Original Article

Patients' concerns about the risk of death after Heart failure

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ABSTRACT

Introduction: Cardiovascular diseases are the main cause of death in the world. Heart failure is one of the most common cardiovascular diseases that is the typical end-stage of heart diseases with an overall mortality higher than other chronic diseases. The cause of death is the exacerbation of heart failure and sudden death due to ventricular arrhythmias. These factors lead to insecurity feelings in a patient about the time of death and the type of death. The present study was conducted to seek and describe the concerns of patients with heart failure about death in order to better understand their needs. Method: This qualitative study was designed based on content analysis. Comprehensive and in-depth interviews were conducted on 15 patients with heart failure. Data analysis was performed with codification and the codes were studied and reviewed in order to extract their common concepts in terms of categories and sub-categories. Results: 15 People, including 7 females and 8 males were enrolled. The results were divided into six general categories, each of which was divided into some subcategories. The main categories were: grief, fear, the need for a soothing relationship, life, and death, coping with the disease, device as a scary savior. Discussion and Conclusions: The extracted concepts showed that the experience of living with heart failure is a complex phenomenon whose psychological aspects of care need more attention. The medical team plays a key role in resolving or even exacerbating the psychological problems of the disease. The support services for patients with heart failure will increase comfort, restoration of confidence, and quality of life improvement.

Keywords: Heart failure, death, concerns about death, qualitative study

Introduction

Heart failure is one of the most common cardiovascular diseases known as a chronic, progressive, and debilitating disorder. It is the typical end-stage of heart diseases [1]. In general, it is expected that with the aging of the population, the improved survival rate of patients after myocardial infarction, as well as recent advances in the treatment of congenital heart disease and reduced mortality increase the number of people with heart failure [2]. Heart failure is a major cause of disability and death in Iran, too. Changes in the age pyramid and aging of the present young population of Iran will increase the current prevalence in the near future [3, 4].

Most of the patients with heart failure consider death as the relief from sufferings and complain about the pain and loss of their independence and dignity in life due to the disease [5]. In addition to psychological symptoms and concerns about the life and death, patients consider the physical symptoms and the resulted disability as disease characteristics [6].

Studies have shown that the serious aspects of the disease are not yet revealed to the public and even experts and there are few studies on the knowledge of patients with heart failure about the prognosis and their understanding of their health status. It is expected that the understanding of the patients' concerns in the social, religious, economic, and cultural context specific to Iranian society lead to an improvement in the knowledge of experts about the disease process and develop the ability to more carefully design and increase the effectiveness of medical care based on the individual needs and concerns of patients.

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Method

This was a qualitative study conducted through in-depth individual interviews with participants, using a direct analysis method.

The study examined 15 patients including 8 males and 7 females, diagnosed with heart failure. The inclusion criteria were: diagnosis of heart failure by a faculty member cardiologist, having heart failure for at least 6 months, at C and D stages of heart failure, Persian language, lack of known speech and hearing problems, having at least secondary school education, and willingness to participate in the study after filing a written consent form. The exclusion criteria were: the patient's unwillingness to continue to participate in the study, dementia, psychiatric disorders including psychotic disorders, and bipolar disorder according to semi-structured interviews by a psychiatric resident.

The process of the study was first described for the participants in a ten-minute interview. After initial familiarity, they were told that they can enter the study by completing the consent form and they reserved the right to exit the study if they did not wish to continue at any stages of the study. The principle of confidentiality was explained and they were assured that their names were not registered anywhere in the study or the collected data. They were also asked for permission for recording their voices and they were assured that the audio files would be deleted after the study.

After this stage, in person and directed individual interviews were conducted by the researcher with each of the participants comprehensively and in-depth. The duration of each interview was 1 to 2 hours. At the beginning of the interview, the information such as name, age, marital status, educational level, and duration of heart failure were asked and a semi-structured psychiatric evaluation was performed to rule out major psychiatric disorders. In order to start the study, the first question was raised as an open question as follows:

"Talk about the impact of heart disease on your life."

Participants shared their experiences and feelings, and the next question was largely determined by their responses. Then, wherever the discussion reached a conclusion and participants finished talking in that field, the next question that was more limited was asked according to the research objectives. The questions were determined based on previous studies which will follow: Do the patients think about death? Do they consider death as a natural part of their life? Do they consider death as a relief from their sufferings? Is death a source of stress and fear for the patients? Are the patients concerned about what happens after death? Are the patients concerned about the future of their relatives? Do the patients wish to prolong their life? Sometimes the predicted structure of the interview was partially abandoned according to the issues raised by the patients in order to allow them to share their experiences and concerns in any way and at any depth that they can. Eventually, the participants were asked to add anything that came to their mind. They sometimes repeated what they thought was more important, which were exactly recorded.

The subjects were randomly selected among patients referring to Shahid Rajaie Heart Hospital in Tehran, Iran. Data were collected and analyzed within 6 months in 2016. When the data were saturated, sampling was stopped. The saturation point was defined as finding no new keywords in the last 3 interviews according to three researchers in this study. Finally, data analysis was begun by data codification. The factor of importance was considered more than the repetition factor in data codification. Interview transcriptions were provided to the colleagues, each of them extracted their codes. Then, they reached a consensus in joint meetings by exchanging views. In the case of reaching no consensus on a code, a new interview was taken from the participants in order to approve or reject the code. The codes were studied and reviewed several times to extract common concepts as categories from them. Finally, six categories including general concepts were extracted. The Lincoln and Guba criteria were used in order to evaluate data trustworthiness. These criteria included credibility, dependability, transferability, and confirmability.

The researcher shared the findings with two patients with heart failure referring to the Shahid Rajaie Heart Hospital who expressed a tangible and understandable feeling about the extracted concepts. For the confirmability criteria (equal to the objectivity criteria in quantitative studies), the researcher recorded the study activities and stages to be reviewable and trackable.

Results

A total of 15 patients were enrolled including 7 males and 8 females. The average age of the participants was 53 years (28 to 72 years) and they were all married. Ten subjects had under diploma education (with at least secondary school education), 4 had a diploma, and 1 had an academic education.

The mean ejection fraction (EF) of the patients was 18% (15 to 30 percent) and the average duration of heart failure was 5 years (6 months - 24 years).

Table 1: Demographic information of the participants

No.	Gender	Age (years)	Marital status	Education	Ejection fraction (EF)	Disease duration
1	Female	38	Married	Under high school diploma	15%	10 years
2	Male	56	Married	Under high school diploma	30 %	6 years
3	Female	52	Married	Under high school diploma	25 %	5 years
4	Male	50	Married	Under high school diploma	20 %	12 years
5	Male	42	Married	Under high school diploma	15%	6 months
6	Female	45	Married	Under high school diploma	25 %	3 years
7	Male	65	Married	Under high school diploma	20 %	4 months
8	Female	28	Married	Under high school diploma	15%	1 years
9	Male	64	Married	High school diploma	15%	5 years
10	Male	55	Married	High school diploma	15%	5 years
11	Female	58	Married	Under high school diploma	15%	24 years
12	Male	61	Married	High school diploma	15%	3 years
13	Female	45	Married	High school diploma	20 %	3 years
14	Female	72	Married	Academic education	15%	7 years
15	Male	68	Married	Under high school diploma	15%	5 years

The results were divided into six general categories, each of which was divided into some subcategories. The main categories were: Grief, fear, need for a soothing relationship, life, and death, coping with the disease, device as a scary savior.

Table 2: Classification of findings

Main categories	Sub-categories
Grief	The initial shock
	Anger
	Bargaining
	Accepting the fate
Fear	Fear induced by physicians
	Fear of the disease consequences
	Fear of death
	Fear of fear
Need for a soothing relationship	Need for God
	Need for improving the relationship with the physician
	Need for the relatives
	Need for nature
Life and death	Close contact with death
	Preoccupation with death
	Preoccupation with the hereafter
	The fate of family after patient's death
Coping with the disease	Escape
	Excessive care
	Submission
Device as a scary savior	

Grief

"Grief" is due to the patients' knowledge of having heart failure.

In the present study, due to cultural, literary and religious aspects in Iran, patients considered heart failure as a great loss, apart from its physical aspect, which led to the "grief" reaction. The sub-categories were: the initial shock, anger, bargaining, and accepting the fate.

1. The initial shock

The initial shock expresses the disbelief about having heart failure, or according to the patients "a weak heart". The disbelief is in the field of non-specific symptoms at the onset of the disease, sudden emergence of symptoms underlying heart failure (such as coronary heart events) and how the patients were informed of heart failure by medical staff.

"I felt dizzy and fell, I thought I had a low blood pressure. They just told me that your heart works only by 30% and it needs a battery." (Patient #2, 56, male)

"I had no pain, I had no problem. I just wanted to see if my heart is working well. I had an ECG and they told me 'don't move! Go to a hospital, you have a heart disease'". (Patient #7, 65, male)

"I did not expect it at all, I was shocked! Understanding to have a heart disease was hard for me." (Patient #8, 28, female)

"They suddenly told me that your heart is weak and you will go into a coma. I was shocked." (Patient #12, 61, male)

2. Anger:

Anger expresses the anger of the patient due to having heart failure. Anger was toward God, themselves, their relatives, and physicians.

"I was very young when I had some children. My husband was not responsible. I couldn't continue. I fought a lot, but I got sick." (Patient #3, 52, female)

"When they told me that your heart is weak, I shouted angrily … I told the doctor 'what do you mean?' You're wrong [anxious and angry, and speaks loudly]". (Patient #5, 42, male)

"I'm angry with many people. I'm angry with my husband. He made me have and IVF. Hormonal drugs that entered my body were too much. Sometimes, I do not have a maternal feeling toward my child. I got sick during pregnancy. During pregnancy, the doctors did not do an ECG on me. They might have diagnosed earlier and I could live more". (Patient #8, 28, female)

"When I was hospitalized, I saw people a lot younger than me and even babies that were sick. I said 'I have sinned and I am paying for it, but what is the guilt of those children God?' … [upset and angry]". (Patient #10, 55, male)

My heart disease was because of my husband's family pressure. They teased me since I was young. They did it to me … [angry]". (Patient #11, 58, female)

"The doctors made a mistake, they only want money. They lied and said that I have a heart disease. I got angry, I did not go to the doctor anymore. It was my own fault. I ate a lot of sweets, I got diabetes. Other diseases followed that." (Patient #14, 72, female)

3. Bargaining

Bargaining expresses complaints of illness and the suffering caused by it. Patients complained against God and fate.

"I am 52, but I am sick for 10 years. I should always take drugs. [Talks with complaints]". (Patient #3, 52, female)

"I'm 45 and I'm sick. My mother is 70, but she is healthier than me. When my mother was my age, she gave birth. But what about me? … I can barely walk … [tears and silence]". (Patient #6, 45, female)

"I had many difficulties to have children. I swear to God, I didn't deserve to have a heart disease … My husband and I got so sad …". (Patient #8, 28, female)

I had many problems. My brother had colorectal cancer and died. My dad died. My mother died. Now I have a heart disease. [Crying]". (Patient #11, 58, female)

4. Accepting the fate

Accepting the fate expresses accepting death as a natural course of human life. In the following examples, patients consider death a part of life despite suffering from the disease, and relying on their religious culture they try to address the issues calmly.

"It's human being. Finally, one day we will die. Whatever that is going to happen, will happen". (Patient #2, 56, male)

"We all will die. Even after a hundred years". (Patient #3, 52, female)

"The life and death are in His hands". (Patient #4, 50, female)

"The disease is from God. Whatever it is, it's from God, I can't do anything about it. I am talking about myself. Life is in His hands, not the humans. If my life finishes, I cannot control it for a second. God has created us and He will take us away". (Patient #11, 58, female)

Fear

For more precise assessment, this category was divided into four subcategories. The subcategories were: Fear induced by physicians, fear of the disease consequences, fear of death, and fear of fear.

1. Fear induced by physicians

It expresses the deep effect of the physicians in certain circumstances. Patients with heart failure have experienced arrhythmias, the need to go to the emergency room, cardiac arrest, receiving ICD shocks, and open heart surgery, and the physician-patient relationships are of great importance in such circumstances. The experiences that most patients had remembered in details were the bold points in their course of the disease.

Despite the positive impact of medical actions taken in the course of therapy and prognosis of heart failure, patients reported difficult moments with a deep sense of fear.

"The doctors said 'If we didn't have the ICD device you were with your ancestors now'", [talking with horror] (Patient #1, 38, female)

"After my surgery, my doctor told me I was his worst patient, it means I was in very bad situations". [Talking with fear] (Patient #4, 50, female)

"I wanted to have a heart surgery, but when I was hospitalized, the doctor said you won't survive the surgery ...". (Patient #9, 64, male)

2. Fear of the disease consequences

The concepts in this category included: Fear of disability, fear of dependence on others, concerns about making troubles for others, and a subsequent sense of guilt. Patients, regardless of the severity of their physical symptoms and rate of recovery, felt the fear of loneliness, helplessness, and dependence even in terms of physical stability.

"Sometimes, I think what shall I do if I get paralyzed? What about my personal affairs? I just wish I don't get worse. I'm afraid of dependence on others". (Patient #1, 38, female)

"I always say to my family and relatives that: I am a cracked china**.** Anyway, I'm not a perfect person, something might happen to me at any time. It is very scary ...". (Patient #10, 42, male)

"If I feel better, I'll do all my personal affairs. I do not like others do my job. I'm afraid of dependence on others". (Patient #6, 45, female)

3. Fear of death

Apart from the mental preoccupation with death, fear of death was specifically one of the patients' concerns. This fear causes anxiety and unwillingness to continue the issue.

"I'm afraid of the death, and how it might be. I'm afraid of after death, too." (Patient #1, 38, female)

"When I realized my heart is weak, I was very afraid. I was afraid to die". (Patient #3, 52, female)

"I don't take a bath when no one is at home. I do not open the hot water. I leave the door open. I'm afraid my life ends in the bathroom. I'm afraid to die". (Patient #11, 58, female)

"I was so scared when I went to the hospital. I thought that's it, I was dying." (Patient #12, 61, male)

4. Fear of fear

In some cases, despite fears of disease progression and death, the patient tried to alleviate the suffering caused by fear. One way is to remove fear and not talking about it; in other words, "fear of fear".

"I have no fear. Whatever you're afraid of will get worse. A coward dies a thousand times before his death. I never let fear to overcome me. If I fear, my heart will stop". (Patient #2, 56, male)

"I'm not afraid of dying at all [pauses]. I do not think of it [has a blaming tone]. Why should I fear? I do not think about the next days and fear. Why should I make my mind busy with bad things?" (Patient #5, 42, male)

"I have no fear. Even during the operation, I was not afraid. You should not be afraid ... [Stressing that fear is a bad feeling.] I'm not afraid. You reach a point that there is no fear. You either die or live!" (Patient #10, 42, male)

Need for a soothing relationship

It expresses patients' need for secure relationships to improve the physical status and mental capacity. This category was divided into four subcategories of need for God, need for improving the relationship with the physician, need for the relatives, need for nature.

1. Need for God

This reflects the importance of spiritual beliefs in relieving the suffering caused by the disease according to the patients. According to the specific religious background of the Iranian community, interviews indicated seeking help from a reliable and available source of power and the need for a relieving relationship with God.

"If I feel dizzy I will be worried about a shock and I'll say Salavat. I seek help from Imam Mahdi and take a deep breath. I trust in God. God will help. I have a prayer rug that is always open. When I am sad I pray on it without letting the children know". (Patient #1, 38, female)

"I go to the mosque. These things make me feel better. We serve people in need with food and we sing religious songs. It's very influential". (Patient #13, 45, female)

2. Need for improving the relationship with the physician

It included the need to be heard, to be taken into consideration, to have training on non-medical solutions to improve symptoms, and to have physician's empathy. Patients were concerned about the need for cooperation between cardiologists and psychiatrists and a special attention to mental health of the patients by the main physician.

"They never ask about these problems. Most students ask and do not listen to me". (Patient #1, 38, female)

"When I visit the doctors, they just ask about drugs. I'll be happy if they ask about problems because they have asked about my life". (Patient #4, 50, female)

"Today, these conversations, was very good. I told my husband when I was coming that I would like to see a psychiatrist and talk to be relieved". (Patient #8, 28, female)

"I was very sad. Last week the heart doctor said 'Why are you disappointed?' You must not have bad thoughts.' After that, I felt better and was more relieved". (Patient #12, 61, male)

"My heart doctor is very good, he is a real doctor, he pays attention to everything. I like to thank him". (Patient #14, 72, female)

3. Need for the relatives

According to the particular culture in Iranian community and the importance of family, the need for a comforting relationship with close relatives was one of the main topics discussed. Perhaps, according to the patients, an empathetic and cooperating family plays an important role in motivating the patient to continue to live while a non-empathetic family disappoints the patient from life.

"My husband says 'trusty in God, be patient'. He helps me with his words". (Patient #1, 38, female)

"My husband does not understand me. They think it is my fault. He makes me feel worse". (Patient #6, 45, female)

4. Need for nature

The need for nature to get the "lost peace" and "feel alive" was one of the raised issues.

"I go to our own orchard in Shahriar. I do not do other physical works, but the orchard is there. It's good to go there. I find peace". (Patient #2, 56, male)

"I go to my friend's flower shop to ease my mind. I am very calm there". (Patient #13, 45, female)

Life and death

According to the concept mentioned about "heart" from the perspective of patients and their unique experiences about death, much of the raised issues were about the concerns of patients about death.

This category was divided into four subcategories including close contact with death, preoccupation with death, preoccupation with the hereafter, and the fate of family after patient's death.

1. Close contact with death

It indicated patients experience facing death. The experience of cardiac arrest and the joy of not dying are in this subcategory. Also, during hospitalization, patients have witnessed the death of other people suffering from heart failure and this unique experience needed to be considered.

"I have had a cardiac arrest for several times and I have received shocks. That is, I have died and came back to life again …". (Patient #2, 56, male)

"In Rah Ahan Hospital, a patient who had an ECG with me died that night. I heard crying voices at midnight. I was shattered. They took me to CCU next morning". (Patient #11, 58, female)

2. Preoccupation with death

According to experiencing a close contact with death, as mentioned before, the patients with heart failure are highly preoccupied with death.

This preoccupation can be divided into several areas including the time of death and waiting for death, the type of death, death as a liberating or agonizing factor, dreaming, and wishing for a longer life.

The time of death and waiting for death

"I am always thinking about death. I say 'God, will I die now? Will I die tomorrow? How long will I live?' Every night when I am sleeping I ask God 'will I wake up in the morning?'" (Patient #6, 45, female)

"It is possible at any time … [tears]. Finally, the life is in His hands. Even when I wanted to have the operation they told me that my chance of survival was only 15%". (Patient #10, 42, male)

"Waiting to die is so hard. Do you understand? I am always waiting". (Patient #51, 68, male)

The type of death

"I think of the death, and how it might be. What if I die and my children are not with me? I have told the landlord to check on me. I'm afraid my children come home and find my dead body. I hope that dying is easy. I pray God to help me when I die". (Patient #1, 38, female)

Death as a liberating or agonizing factor

"God! Help me the first night after death. I am afraid of Punishment of the Grave. I tell my children not to leave me alone the first night in the grave to read Quran for me, or I wish it finishes soon. I pray God to take my life sooner or cure me. I sometimes think if I die I will get rid of this shortness of breath and I will breathe easily in the hereafter". (Patient #1, 38, female)

Dreaming

"My thoughts and dreams are mostly about death. I always think about death. Last night I dreamed that I told my son I'm dying. I saw I was in a barren desert, alone, and it was my funeral. I do not know where I was. I heard crows. No one was there. I was saying 'God, forgive me'. Last night was Ehya night. God has forgiven me". (Patient #1, 38, female)

Wishing for a longer life

"I want to live to see my daughter's wedding". (Patient #3, 52, female)

"I like a long life, but it's hard with illness". (Patient #7, 65, male)

3. Preoccupation with the hereafter

According to the Iranian community religious beliefs and the belief in life after death, much of the patients' concern was focused on the afterlife. They saw death is approaching and also were worried about their fate after death.

"I say, 'God, how do I want to die with all my sins? What do I do with my prayers and fastings that I didn't do? What about my words that have offended others?' When I was hospitalized, I always asked for forgiveness". (Patient #1, 38, female)

4. The fate of family after patient's death

Most mentioned concerns were about the fate of family members after the death of the patient. Given the importance of children in the Iranian community and a sense of responsibility of parents for their children's future, this concern was one of the key points of the study.

"All my thoughts are about my children. I think what will happen to them if I die?"(Patient #1, 38, female)

Coping with the disease

It indicates how the patient deals with having heart failure. It is divided into three general subcategories including scape, excessive care, and surrender.

1. Escape

Some patients chose to escape from the disease. Of course, this type of dealing with the disease occurs in the early months and years after disease diagnosis.

This subcategory has two approaches. The first approach was abandoning the medical follow-ups or initiating treatment. The second approach included multiple visits to various doctors in order to be sure about the disease, which sometimes lasted a long time and without starting the treatment.

"From the very beginning, they said I have to undergo the surgery, but I refused because I didn't have any problems. I was active, I exercised. Is it possible to have no symptoms? They said you will go and come back in a year … And I did [silence]. After a year I was short of breath … (Patient #10, 42, male)

2. Excessive care

It expresses a self-care that patients exercise in order to survive and prolong their life beyond the medical advice. In fact, there was a kind of anxiety about problems' exacerbation in patients' speech, which led to excessive control of environmental factors.

"It is about two years that I have found that I shouldn't get tired. I mean I care not to get tired. I should care for myself." I used to be more selfless than others … Since I found that my heart is sick, I know I have to take care of myself. I'm always caring for my heart not to stop working. I don't go everywhere. For example, annoying places". (Patient #3, 52, female)

3. Surrender

A number of patients had surrendered to the disease. In other words, without acceptance, which can be a source of good feelings for the patient, they have just yielded to the fate and the disease and were disappointed.

"When they told me that I have a heart disease, I drooped. I really did". (Patient #12, 61, male)

Device as a scary savior

In the course of heart failure, a device (ICD) is sometimes needed to be embedded in the heart to regulate heart rhythm and prevent sudden death. This category is dedicated to those who have had this experience. In this study, people had a dual perception of the device. On one hand, they considered it a rescuing device while on the other hand, they were afraid that it might be not reliable, or even the device operation might be frightening and traumatic.

"I felt dizzy. I leaned my head against a tree. My son went to fetch water, I fell and I did not understand anything else. I heard a bomb blast and I became conscious. I asked: 'Did you hear the sound?' Everyone said no. My wife took me to the hospital and I found that the device has gave me a shock … If it wasn't for the device, I was dead and it was my funeral … I was so scared. I thought: What if it doesn't give a shock! When I feel dizzy I get worried about the shock. (Patient #1, 38, female)

Discussion

Several studies indicated depression, agitation, anxiety and the need for a peaceful haven among patients with heart failure. Those findings were compatible with this study. Each of the stages of grief that was obtained in this study could partly explain different experiences of previous studies. This was consistent with the stages of grief according to Kubler Ross [7]. He introduces grief in 5 stages which include:

1. Not me
2. Why me
3. Yes me but …
4. I am depressed
5. Yes me but I am ready

The first stage corresponds with the "initial shock", the second with "anger", the third and forth with "bargaining", and the fifth with "accepting the fate" in this study. In other words, it can be justified in a coherent theory that each of the patients with heart failure can have different experiences in different stages of grief and consequently, they need individual consulting and education services, which should be addressed in medical educations.

The fears found in studies were fear of death, fear of disablement, fear of after death, and fear of dependence on others [8-10]. The major fears in other patients with chronic debilitating disorders were fear of how to die, fear of pain, fear of losing independence and dyspnea [11].

The findings of this study were consistent with the above-mentioned studies. The only difference was patients' reports of experiencing a "fear induced by the physicians" in this study, which is important. The patients reported a severe and life-threatening fear that was created by the physicians. Interestingly, the goal of physicians has been comforting or reassuring the patient of the medical knowledge and skills, which somehow had an opposite effect. Previous studies have frequently reported that giving bad news has its own delicacies that if not addressed will have a negative impact on the patients and their families [12, 13]. The importance of this issue was evident in this study, but the different point of this study was that the good news was given as bad news. It is a certain event not reported in previous studies, which appears to be a cultural concept. Studies indicate that Iranian physicians use verbal examination more [14] and the dominant model of doctor-patient communication in Iran is paternalistic [15, 16]. In this model, less attention is paid to the mental needs of the patient. In Iranian culture, a special privilege is given to people with an authority like a physician, the debate with the source of power is not recommended, it is advised to cooperate with the source of power and the source of power has a higher position in the expression of thoughts and feelings [16]. It appears that such cultural differences partly justify this phenomenon and this area requires a serious consideration.

Previous studies have reported several needs for patients with heart failure. In the present study, the major need of patients was "communication". The role of culture can justify that.

Iranians have a collective culture. In this type of culture, there is a contrasting combination of strong family relations and a relatively high individualism, which can justify the importance of communication with family on one hand and the inner, spiritual and individual beliefs on the other hand. In addition, because of the importance of connection with the source of power in this culture, communication with the physician has also a special significance [16]. In addition to the above, numerous studies in Iran indicate impaired education in this area. The doctor-patient communication skills need more attention and as studies have shown, paying attention and providing training in this area have been associated with good outcomes [17, 18].

In this study, coping strategies were categorized into three subcategories of surrender, fight and escape. These results were consistent with studies with a cognitive-behavioral psychotherapy approach, based on which some treatment has also been suggested [19].

According to its significance and the unique experiences, the category of "device as a scary savior" was addressed in a separate group even though it was a subcategory of fear. Erroneous shock happens in 11.5% of patients with an implantable cardioverter-defibrillator (ICD). In these cases, the patient experiences the shock in a state of full consciousness which is horrifying and justifies the "scary stranger" feeling in the patients. The shock can lead to death or the experience of death which can be a source of serious trauma. Patients with this experience gave reports like PTSD which, in turn, requires further studies. Additionally, the severe anxiety that such patients experience can lead to cardiovascular instability and perhaps justify that feeling of distrust. On the other hand, 78.8% of patients with ICD have the experience of being saved from death by the shock. The experience obtained in this study was that patients said a few moments after cardiac arrest the shock sound have awakened them and returned them to the world. They experienced the device as a source of comfort.

Finally, the extracted concepts showed that the experience of living with heart failure is a complex phenomenon whose psychological aspects of care need more attention. The medical team played a key role in improving the treatment or even exacerbation of psychological problems of the disease. Therefore, support services for patients with heart failure will lead to increased comfort, restoration of confidence, and improvement of the quality of life.

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