disclose any such information to third parties.

I confirm that information submitted for Data Protection Clearance is correct and that I will abide with conditions issued in same clearance notice.

On the basis of the documentation you submitted, from the MDH data protection point of view you have been cleared to proceed with your study titled **Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners** provided that you obtain approval from MDH CEO (ceo.mdh@gov.mt - please provide the relevant documents including Dr Tiziana Felice's approval and this email)

- Your intermediary to approach potential participants on your behalf is Ms Marilyn Gauci – Staff Nurse who works at the Cardiac Rehab Unit within the Cardiology Department, MDH
- Your potential participants to attend your interviews are adult patients between the age of 55 years to 70 years diagnosed with Coronary Artery Disease who are receiving a service at the Cardiology Department, MDH

All data stored must be anonymized and in no way should you retain any personal details you obtain from your research and these should be destroyed at the end of your study and /or if any of your participants decides to withdraw. Remember that participants reserve the right to be forgotten.

Anonymisation and Data minimisation

Participant consent forms must be separated from the interview answers at source, meaning that there will be no correlation between one and the other that will indicate how participants replied.

ALL data presented to your supervisors / tutors or examiners or any other personnel from UOM or anyone else must be **already anonymized**; meaning that you must not divulge to anyone the identity of your participants and / or how they replied. There shall not be any exceptional circumstances allowing the supervisors, examiners or anyone else to access personal identifiable data.

Data Protection Clearance Declaration Form

REF: 131/2024

Consent Criteria

- This clearance does not allow viewing of medical records nor access to Health Information Systems.
- All your participants must be reached and approached for invitation when physically at the Cardiology Department, MDH grounds (through Ms Marilyn Gauci) and NOT via postal services, email, telephone or any other means. You cannot be handed any contact details of potential participants, otherwise consent would be bypassed.
- Potential participants must be approached by Ms Marilyn Gauci for invitation and not directly by you. You can approach only after the participants will consent.
- Personal identifiable data such as signed consent forms or pseudonym lists are not to be sent via email (not even relayed to yourself), replicated and/or uploaded to any server, cloud storage, site or any other media given that participants will not consent any service provider to store their personal identifiable data.

- Audio recordings must be strictly accessed and listened only by you (not even by your tutors, supervisors or any personnel from UOM/ FHS) and that all data (including transcripts) presented to UOM / FHS must be completely anonymised. Such recordings are not to be sent via email, replicated and/or uploaded to any server, cloud storage, site or any other media. Audio recordings must be destroyed after the conversation will be transcribed or if a participant decides to withdraw from your study.
- If a transcription software will be used, it is in your responsibility to ensure that this is not connected online to any cloud service or server and that such software operates in an offline mode. All cashed data and any other personal identifiable data should be immediately wiped out after the transcript is produced and anonymised.
- Video recordings and photography are not allowed for this research.

Clarifications

- This clearance does not cover ethical approval.
- All documents presented to your participants must include UOM's logo.
- This clearance does not allow verbal consent.
- This clearance is valid for your report to be included with your dissertation only and not in medical journals or elsewhere given that you are not obtaining approval from MDH legal office.
- Your submitted documentation must remain unchanged.
- What was declared during this clearance process is what you will abide to.
- You must abide with all the articles of the GDPR (EU) 2016 / 679 throughout the data collection process and thereafter.
- You are requested to submit a copy of your findings to this office at the end of your study.
- This clearance covers your research to be carried out only at the Cardiology Department, MDH and not in any other department / institution such as Primary Healthcare, GGH, KGH, MHS, SVPR, DHIR or any other institution / department that doesn't form part of MDH Data Controller.

Data Protection Clearance Declaration Form

REF: 131/2024

I also declare that I am aware of the provisions of the:

- General Data Protection Regulation (2016)

  (ref: https://idpc.org.mt/en/Pages/gdpr.aspx),

- Computer misuse provisions of the Criminal Code

  (ref: http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8574),

and, the

- Professional Secrecy Act

  (ref: http://www.justiceservices.gov.mt/DownloadDocument.aspx?app=lom&itemid=8844&l=1)

and that I will abide by all Government and Hospital regulations related to data, information and use of IT Systems and services (ref: http://ictpolicies.gov.mt , http://www.kura.gov.mt).

Full Name: Christine Gauci

ID Number: 0115998M

Approval Date from DPO: 25th June 2024

Approval Date from CEO: 16th July 2024

Data Collection Period (From – To): July 2024 – October 2024

MDH Official Approval Names: Dr T Felice

Name of Study / Audit: Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners

Applicant's Signature: Ms Christine Gauci
Ms Christine Gauci (Jul 17, 2024 09:28 GMT+2)

Approval from the Chief Executive Officer of Gozo General Hospital

RE: Request for the possibility of acting as a gatekeeper

Ogilvie-Galea Carmen at MHA - GGH <carmen.ogilvie-galea@gov.mt>
Wed 05/06/24 15:07
To:Christine Gauci <christine.gauci.16@um.edu.mt>
Cc:Xuereb Claire at MHA - GGH <claire.p.xuereb@gov.mt>

Approved

Carmen Ogilvie-Galea

Director General
Gozo General Hospital
MHA-Gozo General Hospital
t +356 23446404 e carmen.ogilvie-galea@gov.mt

GOZO GENERAL HOSPITAL, TRIQ L-ARCISQOF PIETRU PACE, VICTORIA, GOZO, MALTA

GOZO GENERAL HOSPITAL

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: Thursday, May 23, 2024 1:42 PM
To: Ogilvie-Galea Carmen at MHA - GGH <carmen.ogilvie-galea@gov.mt>
Cc: Xuereb Claire at MHA - GGH <claire.p.xuereb@gov.mt>
Subject: Request for the possibility of acting as a gatekeeper

Dear Ms Ogilvie Galea,

Good afternoon. I hope this email finds you well. I am reading for a Masters of Psychology in Health Psychology at the University of Malta. My research is entitled "Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners" and intends to explore the holistic consequences of coronary artery disease on post-menopausal women and their partners, under the supervision of Dr Pamela Portelli. I will be employing interviews with post-menopausal women diagnosed with coronary artery disease and their partners. These will be audio-recorded, transcribed and analysed. Moreover, pseudonyms will be used thus safeguarding the participants' identity. Participants for this study need to have the following criteria:

Post-menopausal women

- Between the ages of 55 - 70 years
- diagnosed with coronary artery disease.

Their partners

- Male
- They have been in a relationship when their partner experienced the symptoms and got diagnosed.

- All participants who wish to partake in this study need to consent to have the interview audio recorded.

This proposal has been submitted to FREC (Faculty Ethics Research Committee) who provided ethical clearance. Hence, I am writing to enquire if you would have any objection to forwarding my request to your clients. Should you consent, I will send a detailed information letter and consent forms accordingly whilst attaching your reply as an appendix within my study.

Kind regards,

Christine Gauci (115998M).

Approval from the intermediary working within the Gozo General Hospital

From: Attard Assunta at MHA - GGH <assunta.attard@gov.mt>
Sent: Monday, July 15, 2024 2:55 PM
To: Christine Gauci <christine.gauci.16@um.edu.mt>
Subject: RE: Enquiry regarding possibility to act as my intermediary

Dear Christine,

Yes I will act as your intermediary for this study.

Kind regards,
Assunta

Assunta Attard
Practice Nurse
Nursing Administration
MHA-Gozo General Hospital
t +356 23446377 e assunta.attard@gov.mt
https://health.gov.mt | [www.publicservice.gov.mt]
www.publicservice.gov.mt | fb.com/servizzpubbliku
Kindly consider your environmental responsibility before printing this e-mail

MINISTRY FOR HEALTH AND ACTIVE AGEING
GOZO GENERAL HOSPITAL, TRIQ L-ARCISQOF PIETRU PACE,
VICTORIA, GOZO, MALTA

From: Christine Gauci <christine.gauci.16@um.edu.mt>
Sent: Monday, 15 July 2024 14:47
To: Attard Assunta at MHA - GGH <assunta.attard@gov.mt>
Subject: Enquiry regarding possibility to act as my intermediary

Dear Ms Attard,

Good afternoon. I hope this email finds you well. I am reading for a Masters of Psychology in Health Psychology at the University of Malta. My research is entitled "Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners" and intends to explore the holistic consequences of coronary artery disease on post-menopausal women and their partners, under the supervision of Dr Pamela Portelli. I will be employing interviews with post-menopausal women diagnosed with coronary artery disease. These will be audio-recorded, transcribed and analysed.

I am sending you this email to enquire if you would be interested in acting as my intermediary to contact participants with the following criteria:

Post-menopausal women

- Between the ages of 55 - 70 years
- diagnosed with coronary artery disease.

- - currently or in the past made use of the services provided by Gozo General Hospital

I have received ethical clearance from the University to conduct this study. Moreover, I have received approval from Ms Ogilvie Galea to conduct my study within Gozo General Hospital.

Thank you very much in advance,

Kind regards,

Christine Gauci (115998M).

Appendix D

Information Sheet (English Version)

11.06.2024

Information letter

Dear Sir/Madam,

My name is Christine Gauci and I am a student at the University of Malta, presently reading for a Master of Psychology in Health Psychology. I am presently conducting a research study for my dissertation titled Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners; this is being supervised by Dr Pamela Portelli. This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

The aim of my study is to explore the biopsychosocial repercussions of coronary artery disease in post-menopausal women, to explore the effects of coronary artery disease on partners of post-menopausal women, to explore how post-menopausal women with coronary artery disease and their partners cope with such condition and to explore the participants' perceptions of services available and how these can be improved. Your participation in this study would help increase awareness of the complex implications coronary artery disease has on post-menopausal women and their partners. Any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, you will be asked to sit for an interview lasting between 60 – 90 minutes. The interview will be conducted either in Maltese or English according to your preference and will take place somewhere where you find most comfortable and convenient. The interview will be audio-recorded, transcribed and analysed. You will be asked to choose

your pseudonym. I will make sure that these recordings are kept in a safe place. The inclusion criteria for this study are as follows: post-menopausal women (between the ages of 55 - 70 years), diagnosed with coronary artery disease. Concerning the partners, the inclusion criteria is that they are male and have been in a relationship when their partner experienced the symptoms and got diagnosed. Participants who would like to partake in this study should also consent to have the interview audio-recorded. The exclusion criteria would be women with coronary artery disease younger than 55 years and older than 70 years, female partners and participants who would not like their interview to be audio recorded. For this study, no inducements will be offered. During the interview, post-menopausal women who meet the criteria mentioned above will be asked to narrate their experience when they were diagnosed with coronary artery disease. When it comes to their partners, they will be asked to narrate their experience of having their partner diagnosed with coronary artery disease, the implications this condition had on their relationship, their perception of how this impacted their significant other and their perception of services available. All the disclosed information will be kept strictly confidential.

Data collected will be saved with the participants' chosen pseudonym to ensure confidentiality and anonymity. In addition to this, I will make sure not to utilise any details which could identify your identity at any stage of the research. The audio recordings of the interviews will then be transcribed as soon as possible in a verbatim manner. Once the interview is completed, I will you how would you like to receive the transcript e.g. email or registered mail, and you have 4 weeks to amend as needed thus ensuring accuracy, credibility and audit trail. Extracts from what you say, obtained from the interview and that might be quoted in the dissertation will be kept anonymous.

Should you wish to hold the interview online, Zoom accessed through my university account will be utilised. You and I will have the cameras on to see each other for better conversation.

Furthermore, I will send instructions before the interview, as well to help you on the day of the interview, to change their zoom name to only display your chosen pseudonym. Additionally, I will orally only use your pseudonym throughout the interview so that the audio recordings, as well as the verbatim transcripts, are pseudonymised. If the interview is held online, you will be informed that when a session on zoom is recorded, 2 files are downloaded (the voice recording of the interview and a video recording of the interview). Once the interview is completed the video recording will be deleted immediately. Only the audio recording will be used.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

If you choose to participate, please note that there are the following direct benefits to you: narrating your experience which could motivate others who might be going through a similar period to not give up. In addition, such narratives can assist others by portraying that life does not stop after receiving such diagnosis but there is still hope and positivity once the individual processes it accordingly. Furthermore, some indirect benefits could assist both the participants and society as a whole. For instance, this study will add to the local lacuna of research, increase awareness, could be used for policy development and/or improvements in existing institutions. Your participation does not entail any known or anticipated risks however should you feel that you would like to make use of therapeutic services I will be sharing with you a document with several services that offer such support free or with payment should you wish to contact them.

Please note also that, as a participant, you have the right under the General Data Protection Regulation (GDPR) and national legislation to access, rectify and where applicable ask for the data concerning you to be erased. All data collected will be pseudonymised. With regards to the filled in consent form, these will be stored in a filing cabinet under lock and key. Documents containing information disclosed yourself (ie. Transcripts and consent forms) will be permanently deleted and shredded respectively on 30th May 2025. Access to my dissertation will be made available to my supervisor Dr Pamela Portelli, the examination board and the university students. A copy of this information sheet is being provided for you to keep and for future reference.

Thank you for your time and consideration. Should you have any questions or concerns, please do not hesitate to contact me by e-mail christine.gauci.16@um.edu.mt; you can also contact my supervisor over the phone: 2340 2312 or via email: pport03@um.edu.mt.

Sincerely,

Christine Gauci

christine.gauci.16@um.edu.mt

Dr Pamela Portelli

pport03@um.edu.mt

23402312

Information Sheet (Maltese version)

11.06.2024

Għażiż/a Sinjur/a,

Jiena Christine Gauci, student/a fl-Università ta' Malta, u bħalissa qed insegwi Master tal-Psikoloġija fil-Psikoloġija fil-qasam tas-saħħa. Ir-riċerka għad-dissertazzjoni tiegħi jisimha: Kwistjonijiet tal-Qalb: il-konsegwenzi tal-mard tal-arterji koronarji fuq nisa wara l-menopawża u l-imsieħba tagħhom; it-tutur tiegħi hi Dr Pamela Portelli. B'din l-ittra nixtieq nistiednek tipparteċipa fir-riċerka. Hawn taħt issib aktar informazzjoni fuq l-istudju li qed nagħmel u fuq xi jkun l-involviment tiegħek jekk tiddeċiedi li tieħu sehem.

L-għan tal-istudju hu li tesplora r-riperkussjonijiet bijopsikosoċjali tal-mard tal-arterji koronarji f'nisa wara l-menopawża, biex tesplora l-effetti tal-mard tal-arterji koronarji fuq l-imsieħba ta' nisa wara l-menopawża, biex tesplora kif in-nisa li għaddew mill- menopawża b' mard fl-arterji koronarji u l-imsieħba tagħhom ikampaw b'din il-kundizzjoni u biex tesplora l-perċezzjonijiet tal-parteċipanti fuq servizzi disponibbli u kif dawn jistgħu jittejbu. Sehmek jgħin biex ikun hawn iżjed għarfien dwar tal-implikazzjonijiet kumplessi li l-marda tal-arterji koronarji għandha fuq in-nisa wara l-menopawża u l-imsieħba tagħhom. L-informazzjoni kollha li tinġabar fir-riċerka tintuża biss għall-fini ta' dan l-istudju.

Jekk taqbel li tipparteċipa, tintalab tpoġġi għal intervista li ddum bejn 60 – 90 minuta. L-intervista ssir jew bil-Malti jew bl-Ingliż skont il-preferenza tiegħek u ssir xi mkien fejn issib l-aktar komdu u konvenjenti. L-intervista se tiġi rrekordjata bl-awdjo, traskritta u analizzata. Inti tintalab tagħżel il-psewdonimu tiegħek. Dawn ir-reġistrazzjonijiet jinżammu f'post sigur. Il-kriterji ta' inklużjoni għal dan l-istudju huma kif ġejjin: nisa wara l-menopawża (bejn l-

etajiet ta' 55 - 70 sena), għandhom dijanjostikati tal- mard tal-arterja koronarja. Rigward is-sieħeb, il-kriterji ta' inklużjoni huma li huma irġiel u kienu f'relazzjoni meta s-sieħba tagħhom esperjenzat s-sintomi u ġie djanjostikata. Il- parteċipanti li jixtiequ jieħdu sehem f'dan l-istudju għandhom jaqblu wkoll biex l-intervista' tiġi rrekordjata. Il-kriterji ta' esklużjoni jkunu nisa b'mard tal-arterji koronarji iżgħar minn 55 sena u akbar minn 70 sena, imsieħba nisa u parteċipanti li ma jixtiqux li l-intervista' tiġi irrekordjata. Għal dan l-istudju, mhux se jiġu offruti inċentivi. Waqt l-intervista, nisa li spiċċaw l-menopawsa li jissodisfaw il-kriterji msemmija hawn fuq se jintalbu jirrakkontaw l-esperjenza tagħhom meta ġew iddijanjostikati b'mard tal-arterja koronarja. Fejn jidħlu l-imsieħba tagħhom, huma se jintalbu jirrakkontaw l-esperjenza tagħhom meta s-sieħba tagħhom ġiet djanjostikata b'mard tal-arterja koronarja, l-implikazzjonijiet li din il-kundizzjoni kellha fuq ir-relazzjoni tagħkhom, il-perċezzjoni tiegħek ta' kif dan kellu impatt fuq s-sinifikanti tagħhom u l-perċezzjoni tiegħek tas-servizzi disponibbli. L-informazzjoni kollha żvelata se tinżamm strettament kunfidenzjali.

L-informazzjoni miġbura tiġi irreġistrata bil-psewdonimu magħżul minnek biex tiġi żgurata l-kunfidenzjalità u l-anonimità. Barra minn hekk, ser niżgura li ma nutilizza l-ebda dettalji li jistgħu jidentifikaw l-identità tiegħek fi kwalunkwe stadju tar-riċerka. Ir-reġistrazzjonijiet awdjo tal-intervisti mbagħad jiġu traskritti malajr kemm jista' jkun b'mod verbatim. Ladarba titlesta l-intervista, jiena ser insaqsik kif tixtieq tirċievi t-traskrizzjoni eż. email jew posta reġistrata, u inti ser tkun infurmat li għandek 4 ġimgħat biex tamenda kif meħtieġ biex b'hekk jiġu żgurati l-eżattezza, il-kredibilità u l-verifika. Siltiet minn dak li tgħid, miksuba mill-intervista u li jistgħu jiġu kkwotati fid-dissertazzjoni se jinżammu anonimi.

Jekk tixtieq tagħmel l-intervista online, se jintuża zoom aċċessat permezz tal-kont tal-università tiegħi. Inti u jien ikollna il-cameras biex naraw lil xulxin għal konversazzjoni aħjar. Jiena, ser nibgħat istruzzjonijiet qabel l-intervista, kif ukoll biex ngħinek fil-jum ta' l-intervista, biex biddel l-isem tiegħek halli zoom juri biss il-psewdonimu li inti għażilt. Jiena ser nuża biss il-pseudonim tiegħek matul l-intervista sabiex ir-reġistrazzjonijiet tal-awdjo, kif ukoll it-trascripts verbatim, jkunu psewonimizati. Jekk l-intervista ssir online, ser tkun infurmat/a li meta tiġi rrekordjata sessjoni fuq iz-zoom, jitniżżlu 2 fajls (ir-reġistrazzjoni tal-vuċi tal-intervista u reġistrazzjoni bil-vidjo tal-intervista). Ladarba titlesta l-intervista, ir-reġistrazzjoni tal-vidjo se titħassar immedjatament. Se jintuża biss ir-reġistrazzjoni tal-awdjo. Il-parteċipazzjoni tiegħek f'dan l-istudju tkun għalkollox volontarja; fi kliem ieħor, inti liberu/a li taċċetta jew tirrifjuta li tieħu sehem, mingħajr ma tagħti raġuni. Inti wkoll liberu/a li twaqqaf il-parteċipazzjoni tiegħek fl-istudju meta tixtieq, mingħajr ma jkollok tagħti spjegazzjoni u mingħajr ebda riperkussjoni. Jekk tagħżel li tirtira mir-riċerka, l-informazzjoni li tkun laħqet ittieħdet fl-intervista miegħek titħassar dment li dan ikun teknikament possibbli (ngħidu aħna, qabel ma tiġi anonimizzata jew ippubblikata), u sakemm l-għanijiet tar-riċerka jkunu jistgħu jintlaħqu u ma jintlaqtux serjament. F'dak il-każ, l-informazzjoni tiegħek tintuża u tinżamm anonima.

Jekk tagħżel li tipparteċipa, jekk jogħġbok innota li hemm dawn il-benefiċċji diretti għalik: tirrakkonta l-esperjenza tiegħek tista' timmotiva lil oħrajn li jistgħu jkunu għaddejjin minn perjodu simili biex ma jaqtgħux qalbhom. Barra minn hekk, narrattivi bħal dawn jistgħu jgħinu lill-oħrajn billi jaqsmu li l-ħajja ma tieqafx wara li tirċievi dijanjosi bħal din iżda xorta hemm tama u pożittività ladarba l-individwu jipproċessaha kif xieraq. Barra minn hekk, hemm ukoll xi benefiċċji indiretti li jistgħu jgħinu kemm lill-parteċipanti kif ukoll lis-soċjetà.

Pereżempju, dan l-istudju se jżid mal-lakuna lokali tar-riċerka, iżid l-għarfien, jista' jintuża għall-iżvilupp u/jew titjib f'istituzzjonijiet eżistenti.

Il-parteċipazzjoni tiegħek ma fiha l-ebda riskju magħruf jew mistenni madankollu jekk tħoss li tixtieq tagħmel użu minn servizzi terapewtiċi, se inkun qed nagħtik dokument ta' diversi servizzi li joffru tali appoġġ b'xejn u/jew bil-ħlas li inti tkun tista' tikkuntattja.
Bħala parteċipant/a, għandek id-dritt, skont ir-Regolament Ġenerali dwar il-Protezzjoni tad-Data (GDPR) u l-leġiżlazzjoni nazzjonali, li taċċessa, tikkoreġi u fejn hu applikabbli, titlob li l-informazzjoni li tikkonċernak titħassar. L- informazzjoni kollha miġbura tiġi psewdonimizzata. Fir-rigward tal-formola tal-kunsens mimlija, dawn se jinħażnu f'kexxun imsakkar. Dokumenti li fihom informazzjoni żvelata fuqek innifsek (jiġifieri Traskrizzjonijiet u formoli ta' kunsens) se jitħassru u jitqattgħu b'mod permanenti rispettivament fit-30 ta' Mejju 2025. L-aċċess għad-dissertazzjoni tiegħi se jkun disponibbli għas-superviżur tiegħi Dr Pamela Portelli, il-bord tal-eżaminaturi u l-istudenti universitarji.

Qed ngħaddilek kopja ta' din l-ittra biex iżżommha bħala referenza.
Grazzi tal-ħin u l-kunsiderazzjoni tiegħek. Jekk ikollok xi mistoqsija, tiddejjaqx tikkuntattjani fuq christine.gauci.16@um.edu.mt; tista' tikkuntattja wkoll lit-tutur/i tiegħi fuq: 2340 2312 jew elettronikament fuq: pport03@um.edu.mt

Tislijiet,

Christine Gauci
christine.gauci.16@um.edu.mt

Dr Pamela Portelli
pport03@um.edu.mt
23402312

Appendix E

Consent form (English Version)

Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners.

I, the undersigned, give my consent to take part in the study conducted by Christine Gauci. This study is being supervised by Dr Pamela Portelli. This consent form specifies the terms of my participation in this research study.

1. I have been given written and/or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction.
2. I also understand that I am free to accept to participate, or to refuse or stop participation at any time without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.
3. I understand that I have been invited to participate in an interview in which the researcher will ask post-menopausal women with coronary artery disease to narrate their experience when they were diagnosed with coronary artery disease. When it comes to their Male partners, they will be asked to narrate their experience of having their partner diagnosed with coronary artery disease, the implications this condition had on their

relationship, their perception of how this impacted their significant other and their perception of services available. This study aims to explore the biopsychosocial repercussions of coronary artery disease in post-menopausal women, to explore the effects of coronary artery disease on partners of post-menopausal women, to explore how post-menopausal women with coronary artery disease and their partners cope with such condition and to explore the participants' perceptions of services available and how these can be improved. I am aware that the interview will take approximately will last between 60 – 90 minutes. I understand that the interview is to be conducted in a place and at a time that is convenient for me.

4. I understand that my participation does not entail any known or anticipated risks.
5. I understand that there are the following direct benefits to me: narrating your experience which could motivate others who might be going through a similar period to not give up. In addition, such narratives can assist others by portraying that life does not stop after receiving such diagnosis but there is still hope and positivity once the individual processes it accordingly. I also understand that this research may benefit others by: adding to the local lacuna of research, increase awareness, could be used for policy development and/or improvements in existing institutions.
6. I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased.
7. I understand that all data collected will be erased on completion of the study and following publication of results on 30th May 2025.
8. I have been provided with a copy of the information letter and understand that I will also be given a copy of this consent form.

9. I am aware that, by marking the first-tick box below, I am giving my consent for this interview to be audio recorded and converted to text as it has been recorded (transcribed).

   □ I agree to this interview being audio recorded.

   □ I do not agree to this interview being audio recorded.

10. I am aware that extracts from my interview may be reproduced in these outputs, either in anonymous form, or using a pseudonym [a made-up name or code – e.g. respondent A].

    □ I would like to review extracts of my interview transcript that the researcher would like to reproduce in research outputs before these are published. Should you wish to review the transcript, the researcher will ask you how you would like to receive the transcript e.g. email or registered mail, and you have 4 weeks to amend as needed thus ensuring accuracy, credibility and audit trail.

    □ I would not like to review my interview transcript extracts that the researcher would like to reproduce in research outputs before these are published.

11. Should I request my interview to be held online, the researcher will use Zoom and will activate the Require Encryption for 3rd party endpoints SIP/H-323 function. The researcher will only audio record the session. Both the researcher and I will have the cameras on to see each other for better conversation. Furthermore, the researcher will send instructions before the interview, as well to me on the day of the interview, to change my zoom name to only display my pseudonym. Additionally, the researcher will orally only use my pseudonym throughout the interview so that the audio recordings, as well as the verbatim transcripts, are pseudonymised. I will be given the option to choose my own pseudonym, and my identities will be pseudonymised throughout the dissertation.

12. I am aware that my data will be pseudonymised; i.e., my identity will not be noted on transcripts or notes from my interview, but instead, a code will be assigned. The codes that link my data to my identity will be stored securely and separately from the data, in an encrypted file on the researcher's password-protected computer, and only the researcher and academic supervisor/s will have access to this information. Any hard-copy materials will be placed in a locked cabinet/drawer. Any material that identifies me as a participant in this study will be destroyed on 30th May 2025.
13. I am aware that my identity and personal information will not be revealed in any publications, reports or presentations arising from this research.
14. If I feel that the interview has distressed me in any way, I may make use of the support services information that Christine Gauci will give me at the beginning of the interview. I am aware that this document comprises a list of free services. The document also includes fee-paying services which I understand I will have to pay for should I decide not to use free services.

I have read and understood the above statements and agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____

Christine Gauci

christine.gauci.16@um.edu.mt

Dr Pamela Portelli

pport03@um.edu.mt

23402312

Consent form (Maltese Version)

Kwistjonijiet tal-Qalb: il-konsegwenzi tal- mard tal-arterji koronarji fuq nisa wara l-menopawża u l-imsieħba tagħhom

Jiena, hawn taħt iffirmat/a, nagħti l-kunsens tiegħi li nieħu sehem fl-istudju ta' Christine Gauci. Dan l-istudju qed jiġi ssorveljat minn Dr Pamela Portelli. Din il-formola tal-kunsens tispjega t-termini tas-sehem tiegħi f'din ir-riċerka.

1. Ingħatajt l-informazzjoni bil-miktub u/jew bil-fomm dwar l-iskop tar-riċerka; kelli l-opportunità nagħmel il-mistoqsijiet, u kull mistoqsija ngħatajt tweġiba għaliha b'mod sħiħ u sodisfaċenti.
2. Nifhem ukoll li jiena liberu/a li naċċetta li nieħu sehem, jew li nirrifjuta, jew li nwaqqaf il-parteċipazzjoni tiegħi meta nixtieq mingħajr ma nagħti spjegazzjoni jew mingħajr ma niġi penalizzat/a. Jekk nagħżel li nipparteċipa, jaf niddeċiedi li ma nweġibx kull mistoqsija li ssirli. F'każ li nagħżel li ma nkomplix nieħu sehem fl-istudju, l-informazzjoni li tkun laħqet inġabret mingħandi titħassar dment li jkun teknikament possibbli (ngħidu aħna, qabel ma tiġi anonimizzata jew ippubblikata), u sakemm l-għanijiet tar-riċerka jkunu jistgħu jintlaħqu u ma jintlaqtux serjament. F'dak il-każ, l-informazzjoni tiegħi tintuża u tinżamm anonima.
3. Nifhem li ġejt mistieden/mistiedna nipparteċipa f'intervista' u l-persuna li qed tagħmel ir-riċerka se jitlob lin-nisa b'mard tal-arterji koronarji biex jirrakkontaw l-esperjenza tagħhom meta ġew iddijanjostikati b'mard tal-arterji koronarji. Fejn jidħlu l-imsieħba irġiel tagħhom, huma se jintalbu jirrakkontaw l-esperjenza tagħhom meta sieħbu/a tagħhu/tagħhu ġiet djanjostikat b'mard tal-arterja koronarja, l-implikazzjonijiet li din il-kundizzjoni kellha fuq ir-relazzjoni tagħhom, il-perċezzjoni tagħhom ta' kif dan kellu

impatt fuq l-sinifikanti tagħhom u l-perċezzjoni tagħhom tas-servizzi disponibbli. Din ir-riċerka ser tesplora ir-riperkussjonijiet bijopsikosoċjali tal-mard tal-arterji koronarji f'nisa wara l-menopawsa, ser jiġu esplorati l-effetti tal-mard tal-arterji koronarji fuq imsieħba ta' nisa wara l-menopawża, biex tesplora kif in-nisa wara l-menopawża b'mard tal-arterji koronarji u l-imsieħba tagħhom ikampaw ma' din il-kundizzjoni u biex tesplora il-perċezzjonijiet tal-parteċipanti fuq is-servizzi disponibbli u kif dawn jistgħu jittejbu. Jiena konxju/a li l-intervista' se jdum/ddum bejn wieħed u ieħor 60 – 90 minuta. Nifhem li l-intervista' se jsir/ssir f'post u f'ħin li huma komdi għalija.

4. Nifhem li l-parteċipazzjoni tiegħi ma fiha l-ebda riskju magħruf jew mistenni.
5. Nifhem li bil-parteċipazzjoni tiegħi f'dan l-istudju, hemm dawn il-benefiċċji diretti għalija: nirrakkonta l-esperjenza tiegħek tista' timmotiva lil oħrajn li jistgħu jkunu għaddejjin minn perjodu simili biex ma jaqtgħux qalbhom. Barra minn hekk, narrattivi bħal dawn jistgħu jgħinu lill-oħrajn billi jaraw li l-ħajja ma tieqafx wara li tirċievi dijanjosi bħal din iżda xorta hemm tama u pożittività ladarba l-individwu jipproċessaha kif xieraq. Nifhem ukoll li din ir-riċerka jaf tkun ta' benefiċċju għall-oħrajn għax din ir-riċerka qiegħda żżid mal-lakuna lokali tar-riċerka, iżżied fl-għarfien, tista' tintuża għall-iżvilupp tal-servizzi ġodda u/jew titjib fl-istituzzjonijiet eżistenti.
6. Nifhem li, skont ir-Regolament Ġenerali dwar il-Protezzjoni tad-Data (GDPR) u l-leġiżlazzjoni nazzjonali, għandi dritt naċċessa, nikkoreġi u, fejn hu applikabbli, nitlob li l-informazzjoni li tikkonċernani titħassar.
7. Nifhem li l-informazzjoni kollha miġbura se titħassar meta jintemm l-istudju u wara li joħorġu r-riżultati fit-30 ta' Mejju 2025.
8. Ingħatajt kopja tal-ittra ta' tagħrif biex inżommha u nifhem li se ningħata wkoll kopja ta' din il-formola tal-kunsens.

9. Konxju/a li, jekk nimmarka l-ewwel kaxxa t'hawn taħt, inkun qed nagħti l-kunsens tiegħi biex l-intervista' tiġi rrekordjata u maqlub/a f'kitba fl-istess waqt (traskrizzjoni).
   - ☐ Naqbel li l-intervista' tiġi rrekordjata bl-awdjo.
   - ☐ Ma naqbilx li l-intervista' tiġi rrekordjata bl-awdjo.
10. Konxju/a li siltiet mill-intervista tiegħi jistgħu jiġu riprodotti b'mod anonimu jew bl-użu ta' psewdonimu [isem ivvintat jew kodiċi - eż. parteċipant A].
    - ☐ Nixtieq nara siltiet mit-traskrizzjoni tal-intervista miegħi li r-riċerkatriċi/riċerkatriċi se j/tirriproduċi fir-riżultati tar-riċerka qabel ma jiġu ppubblikati. Jekk tixtieq tirrevedi t-traskrizzjoni, ir-riċerkatriċi tistaqsik kif tixtieq tirċievi t-traskrizzjoni eż. email jew posta reġistrata, u għandek 4 ġimgħat biex temenda kif meħtieġ biex b'hekk tiżgura l-eżattezza, il-kredibilità u l-verifika.
    - ☐ Ma nixtieqx nara siltiet mit-traskrizzjoni tal-intervista miegħi li r-riċerkatriċi/riċerkatriċi se j/tirriproduċi fir-riżultati tar-riċerka qabel ma jiġu ppubblikati.
11. Jiena naf li jekk inkun irrid nagħmel l-intervista online; u r-riċerkatriċi se tuża ż-Zoom u se tattiva l-għażla tar-Require Encryption for 3rd party endpoints SIP/H-323. Ir-riċerkatriċi se tirrekordja d-diskors biss ta' waqt is-sessjoni, mingħajr filmat. Kemm ir-ricerkatriċi u jiena ser ikollna il-cameras mixewlin biex naraw lil xulxin u għal konversazzjoni aħjar. Ir-riċerkatriċi se tibgħat istruzzjonijiet qabel l-intervista, kif ukoll fil-jum ta' l-intervista, fuq kif tbiddel l-isem tiegħek fuq zoom. Ir-riċerkatriċi se tuża biss il-pseudonimu tiegħek matul l-intervista sabiex ir-reġistrazzjonijiet tal-awdjo, kif ukoll it-trascripts verbatim, jkunu psewonimizati. Int tingħata l-għażla li għażel il-psewdonim tiegħek stess, u l-identita tiegħek se jkunu psewonimizati matul id-dissertazzjoni.
12. Jiena konxju/a li l-informazzjoni tiegħi se tkun psewdonimizzata, jiġifieri l-identità tiegħi mhix se titniżżel fit-traskrizzjonijiet jew fin-noti tal-intervista, imma minflok, se niġi

assenjat/a kodiċi. Il-kodiċijiet li jorbtu l-informazzjoni dwari mal-identità tiegħi se jinżammu b'mod sigur u separat mill-informazzjoni, f'file kodifikat fuq il-kompjuter tar-riċerkatriċi/riċerkatriċi, protetti b'password, u r-riċerkatriċi u it-tutur se jkollhom aċċess għal din l-informazzjoni. Kwalunkwe materjal stampat se jitqiegħed f'armarju msakkar. Kwalunkwe materjal li jidentifikani bħala parteċipant/a f'dan l-istudju se jinżamm b'mod sigur sakemm isir l-istudju u se jinqered f' 30 ta' Mejju 2025.

13. Konxju/a li l-identità tiegħi u d-dettalji personali tiegħi mhux se jiġu żvelati f'xi pubblikazzjoni, rapport jew preżentazzjoni li tista' toħroġ minn din ir-riċerka.
14. Jekk inħoss li l-intervista' b'xi mod iddisturbani, nista' nirreferi għat-tagħrif dwar is-servizzi ta' appoġġ li Christine Gauci se tgħaddili fil-bidu tal-intervista'. Naf li d-dokument bit-tagħrif jinkludi lista ta' servizzi bla ħlas. Id-dokument fih ukoll xi servizzi bil-ħlas, li jkolli nagħmlu minn buti f'każ li ma nagħżilx is-servizzi bla ħlas.

Qrajt u fhimt l-istqarrijiet t'hawn fuq, u naqbel li nipparteċipa f'dan l-istudju.

Isem il-parteċipant/a: _____

Firma: _____

Data: _____

_____ _____

Christine Gauci

christine.gauci.16@um.edu.mt

Dr Pamela Portelli

pport03@um.edu.mt

23402312

Appendix F

A 15-point checklist of criteria for good thematic analysis (Braun & Clark, 2006, p. 20)

Process	No.	Criteria
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as *active* in the research process; themes do not just 'emerge'.

Appendix G

Definitions of the 6Rs for Coding in Thematic Analysis (Naeem et al., 2023, p. 10)

6Rs	Definitions
Robust	Robust coding refers to the representation of raw data in a meaningful and comprehensive manner, which encapsulates various aspects of the data under consideration
Reflective	Reflective coding involves creating codes, based on the keywords, which reflect a relationship between facts and theories and provide an interpretive lens for understanding the facts
Resplendent	Resplendent codes are rich and powerful, and provide a comprehensive explanation of the context under study; they effectively capture the essence of the data
Relevant	Relevant codes are inferential and descriptive, closely related to the research question, and are applied consistently to every piece of information with justified reasoning
Radical	Radical codes are unique and well defined, preventing overlaps, and might even offer insights that may contradict the main narrative of the analysis
Righteous	Righteous coding ensures codes logically fit within the larger coding and align with the research's purpose; they maintain consistency and understanding of the decisions made during coding

Appendix H

Definitions of the 4Rs for Theming in Thematic Analysis (Naeem et al., 2023, p. 12)

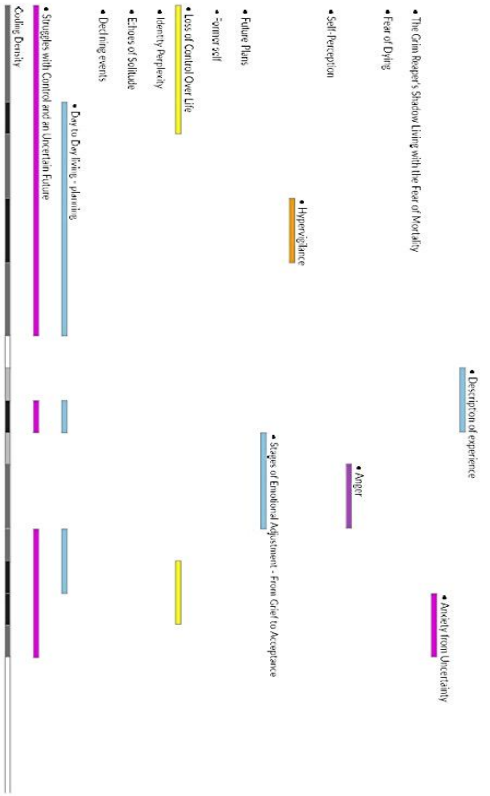
R	Definitions
Reciprocal	Refers to the mutual connection between codes in the development of a theme. It highlights the interrelationship between various codes that binds them together into a cohesive thematic concept
Recognizable	Emphasizes the importance of themes being closely aligned with, and easily identifiable from, the original data. A recognizable theme reflects recurring patterns derived from the data; it contributes to the development of a conceptual model
Responsive	Speaks to the capacity of a theme to align with and address the research's aims and objectives. Even themes that may initially seem unrelated to the research questions can be responsive if they contribute to fulfilling the overall goals of the study
Resourceful	Describes the role of themes in providing useful insights to answer research questions. Themes in this context are seen as resources that contribute to developing a story/theme that helps resolve the research issue or understand the studied phenomenon

Appendix I

Short Excerpt from an Analysed Transcript

Clara: Initially, coping with my heart condition was hard. There were times where I felt like I was a passenger in my own body. It was like my life was not mine anymore; it was controlled by something I couldn't see, couldn't control. ... Its like I am going along for the ride whilst praying that the driver knows where they're going. ... like I'm no longer in control. Before I was completely carefree but this changed. Now I feel like I need to be careful of everything I do….. Like needing to think twice about things that were typical in my lifestyle which I used to do automatically. …. Ever since I had my heart condition, I need to constantly use my smartwatch to monitor my heart to ensure that it is in a safe range. No matter how small an activity is it has to be calculated …. Like waking up the stairs, doing errands, doing home chores. I am constantly thinking if this activity is safe for my heart.

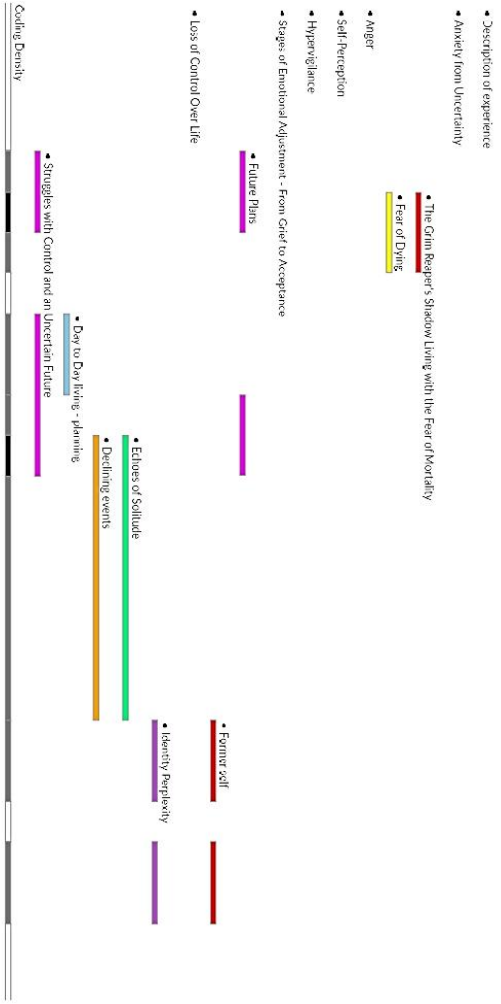
I can deal with the physical consequences like palpitations, difficulty breathing etc but the mental heaviness is too overwhelming. My heart condition feels like an emotional storm inside me. Although I do try to control it there are times when it just swipes me off my feet. …. I constantly juggle fear, sadness, frustration, and anger all at once. The anger was mostly present when I got diagnosed as I always took care of my health, but then to have this diagnosis that is typically linked to obesity. ….. Ahh, I get so frustrated. Sometimes it's too much. Planning and organising helps me stay focused and in control but I cannot do this with my condition. Anything can happen at any moment. I can try to control it but things happen…. I think the best way to describe it …. it's like walking on a rope without knowing where the next step will land. This adds to my anxiety as I cannot plan and does not make me feel secure cause I am constantly wondering when my heart is going to fail. I am constantly thinking one bad step, one moment of neglect and everything could change. All I have done



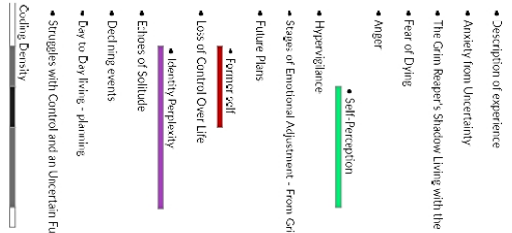
so far could go to ruins. And the potential thought that I might need to start over again fears me.

I: Uncertainty sounds like it added another layer of exhaustion.

Clara: It does. Another thing that scares me is the future which is one of the hardest parts of the condition I think. At least in my opinion. ….. I am still young but the fear of my heart giving out is always on my mind. I look at my friends and others my age, they are busy planning their future like where they will travel etc. Even simple things like what they want to do next week. But I am here wondering if my heart will make it through the year. While others make plans with no concerns, I have to always think 2 steps ahead. Although I do try to stay positive, I do feel that this condition has taken my liberty of plans making me feel like I am not my own being which irritates me. … It is not the first time where I had to decline certain activities with my friends like hiking as I knew I would affect the pace of others keeping them behind and I do not like being the centre of attention you know…. What if something happens and I ruin their plans? What if because of me they had to cancel or even worse like causing a medical emergency? How will I face them again? How will they look at me? … For me, that is not acceptable so I just decline. But, this comes with a price as not going today and not going tomorrow, they [her friends] will stop asking leading to isolation. Which I don't blame them. …. But ….. this is hard you know. …. Before I was not like this, I was energetic, always on the go like a force of nature. Nothing used to stand in my way but now I need to depend more on others which goes against my independence leaving me feeling a sense of powerlessness and helplessness. ... But now I no longer feel like a force of nature... I had to accept my vulnerabilities. At times my condition already makes me feel like I cannot do things but it's hard fighting with your own body. It has a limit and like it or not I need to



ask for help when I have reached that point. …… It's hard letting go of everything I knew before… of everything I was before. At times I do compare myself to how I was before but I feel that the person I used to be seems like a distant memory. It's like it hits me …. Did this condition affect me so much that it sometimes feels like I am on the outside seeing myself as if I was in a movie? …. It makes me question what other changes will this condition do to me.



Appendix J

Approval from the University of Malta's Faculty Research Ethics Committee

Research Ethics Application - Approved by FREC, no UREC decision needed

SWB FREC <research-ethics.fsw@um.edu.mt>

Fri 17/05/24 14:26

To:Christine <christine.gauci.16@um.edu.mt>
Cc:Pamela Portelli <pport03@um.edu.mt>;Dr Gottfried Catania <gottfried.catania@um.edu.mt>

1 attachments (115 KB)
[SWB-2024-00311 - Feedback Sheet 2].pdf;

REDP Application ID: SWB-2024-00311

Dear Christine Gauci

Your ethics application regarding your research titled *Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners* has been **approved**.

Attached find a **copy of the feedback sheet** containing FREC's feedback and approval. Kindly check the sheet in case of any comments from FREC.

Faculty Research Ethics Committees are authorised to review and approve research ethics applications on behalf of the University of Malta, except in the case of sensitive personal data. In this regard, your ethics proposal **does not need to be sent to UREC-DP**. Hence, **you may now start your research**.

Disclaimer: *The research team should note that only the English versions of the documents submitted have been reviewed by FREC. It is the duty of the research team to ensure that all documents in Maltese (or any other language) are faithful translations of the English version.*

Regards,

L-Università ta' Malta

Faculty Research Ethics Committee

Faculty for Social Wellbeing
Room 113, Humanities A Building
+356 2340 2237 / 3220 / 3625

Website: www.um.edu.mt/socialwellbeing/students/researchethics

*The contents of this email are subject to **these terms**.*

Appendix K

Support Services document (English version)

FREE & FEE-PAYING SUPPORT SERVICES

Name of student researcher:	Christine Gauci
Course:	Master of Psychology in Health Psychology
Student's contact email:	christine.gauci.16@um.edu.mt
Student's contact number:	+356 77520492
Research supervisor:	Dr Pamela Portelli
Supervisor's email:	pport03@um.edu.mt
Supervisor's contact number:	23402312
Title of Research Study:	Matters of the Heart: unravelling the implications of coronary artery disease on post-menopausal women and their partners.

Dear Participant,

I hope this email finds you well.

I would like to take this opportunity to thank you for your participation in this study. I appreciate your involvement and cooperation throughout this entire process.

I would like to remind you of the aims of this study; namely to explore the biopsychosocial repercussions of coronary artery disease in post-menopausal women, to explore the effects of coronary artery disease on partners of post-menopausal women, to explore how post-menopausal women with coronary artery disease and their partners cope with such condition and to explore the participants' perceptions of services available and how these can be improved.

This study was not anticipated to cause distress and the interview questions were formatted in as sensitive a manner as possible. However, if your participation has led you to experience any distress or discomfort for whatever reason, then overleaf I have included some information about services that offer free and fee-paying professional support that you might find helpful.

Kindly do not hesitate to contact me if you have any queries. If you require any additional information or wish to report any concerns about this study, please do not hesitate to contact both myself, on **+356 77520492** or my research supervisor on **23402312**.

Kind regards,
Christine Gauci

FREE SERVICES

Richmond Foundation
info@richmond.org.mt +356 21224580/ 21482336/ 21480045
Supports both individuals who are experiencing mental health problems as well as those around them. Apart from supporting individuals by offering therapeutic help, Richmond Foundation also guides
individuals by teaching the necessary skills to live and work independently. Their services include support groups, assisted living solutions, educational programmes, as well as counselling services.

Supportline 179 (24/7 access)
This is Malta's national helpline acting to provide support, information about local social welfare and other agencies, as well as a referral service to individuals who require support. It is also a national service to individuals
facing difficult times or a crisis. Their primary mission is to provide
immediate and unbiased help to whoever requires it.

Kellimni.com (24/7 access)
http://kellimni.com/ +356 21244123/21335097
kellimni.com is an online support service in which trained staff and volunteers are available for support 24/7 via email,
chat and smart messaging. This service is managed by SOS Malta.

Crisis Resolution Malta

crisismalta@gmail.com/ +356 99339966

Offers immediate care. Crisis resolution 24/7. The team of volunteers who answer the phone are all professionals, and the consultation service is free.

Crisis Intervention Mater Dei

+356 25453950

Supports in various crisis situations related to mental health. Monday to Friday 7am-5.30pm.

PAID PROFESSIONALS

Counsellors:	Malta Association for the Counselling Profession (MACP)	https://macpmalta.org/
	Council for the Counselling Profession (CCP)	ccp.msfc@gov.mt
Family Therapists:		www.ift-malta.com
Psychologists:	Malta Chamber of Psychologists	mcp.org.mt
	Malta Psychology Profession Board	mppb.msfc@gov.mt
Malta Association of Psychiatrists:		map.org.mt
Psychotherapists:		www.facbook.com/MaltaAssociationForPsychotherapy

Support Services document (Maltese version)

LISTA TA' SERVIZZI TA' SAPPORT B'XEJN JEW BI ĦLAS

Isem tal-istudenta riċerkatura:	Christine Gauci
Kors:	Master tal-Psikoloġija fil-Psikoloġija fil-qasam tas-saħħa
L-imejl tal-istudent/a riċerkatur/a:	christine.gauci.16@um.edu.mt
Nru tat-telefon tal-istudent/a riċerkatur/a:	+356 77520492
Isem tas-superviżur tar-riċerka:	Dr Pamela Portelli
L-imejl tas-superviżur tar-riċerka:	pport03@um.edu.mt
Nru tat-telefon tas-superviżur tar-riċerka:	
Titlu ta' l-Istudju/Riċerka:	Kwistjonijiet tal-Qalb: il-konsegwenzi tal-mard tal-arterji koronarji fuq nisa wara l-menopawża u l-imsieħba tagħhom

Għażiż Parteċipant,

Nittama li dan l-imejl isibek tajba.

Nixtieq nieħu din l-opportunità biex nirringrazzjak tal-parteċipazzjoni tiegħek f'dan l-istudju. Napprezza l-involviment u l-kooperazzjoni tiegħek matul dan il-proċess kollu.

Nixtieq infakkrek fl-għanijiet ta' dan l-istudju; li bażikament huma li tesplora r-riperkussjonijiet bijopsikosoċjali tal-mard tal-arterji koronarji f'nisa wara l-menopawża, biex tesplora l-effetti tal-mard tal-arterji koronarji fuq l-imsieħba ta' nisa wara l-menopawża, biex tesplora kif in-nisa wara l-menopawża b'mard tal-arterji koronarji u l-imsieħba tagħhom ikampaw ma' din il-kundizzjoni u biex tesplora l-perċezzjonijiet tal-parteċipanti fuq servizzi disponibbli u kif dawn jistgħu jittejbu.

Dan l-istudju ma kienx antiċipat li jikkawża diffikultà u l-mistoqsijiet tal-intervista ġew ifformattjati bl-iktar mod sensittiv possibbli. Madankollu, jekk id-diskussjoni wasslitek biex tesperjenza kwalunkwe tbatija jew skumdità għal kwalunkwe raġuni, fil-paġna ta' wara jien inkludejt xi informazzjoni dwar servizzi li joffru appoġġ professjonali b'xejn jew bi ħlas li tista' ssib utli.

Ġentilment toqgħodx lura milli tikkuntattjani jekk għandek xi mistoqsijiet. Jekk teħtieġ xi informazzjoni addizzjonali jew tixtieq tirraporta kwalunkwe tħassib dwar dan l-istudju, jekk

jogħġbok toqgħodx lura milli tikkuntattja kemm lili stess, fuq **+356 77520492** jew is-superviżur tar-riċerka tiegħi fuq 23402312.

B'xewqat tajba,
Christine Gauci

SERVIZZI B'XEJN

Richmond Foundation
info@richmond.org.mt +356 21224580/ 21482336/ 21480045
Tappoġġja kemm individwi li qed jesperjenzaw problemi ta' saħħa mentali kif ukoll dawk ta' madwarhom. Minbarra li tappoġġja
individwi billi toffri għajnuna terapewtika, Richmond Foundation
tiggwida wkoll inidividwi billi tgħallem il-ħiliet meħtieġa biex jgħixu u jaħdmu b'mod indipendenti. Is-servizzi tagħhom jinkludu gruppi ta' appoġġ, soluzzjonijiet ta' għajxien assistit, programmi edukattivi, kif ukoll servizzi ta' pariri.

Supportline 179 (24/7 access)
Din hija l-linja ta' għajnuna nazzjonali ta' Malta li taġixxi biex tipprovdi appoġġ, informazzjoni dwar il-benesseri soċjali lokali u aġenziji oħra, kif ukoll servizz ta' riferiment għal individwi
li jeħtieġu appoġġ. Huwa wkoll servizz nazzjonali għal
individwi li qed jaffaċċjaw żminijiet diffiċli jew kriżi. Il-missjoni primarja tagħhom hija li jipprovdu għajnuna immedjata u imparzjali lil kull min ikun jeħtieġha.

Kellimni.com (24/7 access)
http://kellimni.com/ +356 21244123/21335097
kellimni.com huwa servizz ta' appoġġ *online* li fih persunal imħarreġ u voluntiera huma disponibbli għall-appoġġ 24/7 permezz ta' imejl, *chat* u messaġġi intelliġenti. Dan is-servizz huwa amministrat minn SOS Malta.

Crisis Resolution Malta crisismalta@gmail.com/ +356 99339966
Joffri kura immedjata. Riżoluzzjoni ta' kriżi 24/7. It-tim ta' voluntiera li jwieġbu t-telefon huma kollha professjonisti, u s-servizz ta' konsultazzjoni huwa b'xejn.

Crisis Intervention Mater Dei +356 25453950
Jappoġġja f'diversi sitwazzjonijiet ta' kriżi relatata mas-saħħa mentali. Mit-Tnejn sal-Ġimgħa 7am-5.30pm.

PROFESSJONISTI MĦALLSA

Counsellors: Malta Association for the Counselling Profession (MACP) www.macpmalta.org
Council for the Counselling Profession (CCP) ccp.msfc@gov.mt

Terapisti tal-Familja www.ift-malta.com

Psikologi: Malta Chamber of Psychologists mcp.org.mt
Malta Psychology Profession Board mppb.msfc@gov.mt

Assoċjazzjoni Maltija tal-Psikjatri: map.org.mt

Psikoterapisti: www.facbook.com/MaltaAssociationForPsychotherapy