Physical and Psycho-social status of Patients with Myocardial Infarction in Slemani City

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Abstract:

Quantitative design (a descriptive study) was conducted in the Coronary Care Unit (CCU) in the Sulaimani Teaching Hospital, for the period of 15th of April 2013 up to the end of June 2014. The study objectives are to assess the Physical and Psycho-social status of the patients with MI, and to find out the relationship between the Physical and Psycho-social status of the patients and some Sociodemographic characteristics such as age, gender, level of education, family history, occupation, marital status, monthly income, and residential area. To achieve the objectives of the study, a non probability (purposive) sample of 56 patients (male and female), who were admitted to the CCU in the Sulaimani Teaching Hospital.

The data were collected through the utilization of a constructed questionnaire. It contained 51 items, the first part consists of (9) items which included the demographic characteristics, the second one consists of (3) items which included some risk factors of MI. And the third one consist of (18) items included physical status, and the fourth part consist of (19) items included psychosocial status. The content validity of the instrument was established through a penal of 7 expert. Reliability of the instrument was determined through the (Split-half) approach, (r=0.87)

Data was collected by interviewing the patients themselves using the questionnaire formal and data was gathered and analyzed by application of descriptive and inferential statistical method.

The result of the study indicated that there is significant relationship between marital status, Monthly income, Smoking, and BMI with MI. And there is significant relationship between Marital status and stress with MI. The study recommended that increased awareness about dealing with psychosocial stresses management, coping strategies, and adaptation to its, and increased individual awareness about smoking danger and decrease body weight by life style such as healthy dietary pattern and increased daily activity.

Introduction

Ischemic Heart disease (IHD) is still considered as a serious danger to life and health of human beings and has been the main cause of death in most of the developing countries up to this time (Nateghian, 2008)

Acute myocardial Infarction (AMI), necrosis (death) of myocardial cells, is a life threatening event. If circulation to the affected myocardium is not promptly restored, functional loss of myocardium affects the heart's ability to maintain an effective cardiac output. This may ultimately lead to carcinogenic shock and death. Myocardial Infaraction occurs when blood flow to a portion of cardiac muscle is blocked, resulting in prolonged tissue ischemia and irreversible cell damage (Lemone and Burke, 2004)

Myocardial Infaraction is the medical term for an event commonly known as a heart attack. It happens when blood stops flowing properly to part of the heart and the heart muscle is injured due to not receiving enough oxygen. Usually this is because one of the coronary arteries that supplies blood to the heart develops a blockage due to an unstable buildup of white blood cells, cholesterol and fat (Anand, et al., 2008)

A person having an acute MI usually has sudden chest pain that is felt behind the breast bone and sometimes travels to the left arm or the left side of the neck, and jaw. Additionally, the person may have shortness of breath, sweating, nausea, vomiting, abnormal heartbeats, and anxiety. Women experience fewer of these symptoms than men, but usually have shortness of breath, weakness, a feeling of indigestion, and fatigue (Kosuge et al., 2006)

In many cases, in some estimates as high as 64%, the person does not have chest pain or other symptoms, these are called "silent" myocardial infarctions (Valensi et al., 2011)

Exercise improving cholesterol levels and blood pressure and maintaining weight, inactive people with multiple cardiac risk factors are more likely to develop MI, studies conclude that at least 30 – 40 minutes of moderate exercise three to four times per week carries cardio protective effect (Heidrich, et al 2003)

Regular physical exercise reduces the risk for MI; it lowers Low density lipoprotein (LDL) and triglycerides levels and raises High density lipoprotein (HDL) levels (Shang, et al 2009)

Patient who underwent any structured exercises had a lower incidence of cardiac disease when compared to those who received the usual care with no exercise; there were significant reduction in total cholesterol, and triglyceride levels (Manson, et al., 2012)

Behavioral patterns, social changes, emotional state and stressful life events may be risk factors of occurrence of MI (Bush, et al., 2005)

Psychosocial factors were evaluated with four simple questions about work, home, financial stress, and major life events in the past year, psychosocial stressors significantly increased the risk of Ischemic Heart disease (Rosengren, et al., 2004)

Patients and methods

Quantitative design (a descriptive study), was employed at Sulaimani center of Heart Disease, to assess the Physical and Psycho-social status of Patient with Myocardial Infaraction from the 15th of April 2013 up to the end of Jun, 2014.

A non-probability (purposive) sample of 56 cases that were definitely diagnosed as having myocardial Infaraction.

Through extensive review of relevant literature a questionnaire was constructed for the purpose of the study with interview technique with the patients and their families. Overall items included in the Questionnaire were 51items. The questionnaire consists of demographic data composed of 9 items, that represent the demographic data of the sample such as age, gender, level of education, family history, occupation, marital status, number of children, monthly income, and residential area, and some contributing factors composed of 3 items include Smoking, Body mass index (BMI), and stressful life events, Physical status involves 18 items, and Psychosocial status involves 19 items.

All items were measured on three levels of Likert scale and rating as, always (3), sometimes (2), and never (1). (Polit and Hungler, 1999)

The content validity of the questionnaire was determined through a panel of seven experts

A pilot study was carried out to check the reliability of the questionnaire (Internal consistency) which is estimated as (r = 0.87) for the Physical and psychosocial status. Sample of pilot study was included with the study sample.

The data were analyzed through the application of descriptive statistical analysis that includes (frequency, percentage, mean, and inferential statistical analysis that includes mean of score, correlations and Pearson correlation coefficient). Mean of score of < 1.66 was considered low significant, (1.67 - 2.32) was considered moderate significant and (2.33- 3) was considered high significant. This rating of score applied for Physical and Psychosocial statues.

Results

Table (1): Distribution of the demographic data of the MI patients admitted to CCU. This table shows the distribution of 56 patients with MI, which indicated that 55.4%

of them were 60-69 years, (62.5%)of them were female, 60.7% of them has family

history of Myocardial Infarction, (41.1%) of them were read and Write, 57.1%

of them were married, 39.3 were widow/er, 64.4% were unemployed (Retired),

28.6 were house wife, 51.8 % were Barley sufficient Monthly income, and 48.2%

were lived in urban area.

Variables	F	%	Cumulative %
Age			
30-39 years	2.0	3.6	3.6
40-49 years	4.0	7.1	10.7
50-59 years	16	28.6	39.3
60-69 years	31	55.4	94.6
≥ 70 years	3.0	5.4	100.0
Total	56	100	
Gender	**F**	**%**	**Cumulative %**
Male	21	37.5	37.5
Female	35	62.5	100.0
Total	56	100	
Family History with MI	**F**	**%**	**Cumulative %**
Yes	34	60.7	60.7
No	22	39.3	100.0
Total	56	100	
Level of Education	**F**	**%**	**Cumulative %**
(Illiterate) Not read and Write	17	30.4	30.4
Read and Write	23	41.1	71.4
Primary School Graduate	10	17.9	89.3
High Institute Graduate	3.0	5.4	94.6
College and post Graduate	3.0	5.4	100.0
Total	56	100	
Marital Status	**F**	**%**	**Cumulativ**

			e %
Single	2.0	3.6	3.6
Married	32	57.1	60.7
Widow/er	22	39.3	100.0
Total	56	100	
Occupation			Cumulative %
Employed	F	%	
Governmental	2.0	3.6	3.6
Self employed	2.0	3.6	7.1
Unemployed	F	%	
Retired	26	46.4	53.6
House wife	16	28.6	82.1
(Out of work(jobless)	10	17.9	100.0
Total	56	100	
Monthly income	F	%	Cumulative %
Sufficient	7.0	12.5	12.5
Barley sufficient	29	51.8	64.3
Insufficient	20	35.7	100.0
Total	56	100	
Residential Area	F	%	Cumulative %
Urban	27	48.2	48.2
Sub urban	19	33.9	82.1
Rural	10	17.9	100.0
Total	56	100	

Table (2): Risk factors to MI.

This table shows the distribution of 56 patients with MI, which indicated that 41% of the study sample was obese, 82.1% were not smoker, and 73.2% were not expose to stressful life events.

Body Mass Index	F	%	Cumulative %
Normal weight (18.5 – 24.99)	2.0	3.6	3.6
Over weight (25 – 29.9)	23	41	44.6
Obese (30 – 39.9)	21	37.5	82.1
Morbidity obese > 40	10	17.9	100.0
Total	56	100	
Smoking	F	%	Cumulative %
No smoke	46	82.1	82.1
1-10 Cigarettes/ day	1.0	1.8	83.9

11-20 Cigarettes/ day	**3.0**	**5.4**	**89.3**
21-30 Cigarettes/ day	**5.0**	**8.9**	**98.2**
> 30 Cigarettes/ day	**1.0**	**1.8**	**100.0**
Total	**56**	**100**	
Do you expose to stressful life events before?	**F**	**%**	**Cumulative %**
Yes	**15**	**26.8**	**26.8**
No	**41**	**73.2**	**100.0**
Total	**56**	**100**	

Table (3): Level of Physical status distribution of MI patients admitted to CCU.
This table has revealed Mean of scores for items of Physical statues. It indicates that the mean of score was moderate significant on items (7, 10, 12, 13, and 15), and low significant for item (3, and 9) and highly significant for the remaining items.

N0	Scale / Items	Always		Sometimes		Never		S.D	M.S	S
		F	%	F	%	F	%			
1.	I feel pain when I lift heavy objects.	46	82.1	10	17.9	0.0	0.0	2.4	2.8	H*
2.	I feel pain when I do routine activity.	24	42.9	32	57.1	0.0	0.0	0.49	2.4	H*
3.	I feel pain and discomfort when I think about my disease.	0.0	0.0	34	60.7	22	39.3	0.49	1.6	L***
4.	I feel pain and discomfort when I think about stressful life events.	46	82.1	10	17.9	0.0	0.0	0.38	2.8	H*
5.	My sleep becomes disturbed after disease.	14	25	42	75	0.0	0.0	0.43	2.6	H*
6.	I suffer from nightmares during sleep.	22	39.3	34	60.7	0.0	0.0	0.49	2.4	H*
7.	My sleep becomes difficult.	12	21.4	23	41	21	37.5	0.75	1.8	M**
8.	I suffer from fatigue when I do any work.	30	53.6	23	41	3.0	5.4	0.6	2.5	H*
9.	I need help when I do work even change clothes and take shower.	3.0	5.4	23	41	30	53.6	0.6	1.5	L***
10.	Some time I feel tired even without doing any work.	9.0	16	43	76.8	4.0	7.1	0.47	2.0	M**
11.	I get tired easily.	22	39.3	34	60.7	0.0	0.0	0.49	2.4	H*
12.	I suffer from shortness of breathing.	23	41	12	21.4	21	37.5	0.89	2.0	M**
13.	I neglect sport and driving mobile.	22	39.3	10	17.9	24	42.9	0.91	2.0	M**
14.	I give up sexual activates.	31	55.4	22	39.3	3.0	5.4	0.6	2.5	H*
15.	I change my occupation because of my disease.	32	57.1	3.0	5.4	21	37.5	0.96	2.2	M**

16.	I walk slowly inside the home.	**32**	**57.1**	**21**	**37.5**	**3.0**	**5.4**	**0.6**	**2.5**	**H***
17.	I am difficulty move on steps.	**33**	**58.9**	**23**	**41**	**0.0**	**0.0**	**0.49**	**2.6**	**H***
18.	I feel that I lose my energy.	**44**	**78.6**	**12**	**21.4**	**0.0**	**0.0**	**0.41**	**2.8**	**H***
Total		**445**		**411**		**152**				

*H= High ** M=Moderate ***L=Low M.S= Mean of score S= Severity

Table (4): Level of Psycho-social statues of MI patients admitted to CCU.

This table has revealed Mean of scores for items of psychosocial statues. It indicates that the mean of score was highly significant for items (1,2,3,4,6,7,8,12,14,15, and 18), and moderate significant for items (9,13,17), and low significant on the remaining items.

N0	**Scale Items**	**Always**		**Sometimes**		**Never**		**S.D**	**M.S**	**S**
		F	**%**	**F**	**%**	**F**	**%**			
1.	I mostly think about my health status.	**46**	**82.1**	**10**	**17.9**	**0.0**	**0.0**	**0.38**	**2.8**	**H***
2.	I am anxious about my future.	**22**	**39.3**	**34**	**60.7**	**0.0**	**0.0**	**o.49**	**2.4**	**H***
3.	I am worried about my family future.	**34**	**60.7**	**22**	**39.3**	**0.0**	**0.0**	**0.49**	**2.6**	**H***
4.	I feel that my family is not comfortable.	**46**	**82.1**	**10**	**17.9**	**0.0**	**0.0**	**0.38**	**2.8**	**H***
5.	I feel that my illness affects my financial income.	**10**	**10.9**	**22**	**39.3**	**24**	**42.9**	**0.74**	**1.6**	**L*****
6.	Treatment is costly.	**22**	**39.3**	**34**	**60.7**	**0.0**	**0.0**	**0.49**	**2.4**	**H***
7.	Often I blame myself.	**32**	**57.1**	**20**	**35.7**	**4.0**	**7.1**	**0.49**	**2.5**	**H***
8.	I feel that my responsibility is limited after my disease.	**32**	**57.1**	**24**	**42.9**	**0.0**	**0.0**	**0.5**	**2.6**	**H***
9.	I feel decrease intimacy from others to me.	**22**	**39.3**	**24**	**42.9**	**10**	**17.9**	**0.73**	**2.2**	**M****
10.	I lose my post and job because of my disease.	**0.0**	**0.0**	**32**	**57.1**	**24**	**42.9**	**0.5**	**1.6**	**L*****
11.	I am hopeless.	**0.0**	**0.0**	**32**	**57.1**	**24**	**42.9**	**0.5**	**1.6**	**L*****
12.	I feel mercy from the others.	**22**	**39.3**	**34**	**60.7**	**0.0**	**0.0**	**0.49**	**2.4**	**H***
13.	I feel that I have no any role in my family and in the community.	**0.0**	**0.0**	**46**	**82.1**	**10**	**17.9**	**0.39**	**1.8**	**M****
14.	I feel that my relationship with the others is decreased	**46**	**82.1**	**10**	**17.9**	**0.0**	**0.0**	**0.39**	**2.8**	**H***
15.	I complain from insomnia.	**32**	**57.1**	**24**	**42.9**	**0.0**	**0.0**	**0.5**	**2.6**	**H***
16.	I decreased sharing with the others due to my disease.	**0.0**	**0.0**	**32**	**57.1**	**24**	**42.9**	**0.5**	**1.6**	**L*****
17.	I hate myself after my disease.	**10**	**17.9**	**39**	**69.6**	**7.0**	**12.5**	**0.55**	**2.0**	**M****
18.	I feel that I will die in any time.	**25**	**44.6**	**31**	**55.4**	**0.0**	**0.0**	**0.5**	**2.4**	**H***
19.	I feel that god punished me by my disease.	**0.0**	**0.0**	**22**	**39.3**	**34**	**60.7**	**0.5**	**1.4**	**L*****
Total		**401**		**502**		**161**				

H= High ** M=Moderate ***L=Low M.S= Mean of score S= Severity*

Table 5: Correlations between Total Physical Status and Some Sociodemographic Characteristics.

Variables		Age	Gender	Family History	Level of Education	Marital Status	Occupation	Monthly Income	Residential area	Smoking	BMI	Stress	Total Physical Status
Age	Correlation	1.000	.090	-.133-	-.065-	-.191-	-.078-	.315	-.446-	-.441-	.283	.171	-.424-
	Significance (2-tailed)	.	.507	.328	.632	.159	.567	.018	.001	.001	.035	.207	.001
	df	0	54	54	54	54	54	54	54	54	54	54	54
Gender	Correlation	.090	1.000	-.392-	-.253-	.182	-.268-	.094	-.498-	-.505-	.626	-.198-	-.206-
	Significance (2-tailed)	.507	.	.003	.060	.179	.046	.493	.000	.000	.000	.143	.128
	df	54	0	54	54	54	54	54	54	54	54	54	54
Family History	Correlation	-.133-	-.392-	1.000	.069	-.161-	.369	-.118-	.421	.471	-.580-	-.009-	.194
	Significance (2-tailed)	.328	.003	.	.614	.236	.005	.387	.001	.000	.000	.948	.152
	df	54	54	0	54	54	54	54	54	54	54	54	54
Level of education	Correlation	-.065-	-.253-	.069	1.000	-.007-	.136	-.170-	.237	.265	-.264-	.144	.172
	Significance (2-tailed)	.632	.060	.614	.	.962	.319	.211	.079	.049	.050	.288	.205
	df	54	54	54	0	54	54	54	54	54	54	54	54
Marital status	Correlation	-.191-	.182	-.161-	-.007-	1.000	.226	-.367-	.203	.296	.342	-.740-	.773
	Significance (2-tailed)	.159	.179	.236	.962	.	.093	.005	.134	.027	.010	.000	.000
	df	54	54	54	54	0	54	54	54	54	54	54	54
Occupation	Correlation	-.078-	-.268-	.369	.136	.226	1.000	-.295-	.665	.697	-.537-	-.203-	.591
	Significance (2-tailed)	.567	.046	.005	.319	.093	.	.027	.000	.000	.000	.133	.000
	df	54	54	54	54	54	0	54	54	54	54	54	54
Monthly income	Correlation	.315	.094	-.118-	-.170-	-.367-	-.295-	1.000	-.545-	-.582-	.308	.338	-.630-
	Significance (2-tailed)	.018	.493	.387	.211	.005	.027	.	.000	.000	.021	.011	.000
	df	54	54	54	54	54	54	0	54	54	54	54	54
Residential Area	Correlation	-.446-	-.498-	.421	.237	.203	.665	-.545-	1.000	.955	-.806-	-.137-	.327
	Significance (2-tailed)	.001	.000	.001	.079	.134	.000	.000	.	.000	.000	.316	.000
	df	54	54	54	54	54	54	54	0	54	54	54	54
Smoking	Correlation	-.441-	-.505-	.471	.265	.296	.697	-.582-	.955	1.000	-.790-	-.205-	.818
	Significance (2-tailed)	.001	.000	.000	.049	.027	.000	.000	.000	.	.000	.130	.000
	df	54	54	54	54	54	54	54	54	0	54	54	54
BMI	Correlation	.283	.626	-.580-	-.264-	.342	-.537-	.308	-.806-	-.790-	1.000	-.782-	-.796-
	Significance (2-tailed)	.035	.000	.000	.050	.010	.000	.021	.000	.000	.	.035	.027
	df	54	54	54	54	54	54	54	54	54	0	54	54
Stress	Correlation	.171	-.198-	-.009-	.144	-.740-	-.203-	.338	-.137-	-.205-	-.282-	1.000	-.588-
	Significance (2-tailed)	.207	.143	.948	.288	.000	.133	.011	.316	.130	.035	.	.000
	df	54	54	54	54	54	54	54	54	54	54	0	54
Total Physical Status	Correlation	-.424-	-.206-	.194	.172	.773	.591	-.630-	.727	.818	-.296-	-.588-	1.000
	Significance (2-tailed)	.001	.128	.152	.205	.000	.000	.000	.000	.000	.027	.000	.
	df	54	54	54	54	54	54	54	54	54	54	54	0

This table shows that there is a significant relationship between Physical status and some Sociodemographic Characteristics.

- **BMI: Body Mass Index**

Table 6: Correlations between Total Psychosocial Status and Some Sociodemographic Characteristics.

Variables		Age	Gender	Family History	Level of Education	Marital Status	Occupation	Monthly income	Residential area	Smoking	BMI	Stress	Total Psychosocial Status
Age	Correlation	1.000	.090	-.133-	-.065-	-.191-	-.078-	.315	-.446-	-.441-	.283	.171	-.161-
	Significance (2-tailed)	.	.507	.328	.632	.159	.567	.018	.001	.001	.035	.207	.236
	df	0	54	54	54	54	54	54	54	54	54	54	54
Gender	Correlation	.090	1.000	-.392-	-.253-	.182	-.268-	.094	-.498-	-.505-	.626	-.198-	.067
	Significance (2-tailed)	.507	.	.003	.060	.179	.046	.493	.000	.000	.000	.143	.624
	df	54	0	54	54	54	54	54	54	54	54	54	54
Family History	Correlation	-.133-	-.392-	1.000	.069	-.161-	.369	-.118-	.421	.471	-.580-	-.009-	-.181-
	Significance (2-tailed)	.328	.003	.	.614	.236	.005	.387	.001	.000	.000	.948	.182
	df	54	54	0	54	54	54	54	54	54	54	54	54
Level of Education	Correlation	-.065-	-.253-	.069	1.000	-.007-	.136	-.170-	.237	.265	-.264-	.144	.079
	Significance (2-tailed)	.632	.060	.614	.	.962	.319	.211	.079	.049	.050	.288	.565
	df	54	54	54	0	54	54	54	54	54	54	54	54
Marital Status	Correlation	-.191-	.182	-.161-	-.007-	1.000	.226	-.367-	.203	.296	.342	-.740-	.936
	Significance (2-tailed)	.159	.179	.236	.962	.	.093	.005	.134	.027	.010	.000	.000
	df	54	54	54	54	0	54	54	54	54	54	54	54
Occupation	Correlation	-.078-	-.268-	.369	.136	.226	1.000	-.295-	.665	.697	-.537-	-.203-	.308
	Significance (2-tailed)	.567	.046	.005	.319	.093	.	.027	.000	.000	.000	.133	.021
	df	54	54	54	54	54	0	54	54	54	54	54	54
Monthly income	Correlation	.315	.094	-.118-	-.170-	-.367-	-.295-	1.000	-.545-	-.582-	.308	.338	347-
	Significance (2-tailed)	.018	.493	.387	.211	.005	.027	.	.000	.000	.021	.011	.001
	df	54	54	54	54	54	54	0	54	54	54	54	54
Residential Area	Correlation	-.446-	-.498-	.421	.237	.203	.665	-.545-	1.000	.955	-.806-	-.137-	.286
	Significance (2-tailed)	.001	.000	.001	.079	.134	.000	.000	.	.000	.000	.316	.033
	df	54	54	54	54	54	54	54	0	54	54	54	54
Smoking	Correlation	-.441-	-.505-	.471	.265	.296	.697	-.582-	.955	1.000	-.790-	-.205-	.379
	Significance (2-tailed)	.001	.000	.000	.049	.027	.000	.000	.000	.	.000	.130	.004
	df	54	54	54	54	54	54	54	54	0	54	54	54
BMI	Correlation	.283	.626	-.580-	-.264-	.342	-.537-	.308	-.806-	-.790-	1.000	-.282-	.240
	Significance (2-tailed)	.035	.000	.000	.050	.010	.000	.021	.000	.000	.	.035	.075
	df	54	54	54	54	54	54	54	54	54	0	54	54
Stress	Correlation	.171	-.198-	-.009-	.144	-.740-	-.203-	.338	-.137-	-.205-	-.282-	1.000	-.703-
	Significance (2-tailed)	.207	.143	.948	.288	.000	.133	.011	.316	.130	.035	.	.000
	df	54	54	54	54	54	54	54	54	54	54	0	54
Total Psychosocial Status	Correlation	-.161-	.067	-.181-	.079	.936	.308	-.447-	.286	.379	.240	-.703-	1.000
	Significance (2-tailed)	.236	.624	.182	.565	.000	.021	.001	.033	.004	.075	.000	.
	df	54	54	54	54	54	54	54	54	54	54	54	0

This table shows that there is a significant relationship between psychosocial status and some Sociodemographic Characteristics

Discussion:

Throughout the course of data analysis, the present findings indicate that most of the sample was (60-69) years old that were accounted for 46.4 % of the study sample Table1. This finding come along with studies done by Taraghi, (2010), and Anima, et al., (2005), which indicated that the majority of the study sample with Ischemic Heart Disease were (61-71) years old (Taraghi,2010), (Anima et al., 2005)

In relation to gender, the majority of the patients were females (66.1%). This result was in agreement with Harvard, et al., (2003) who found the same ratio they reported that female is more affected than male due to stress and menopause (Harvard, 2003)

The majority of the study sample were married (57%) in low level of education, (25%) illiterate and 41.1% were read and write positive family history of Ischemic Heart Disease (60.7%)(Table 1).

Knowledge is necessary to prevent and control unstable angina. A major public health problem exists, but control rates are dismal in every part of the world, the lack of baseline data in many countries and lack of national data in most countries make it difficult to develop any reasonable prevention projects (Haram, 2006)

Regarding the family history, Ilali, and Taraghi, (2010), stated in their study that 41.1 % of Ischemic Heart Disease (IHD) patients had positive family history (Ilali and Taraghi, 2010)

Also the result of present study agreed with the result of other study done by (Weixian, et al., 2009) which found that the positive family history increased the risk of (IHD) (Weixian, et al., 2009)

In relation to occupation, 28.6% of the study sample was housewives (Table 1).

Unemployment or housewives occupation lead to stress, so there is a significant relationship between Ischemic Heart Disease with occupational and social stress (Kaplan et al., 2004)

Regarding their residential area, the majority of the study sample lived in urban area which counted (82.2%). This finding was supported by Gupta, (2004) who stated that life in urban areas may lead to increase of domestic problems, and more stress (Gupta et al., 2004)

Concerning Monthly income, the majority of the study sample were barley sufficient 51.8 % and in sufficient 25%. Which means that low socioeconomic status play role in occurrence of MI. This result is supported by Zhijie, et al., (2000). Who stated that patient with low socioeconomic status tended to have higher levels of MI risk factors (Zhijie, et al., 2000)

Concerning body mass index, the findings of this study show that the majority of the current study sample were obese, 57% Table 2.

Libby, (2002) documented that the risk of IHD is 5 times higher in the obese as compared to those of normal weight (Libby, 2002)

Chine's study, estimated that excess body weight (include over weight and obesity), accounted for approximately 15 percent of cases of coronary heart disease in men and 10 percent in women. Obese individuals have an increase in fatty tissue that increases their vascular resistance and in turn increases the work the heart has to do to pump blood throughout the body (Murdoch and Hell, 2000)

Regarding to the Physical status, the finding shows that there is significant correlation between Physical status and occurrence of Myocardial Infarction, (Table 5).

Regular physical activity and weight loss, improved functional health status, well being and reduced risk of cardiovascular disease and mortality, furthermore swimming training, this is a clinically important finding since swimming can be a highly useful alternative to land based exercise for IHD patients with obesity (Whelton, et al., 2002)

Leon, and franklin, (2005), declared that aerobic physical activity like walking at least 30 minutes per day, most days of week, help the patient control his or her weight and decrease the risk of IHD and encouragement of regular exercise useful as a treatment method for individuals with unstable angina (Leon and Franklin, 2005)

In relation to psychosocial status the present study shows that there is significant correlation between psychosocial status and occurrence of Myocardial Infarction Table 6.

Life-style diseases are a result of un appropriate relationship of people with their environment, a study suggested that stressful life events may be a risk factor for unstable angina (Mattusch, and Heine, 2000)

The present study finding are compatible with the result obtained from a study done by Haldar, et.al, (2005) who found that an MI Patient was likely to experience stressful life events (Haldar, et al., 2005)

Conclusions:

The study concluded that the majority of the study sample was obese, low education married female patients who live in urban area, in barley sufficient monthly income, furthermore there is a significant correlation between Physical status and occurrence of MI and significant correlation between psychosocial status and occurrence of MI.

Recommendations:

The study recommended that increased awareness about dealing with psychosocial stresses management, coping strategies, and adaptation to it, and increased individual awareness about smoking danger and decrease body weight by healthy dietary pattern and increased daily activity.

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پوختە

ئەم تۆێژینەوەیە تۆێژینەوەیەکی زانستی وەسفیە ئە نجام دراوە لە یەکەی بوژانەوەی دڵ لە نەخۆشخانەی گشتی فێرکاری سلێمانی لەماوەی 15گولان 2013 بۆ جۆزەردانی 2014 , مەبەست لەم تۆێژینەوەیە هەڵسەنگاندنی لایەنی جەستەی و دەروونی و کۆمەلایەتی نەخۆشانی تووش بوو بە جەڵتەی دڵ لە شاری سلێمانی, وە چەند سیفەتێکی دیموگرافی وەك تەمەن,ڕەگەز ,ئاستی ڕۆشنبیری, بۆماوەی , پیشە, باری خێزاندارى, داهاتی مانگانە, شوێنی نیشتە جێبوون ،بە مەبەستی ئاما نجی تۆێژینەوەکە هەستاین بەوەرگرتنی نمونەی بەمبەستی ناگریمانەی پێکهاتوو لە (56) نەخۆش لە هەردوو ڕەگەز تووش بوو بە جەڵتەی دڵ داخل کرابوون لەسەنتەری بوژانەوەی دڵ لە نەخۆشخانەی گشتی فێرکاری سلێمانی .

بەمەستی کۆکردنەوەی نمونە هەستاین بەدانانی فۆرمێکی ڕاپرسی پێکهاتوو لە (51) بڕگە . بەشی یەکەم تایبەت بە دیموگرافی نەخۆش پێکهاتووە لە (9 بڕگە) , وە بەشی دووەم پێکهاتووە لە هۆکاری مەترسی دار (3 بڕگە), وە بەشی سێ یەم لایەنی جەستەی (18 بڕگە) پاشان بەشی چوارەم لایەنی دەرونی و کۆمەلایەتی (19 بڕگە), ڕاپرسیەکە خراوەتە بەردەم (7) پسپۆڕ بۆ دڵنیا بوون لە ڕاستێتی.

بە بەکار هێنانی لێکۆڵینەوەی بەڵگەی بە هۆی ڕێگەی تاقی کردنەوەی دووبارە تاقیکردنەوە و بە بەکار هێنانی(هاوکۆلکەی هاوپەیوەندی پیرسۆن) ڕاستی سەلێنراوە بە ڕێگەی (split half) .نەگۆری دیاری کەنرخی (r=87).

زانیاییەکان کۆکراوەتەوە بەڕێگەی چاوپێکەوتن لەڕێگەی بەکارهێنانی فۆرمی تایبەت پاشان داتاکان شیکراوەتەوە بەڕێگەی (descriptive and inferential statistic).

تۆێژینەوەکە بەو دەر ئە نجامە گەیشت کە پەیوەنی ئاماری بایەخدار هەیە لە نێوان باری خێزانی ,داهاتی مانگانە,جگەرە کێشان,کێشی لەش,لەگەڵ جەڵتەی دڵ . پەیوەنی بایەخدار هەیە لە نێوان باری خێزانی , پەستانی دەرونی لەگەڵ جەڵتەی دڵ .

تۆێژەرەکە بەو دەر ئە نجامەگەیشت کە بایەخدان و خود ئاگای لایەنی کۆمەلایەتی و دەرونی زۆر پێویستە و گرنگە.وە ئاگادار بوون لەوەی جگەرە کێشان ترسناکە و کاریگەری خرا پی هەیە,وە دابەزاندنی کێشی لەش پێویستە,وە پەیڕەوی کردنی شێوازی خۆراکی تەندروست ,وە جوڵەی جەستەی ڕاهێنان زۆر باشەو گرنگە.

الخلاصة:

دراسة وصفية اجريت في وحدة العناية القلبية المركزة في مستشفى السليمانية التعليمي للمدة ما بين 15 نيسان2013 لغاية شهر حزيران 2014, تهدف الدراسة الى تقييم الحالة الجسمية والنفسية والاجتماعية للمرضى المصابين بإحتشاء العضلة القلبية في مدينة السليمانية ، كذلك لإيجاد العلاقة بين الحالة الجسمية والنفسية والاجتماعية وبعض الخصائص الديموغرافية كالعمر الجنس ، المستوى الثقافي، التاريخ العائلي للمرض, المهنة، الحالة الزوجية، الدخل الشهري, ومحل السكن.

ولتحقيق اهداف الدراسة اختيرت عينة غرضيه غير احتمالية مكونة من 56 مريضا من كلا الجنسين من الذين أدخلوا الى وحدة العناية القلبية المركزة في مستشفى السليمانية التعليمي.

ولغرض جمع المعلومات صممت استمارة استبيانيه مكونة من 51 فقرة شمل الجزء الاول الخصائص الديموغرافية للمرضى (9 فقرات) والجزء الثاني شمل عوامل الخطورة (3 فقرات), وشمل الجزء الثالث فقرات الحالة الجسمية (18 فقرة), إضافة الى الجزء الرابع حيث شمل الحالة النفسية والإجتماعية (19 فقرة). عرضت الاستمارة على (7) خبراء لتحديد الصدق. هذا وقد اجريت دراسة استطلاعية وحدد الثبات باستخدام معامل بيرسون وبطريقة (Split-half) وكان (r= 87), وبطريقة المقابلة الشخصية مع عينة البحث جمعت المعلومات وقد حللت باستخدم التحليل الوصفي كذلك التحليل الاستنتاجي, ومن خلال التحليل بينت الدراسة ان هناك علاقة بين(الحالة الزوجية, الدخل الشهري, التدخين, وكذلك الكتلة الجسمية) وبين إحتشاء العضلة القلبية من الناحية الفسيولوجية او الجسمية.. كذلك بينت الدراسة أن هناك علاقة بين (الحالة الزوجية, وكذلك الضغوط النفسية) وبين احتشاء العضلة القلبية من الناحية النفسية والاجتماعية. هذا واوصت الدراسة بضرورة زيادة الوعي للتعامل مع الضغوط النفسية والاجتماعية والتكيف معها, كذلك اوصت الدراسة بتوعية الافراد حول مخاطر التدخين والامتناع عنه, وكذلك تقليل الوزن والالتزام بنمط غذائي صحي والاكثار من الانشطة اليومية.