A NARRATIVE RESEARCH APPROACH: ANXIETY IN HEART FAILURE PATIENTS

Beti Kristinawati [1*], Ahmad Karim Amirullah [2], Riska Nurul Khasanah [3]

Abstract: *The Clinical syndrome that occurs due to decreased cardiac function can lead to anxiety. Excessive and uncontrolled anxiety experienced by patients with heart failure can affect various aspects of life as a whole. The goal of the study was to get an overview of the anxiety experienced by patients with heart failure. The design of narrative research was chosen to gain considerate and formulate anxiety perception by conducting interviews with 17 selected participants with purposive techniques. Thematic analysis was applied to analyze the information obtained from the interviews. The results of the study gained four themes: 1) Fear of death and change of role in the family triggered the onset of anxiety, 2) Physical symptoms occurred when the anxiety arose, 3) The spiritual aspect of it was to reduce the mechanism of anxiety, 4) Emotional support was given to nurses and families to overcome anxiety. Nurses need to have a good understanding of the cause of anxiety, actions to minimize, and attempts to anticipate the emergence of anxiety in patients with heart failure who undergo hospitalization by involving family members. Physical, psycho-social, and spiritual support of nurses and families is needed in the care of heart failure patients.*

Keywords: *Anxiety, Heart Failure, Hospitalization, Patients experience, Narrative Research*

1. INTRODUCTION

Cardiovascular disease is the highest cause of death in the world. Moreover, it became one of the highest causes of death in the United States of 375,000 people per year. Its prevalence is expected to increase to 8 million in 2020. Mortality remains high even though the treatment of heart disease has progressed (Mozaffarian et al., 2016). The main symptoms are often encountered, such as shortness of breath, fatigue, and edema of the lower limbs resulting in the emergence of functional limitations in patients with heart failure. Heart failure is identical to the high number of rehospitalization, the rising cost of treatment, and high mortality (Moser et al., 2016; Rogers, 2015; Vongmany et al., 2016). In addition to functional limitations, heart failure patients are also experiencing psychological stress as the onset of anxious feelings, depression, dryness, and other psychic problems (Tatukude, Rampengan & Panda, 2016).

Depression and anxiety affect biological processes of cardiovascular function in patients with heart failure by changing and function related to the development and progression of heart failure, including the increasing mortality rate (Chapa et al., 2014; Celano et al., 2018). Research conducted by De Jong et al. (2011) suggested that anxiety and disobedience to treatment affect the survival of heart failure patients. Many factors are related to the occurrence of psychological disorders in patients with heart failure.

[1] Beti Kristinawati* is a doctoral student at Universitas Muhammadiyah Surakarta, Indonesia.
[2] Ahmad Karim Amirullah is a doctoral student at Universitas Muhammadiyah Surakarta, Indonesia.
[3] Riska Nurul Khasanah is a doctoral student at Universitas Muhammadiyah Surakarta, Indonesia.
*Correspondence Email: b115@ums.ac.id

Suratinoyo, Rottie, & Massi (2016) obtained the research that the factors affecting the incidence of psychological problems in patients with heart failure are demographic status (age and gender), the severity of the disease, the presence of other diseases complications such as diabetes, and lack of social support. The psychological problems that occur in patients with cardiovascular stultification are more common in women and less educated patients. Independent factors that are associated with depression and anxiety symptoms are post-traumatic stress disorder, low self-esteem, high somatic symptoms, low physical and mental health, active smoking, less physical, and prolonged suffering from the disease (Allabadi et al., 2019)

Anxiety is also associated with negative impacts, such as poor physical health, sleep problems, reduced ability to perform daily activities, increased loneliness, and incidence of urinary incontinence (Mehta et al., 2003; Strine, Chapman, Kobau, & Balluz, 2005; Wetherell & Gatz, 2005). Anxiety in patients with heart failure is one of the symptoms that are often overlooked, although it can increase the day of patient care. These impacts arise as a result of anxiety affecting the patient's breath quality and may lead to panic and chest pain, thereby exacerbating the symptoms of heart failure (Vongmany, Hickman, Lewis, Newton, & Phillips, 2016).

The anxiety experienced by heart failure patients has been assessed objectively using the curable methods and obtained the results that anxiety and high depressive symptoms can exacerbate the main symptoms of heart failure and affect the recovery process (Suratinoyo, Rottie, & Massi, 2016). Patients with persistent heart failure have a higher risk of death. The research of Alhurani, Dekker, Abed, Khalil, Al Zaghal, Lee, (2015) obtained the results that patients with heart failure had an anxiety rate of 60% higher than in healthy elderly, even 40% of heart failure patients experienced severe depressive symptoms. Kaplan & Sadock (2015) found that patients of chronic heart failure were mostly in the category of moderate anxiety. Anxiety is a psychological disorder that can not only be assessed objectively, but it is necessary to explore subjectively from the patient's perception.

The study aims to obtain an overview of the experiences of anxiety undergone by heart failure patients through spoken stories. Riessman's Research (2008) stated that narrative researchers gather stories from individuals about individual-spoken experiences.

2. MATERIALS AND METHODS

This research was conducted in regional hospitals in Surakarta, Central Java Province, Indonesia, from 25 March 2019 until 26 May 2019. Data retrieval was carried out in the outpatient unit of Integrated heart disease. Researchers conducted a qualitative study with an inquiry narrative approach to obtain detailed information about the subjective experience through the stories submitted by the participants. A narrative approach was suitable for use in this research to achieve research objectives, namely exploring the experience of anxiety arising from people with heart failure from the patient's perspective.

2.1 Researcher characteristics and reflexivity

BK, KA, and RNK have experience in qualitative research. BK has a background of cardiovascular specialist education and professional background as a nurse and a teaching staff in nursing school. TRAIN and RNK provide nursing care in the patient's heart failure in

the hospital during the education process of the nurse profession. All authors are accustomed to the research area and accustomed to using Bahasa Indonesia and Javanese language. Researchers are establishing relationships with participants starting with introducing themselves as researchers and explaining the research objectives and requesting informed consent after the study participants expressed their participation in the research.

2.2 Study informants and sampling

Researchers chose heart failure patients undergoing outpatient clinic as participants. Participant selection was done with a purposive technique based on preset criteria, including heart failure patients of Class III and IV of the New York Heart Association/NYHA functional classification, aged over 18 years, and not experiencing cognitive impairment. Class III and IV patients of heart failure of NYHA functional classification were chosen because the majority experienced high anxiety due to physical limitations as a result of decreased heart function. Cardiac failure patients who experienced cognitive impairment were not included in the study, in consideration that they could not tell the experience of anxiety they have experienced in real-time. The demographics' variables of participants are described in Table 1.

Table 1 Demographics' variables of participants

Variable		Frequency	
		Number	Percent %
Total of participants		17	100
Sex	Female	7	41,18
	Male	10	58,82
Age (years)	21-40	3	17,65
	41-60	10	58,82
	61-80	4	23,53
Employment status	Not working	4	23,53
	Self-employed	2	11,76
	Private employee	6	35,30
	Government employee	5	29,41
Education			
	Elementary School	4	23,53
	Junior High School	2	11,76
	Senior High School	6	35,30
	College	5	29,41
Duration of illness (years)	1-2	8	47,06
	3-5	5	29,41
	>5	4	23,53

2.3 Data collection

Data were collected with an in-depth face-to-face interview by KA and RNK until data saturation was reached. The interview was conducted on seventeen participants with a duration of 30 – 60 minutes, adjusted to the availability of time and physical condition of the

participant. When the interview took place, and participants felt exhausted, the interview would be stopped and resumed when the participant felt that the conditions were better. The interview was performed at the desired place by the participant, in the park, or the outpatient clinic waiting room. Researchers offered participants to conduct interviews using the Javanese or Indonesia language before the interview began. During the interview process, researchers used a scripted interview containing a sequence of questions about the research topic as a guideline for interrelated interview processes, including: "Tell me about your anxious experience"; "What causes you to feel anxious?"; "What changes happen when you are anxious?"; What actions do you take to alleviate anxiety? "and" Do you get help to overcome anxiety? Can you tell me? ".

All interviews were recorded using digital voice recorders and were subsequently written word-for-word and verbatim transcript. Nonverbal information from participants was documented in the field records and was the additional information in data analysis. Thematic analysis was used in this study to identify the theme of the experience told by the participants. The coding process is done by researchers to provide definitions of the data being analyzed (Charmaz & Morse, 2013). Researchers used the Open Code software to help extract the unit of meaning in the form of words or sentences, codes and word-for-word categories that have been transcribed. The KA and RNK conducted coding independently. The agreement was achieved after the results were discussed with BK. An example of the coding process is displayed in Table 2.

Table 2 Examples of coding processes

Meaning Unit	Code	Sub-category
Heart disease is identical to a deadly disease, so whenever I can die... (P7)	Deadly	Fear of death
I have long not worked and cannot run my role... (P1)	Unable to carry out obligations	Role changes
I feel easily tired since suffering from heart disease, no longer able to do a heavy activity (P10)	Easy to get tired	Symptomatic heart Failure
… strengthen themselves by hoping for God, and praying for steadfastness and at any time I died my family willingly (P3)	Pray	Draw closer to God
The nurse entertained with the jokes, and when I was worried about the change of physical conditions usually the nurse would be soothing by being near Me (P17)	Soothing the patient	Empathy

2.4 Trustworthiness

Researchers triangulated the source of information on the family members involved in the treatment process to improve the validity of the research results (Houser, 2015). In addition, researchers have also conducted discussions among all the authors to discuss the codes,

categories, and themes generated from the data. Other measures used by researchers to increase the validity of results included credibility, reliability, transferability, and sufficient time allocation for data collection.

2.5 Research Ethics

Participants involved in this study expressed their willingness to participate in the research and approval for the recording of the interview process as well as nonverbal information by signing informed consent. Participants were provided with information that they could stop the recording at any time during the interview process or discontinued participating in the study at any stage. Researchers maintained the confidentiality of participants by writing initials in place of participant names (e.g ., P1, P2,... P17) and only certain information published and approved by participants. The prevailing admirably procedure at the research site was followed before researchers took data from the patient's medical record. This study obtained the ethical approval of the Health Research Ethics commission of the District General Hospital in Surakarta, with the number 308/III/HREC/2019.

3. Results and Discussions

Seventeen patients' heart failure participated in this study. From the thematic analysis results forming the general idea of Creswell (2014), it was obtained by four themes: [1] Fear of death and changing roles in the family triggers anxiety, [2] Symptomatic and psychological changes occur when experiencing anxiety in patients with heart failure, [3] The spiritual aspect is the coping mechanism of heart failure patients to reduce anxiety, [4] Emotional support provided by nurses and family to reduce anxiety of heart failure patients. Table 3 presents the entire category that makes up the theme.

Table 3. The results in the form of categories and themes

Categories	Themes
The patients think about his condition Fear of death Thinking about family members Role change	Fear of death and changes in a role in the family triggers anxiety
Symptomatic heart failure Psychological changes	Symptomatic and psychological changes occur when experiencing anxiety in patients with heart failure
Think calmly Worship of God	The spiritual aspect is the coping mechanism of heart failure patients to reduce anxiety
Emotional support	The emotional support provided by nurses and family to reduce the anxiety of heart failure patients

Fear of death and changes in the role in the family triggers anxiety

Fear of death was interpreted by participants as a feeling of fear that the heart disease they suffered could lead to death at any time. There is a strong connection between the anxiety of

death with the severity of physical symptoms experienced by patients (Menziez, Sharpe, & Dar-Nimrod, 2019). Patients with organ failure who understand the occurrence of their body's function are likely to discuss with the caregiver about death openly and hope the failure of the organ that they suffer does not develop (Kendall, Carduff, Lloyd, Kimbell, Cavers, Buckingham, Murray, 2015). Participants imagined himself when dying and would leave his family. Separation with family or close people is one of the reasons why someone experiences fear of death (Strang, Ekberg-Jansson, & Henoch, 2014). The participant must also prepare when one day they are called by God at the end of their lives. The expression of the participant supporting the theme was presented by P2, P3, P7, and P9. Field notes showed that P3 participants had tears in his/her eyes, P2 turned his/her face while wiping his/her tears while telling his/her experience.

"... What if I should go leave the *family... "(P2)*

"... This shadow of *me is already close called by God. So I have to prepare myself... "(P3)*

"... I'm afraid to die, I'm suffering from heart disease"(P9)

Role changes were interpreted as a change in the duties and obligations of participants in the family due to physical limitations. Participants were initially as the head of the family or housewives, and able to make a living; however, due to illness, they were no longer able to perform their roles. The limitation of a physical condition caused participants to no longer productive and unable to work as they were healthy. The biggest concern felt by long-term illness patients is that they will be a burden for the family; that condition defeats the fear of death (Awang, Mansor, Peng, & Osman, 2018). The expression of participants P1, P2, P5, and P12 indicated a change in the role after they had the disease. From the field notes, participant P1 showed sadness when telling stories, occasional bowing, and speaking in a low tone.

“... Will work again already incapable and all the needs of assisted wives and children "(P2)

“... I have long been not working, have a desire to help the family but rather troublesome. " (P5)

“..Want to be able to help the child to achieve goals, but already incapable.." (P12)

Symptomatic and psychological changes occur when experiencing anxiety in patients with heart failure

Symptomatic and psychological changes as physical changes arise from the heart that fails to run the function of pumping blood throughout the body and fulfills the need for tissue metabolism. Dejean et al. (2013) stated that chronic diseases and anxieties are interconnected;

chronic diseases can cause anxiety, as well as anxiety, which can cause chronic diseases. Sustained anxiety and depression will have a significant impact on patients with heart failure (Alhurani et al., 2015). The psychological changes experienced by participants are difficult to rely on emotions and irritability. When angry, participants had difficulty breathing, heart pounding firmer. Participants also said that when they had many things to think and worry about, they would find it difficult to sleep, worry, and had head pain. The emergence of symptomatic heart failure and psychological changes was expressed by participants P2, P4, P5, P6, P7, and P12. The field note showed that the attitude of the P4 participant when storytelling, that was while holding his/her chest, while P12 clenched his/her fists repeatedly, which showed anxiety.

> *"... If my anger is finally into shortness of breath... Worried if my condition worsened and if it was like that I usually do not sleep bias "(P6)*

> *"... I was often suddenly shocked... If I was so breathless... Can not breathe... " P5*

> *"Hard to sleep, sleepy but can't sleep, want to sleep but can't sleep" (P7)*

> *"My heart palpitations firmly when I feel worried" (P4)*

The spiritual aspect is the coping mechanism of heart failure patients to reduce anxiety

The spiritual aspect of the mechanism is to serve as an attitude to God when experiencing anxiety due to the pain that is currently being sustained. There is a clear connection between spiritual well-being and the enhancement of individual abilities to overcome stress and disease (Friedman, Bowden & Jones, 2010). Spiritual and religion become an independent domain that can improve health, psychological well-being, as well as a source of support in addressing health problems and difficulties in the patients' lives (Basri, Hong, Oon, & Kumagai, 2015; Fradelos et al., 2015; Roger & Hatala, 2018). Participants believed that the illness they suffered today as a test of patience. All participants in this study were Muslim, so the patient always gave his condition to Allah by performing prayers, dhikr, praying, reading Al Qur'an, and still having good prejudice. The patient believed that his/her current situation had been governed by God. Participants were confident that life is always changing, sometimes healthy, sometimes sick, and all are governed by God. Life must continue to strive and surrender to God.

Prayer is the most crucial aspect of one's spirituality and mental health, and most patients pray to get relief from their physical and mental illness; their intention of praying is not only for healing, but prayer can be a source of strength to change their experiences during illness into something positive (Hamilton, Kweon, Brock, & Moore, 2019; Jors, Bussing, Hvidt, & Baumann, 2015). Patients tend to express and reveal their spiritual side in a unique way during illness, and the health care provider is expected to be able to identify and facilitate patients in fulfilling their spiritual needs (Fitch & Bartlett, 2017). The spiritual aspect of this is the mechanism of action when experiencing anxiety expressed by participants of P3, P5,

P6, P9, P10, and P12. Field notes showed that the P10 participant was occasionally looking down when telling stories. Some quotes from participants are as follows:

> *" ... It all depends on God. I am not afraid to die because of my illness, for God's only decisive death "(P9)*

> *"All these trials of God, the condition of people changing, sometimes healthy sometimes hurts. The important patience, no need for emotions... I submit all to God, live or die. A prayer, a lot of dhikrs... I submit all, to God that my life is quiet "(P10)*

> *"... Pray in the mosque, to read the Holy, so that the mind is not tense, not down... "(P12)*

The emotional support provided by nurses and family to reduce the anxiety of heart failure patients

The emotional support provided by nurses and families can soothe and alleviate anxiety. Patients with chronic diseases have difficulty in maintaining the regulation of emotions (Wierenga, Lehto & Given, 2017), and it can lead to decreased body function, so they need support to express their emotions in the right way (De Ridder et al., 2008). The family has the role of providing emotional & economics support, regulating the diet, ensuring the patient adhere to the therapeutic regimen correctly, supporting against depression, and even reducing the adverse effects of stress on patients (Ahmed & Yeasmeen, 2016; Fry, McLachlan, Purdy, et al., 2016). Participants revealed that in addition to the resignation of God and trust in medicine, medical and nursing personnel also provided support, advice, and prayer to relieve the burden felt by the participants. A nurse needs to plan non-pharmacology measures to reduce patient anxiety (Rusmini, Playwright, & Cembun, 2018). A nurse can develop a supportive relationship with the patient through effective communication because effective communication done by the nurse can lower the anxiety (Lukmanulhakim, Suryani, & Anna, 2016; Skilbeck & Payne, 2003). The emotional support was expressed by participants P1, P3, P8, P11, and P12. The P11 participants' field notes showed an energetic attitude and told his/her experience with a loud voice. Some quotes from participants are as follows:

> *"... Doctors and nurses who provide care often say that I don't t much think of negative* things... *"(P1)*

> *"... Nurses give encouragement to keep me healthy..., like having a friend that lightens my burdens" (P3)*

> *"Nurses always approached me and delivered words that kept me calm if I began to feel anxious because of my declining physical condition " (P11)*

4. CONCLUSION

The results of the study can answer the question of the study "How is the experience of anxiety faced by people with heart failure?". The onset of anxiety was triggered by the fear of death and the change of role that occurred in patients due to the disease of heart failure that they suffered. Symptomatic due to failure of heart function and changes in psychology occurred in patients with heart failure. Patients with heart failure had a mechanism in the spiritual aspect when anxiety arose. Families and nurses provided emotional support when heart failure patients experience anxiety. Based on the findings, the aspect of psychology was expected to be examined and entered into the action plan for nursing actions when treating patients with heart failure.

REFERENCES

[1] Ahmed, Z., & Yeasmeen, F. (2016). Active family participation in diabetes self-care : a commentary. *Diabetes Manag*, *6*, 104–107.

[2] Al-Abadi, H., Alkaiyat, A., Alkhayyat, A., Hammoudi, A., Odeh, H., Shtayeh, J., … Probst-Hensch, N. (2019). Depression and anxiety symptoms in cardiac patients: A cross-sectional hospital-based study in a Palestinian population. *BMC Public Health*, *19*(1), 1–14. https://doi.org/10.1186/s12889-019-6561-3

[3] Alhurani, A. S., Dekker, R. L., Abed, M. A., Khalil, A., Al Zaghal, M. H., Lee, K. S., … Moser, D. K. (2015). The Association of Co-morbid Symptoms of Depression and Anxiety with All-Cause Mortality and Cardiac Rehospitalization in Patients with Heart failure. *Psychosomatics*, *56*(4), 371–380. https://doi.org/10.1016/S2214-109X(16)30265-0.Cost-effectiveness.

[4] Awang, H., Mansor, N., Peng, T. N., & Osman, N. A. N. (2018). Understanding aging: Fear of chronic diseases later in life. *Journal of International Medical Research*, *46*(1), 175–184. https://doi.org/10.1177/0300060517710857

[5] Basri, N. A., Hong, G. C., Oon, N. L., & Kumagai, S. (2015). Islamic Religiosity, Depression and Anxiety among Muslim Cancer Patients. *IAFOR Journal of Psychology & the Behavioral Sciences*. https://doi.org/10.22492/ijpbs.1.1.04

[6] Chapa, D. W., Akintade, B., Son, H., Woltz, P., Hunt, D., Friedmann, E., … Thomas, S. A. (2014). Pathophysiological relationships between heart failure and depression and anxiety. *Critical care nurse*, *34*(2), 14–25. DOI:10.4037/ccn2014938

[7] Celano, C. M., Villegas, A. C., Albanese, A. M., Gaggin, H. K., & Huffman, J. C. (2018). Depression and Anxiety in Heart Failure: A Review. *Harvard Review of Psychiatry*, *26*(4), 175–184. https://doi.org/10.1097/HRP.0000000000000162

[8] Charmaz, K. (2009). *Constructing grounded theory: A practical guide through qualitative analysis.* Thousand Oaks: Sage Publication Ltd

[9] Creswell, J. W. (2014). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*, 3rd ed., London: Sage

[10] Dejean, D., Giacomini, M., Vanstone, M., & Brundisini, F. (2013). Patient Experiences of Depression and Anxiety with Chronic Disease : A Systematic Review and Qualitative Meta-Synthesis. *Ontario Health Technology Assessment Series*, *13*(16), 1–33.

[11] De Jong, M. J., Chung, M. L., Wu, J. R., Riegel, B., Rayens, M. K., & Moser, D. K. (2011). Linkages between anxiety and outcomes in heart failure. *Heart & lung: the journal of critical care*, *40*(5), 393–404. DOI:10.1016/j.hrtlng.2011.02.002

[12] de Ridder, D., Geenen, R., Kuijer, R., & van Middendorp, H. (2008). Psychological adjustment to chronic disease. *The Lancet*, *372*(9634), 246–255. https://doi.org/10.1016/S0140-6736(08)61078-8Un

[13] Fitch, M. I., & Bartlett, R. (2017). Patient Perspectives about Spirituality and Spiritual Care. *Asia Pac J Oncol Nurs*, *4*(2), 95–97. https://doi.org/10.4103/apjon.apjon

[14] Fradelos EC, Tzavella F, Koukia E, et al. Integrating Chronic Kidney Disease Patient's Spirituality In Their Care: Health Benefits And Research Perspectives. *Mater Sociomed*. 2015;27(5):354–358. DOI:10.5455/msm.2015.27.354-358

[15] Friedman, Bowden & Jones. (2010). *Family Nursing: Research Theory and Practice*. New Jersey: Prentice-Hall.

[16] Fry, M., McLachlan, S., Purdy, S. *et al.* The implications of living with heart failure; the impact on everyday life, family support, co-morbidities and access to healthcare: a secondary qualitative analysis. *BMC Fam Pract* **17,** 139 (2016). https://doi.org/10.1186/s12875-016-0537-5

[17] Hamilton, J. B., Kweon, L., Brock, L. B., & Moore, A. D. (2019). The Use of Prayer During Life-Threatening Illness: A Connectedness to God, Inner-Self, and Others. *Journal of religion and health*, 10.1007/s10943-019-00809-7. Advance online publication. DOI:10.1007/s10943-019-00809-7

[18] Houser, J. (2015). *Nursing Research: Reading, using, and creating evidence*, 3rd ed., United States of America: Ascent Learning Company

[19] Jors, K., Büssing, A., Hvidt, N. C., & Baumann, K. (2015). Personal prayer in patients dealing with chronic illness: a review of the research literature. *Evidence-based complementary and alternative medicine: eCAM*, *2015*, 927973. DOI:10.1155/2015/927973

[20] Kaplan & Sadock, (2015). *Synopsis Of Psychiatry: Behavioral Sciences/Clinical Psychiatry* (Eleventh Edition). Philadelphia: Wolters Kluwer

[21] Kendall, M., Cardiff, E., Lloyd, A., Kimbell, B., Cavers, D., Buckingham, S., … Murray, S. A. (2015). Different Experiences and Goals in Different Advanced Diseases: Comparing Serial Interviews With Patients With Cancer, Organ Failure, or Frailty and

Their Family and Professional Carers. *Journal of Pain and symptom management*, *50*(2), 216–224. DOI:10.1016/j.jpainsymman.2015.02.017

[22] Lukmanulhakim, L., Suryani, S., & Anna, A. (2016). The relationship between the communication of nurses and the level of anxiety of a patient's family in emergency room dr. Dradjat Prawiranegara hospital, Serang Banten, Indonesia. International Journal of Research in Medical Sciences. 4. 5456-5462. DOI:10.18203/2320-6012.ijrms20164228.

[23] Mehta, K. M., Simonsick, E. M., Penninx, B. W. J. H., Schulz, R., Rubin, S. M., Satterfield, S., & Yaffe, K. (2003). *Prevalence and Correlates of Anxiety Symptoms in Well-Functioning Older Adults: Findings from the Health Aging and Body Composition Study. Journal of the American Geriatrics Society, 51(4), 499–504.* DOI:10.1046/j.1532-5415.2003.51158.x

[24] Menzies, R. E., Sharpe, L., & Dar-Nimrod, I. (2019). The relationship between death anxiety and severity of mental illnesses. *British Journal of Clinical Psychology*, *58*(4), 452–467. https://doi.org/10.1111/bjc.12229

[25] Moser, D. K., Arslanian-Engoren, C., Biddle, M. J., Chung, M. L., Dekker, R. L., Hammash, M. H., … Lennie, T. A. (2016). *Psychological Aspects of Heart Failure. Current Cardiology Reports, 18(12).* DOI:10.1007/s11886-016-0799-5

[26] Mozaffarian, D., Benjamin, E. J., Go, A. S., Arnett, D. K., Blaha, M. J., Cushman, M., … Turner, M. B. (2016). *Heart disease and stroke statistics-2016 update a report from the American Heart Association*. *Circulation* (Vol. 133). https://doi.org/10.1161/CIR.0000000000000350.

[27] Richards, L. & Morse, J. M. (2013). Read me first for a user's guide to qualitative methods, 3rd ed., Thousand Oaks: Sage Publication

[28] Riessman, C. K. (2008). *Narrative Methods for the Human Science.* Los Angeles, CA: Sage

[29] Roger, K. S., & Hatala, A. (2018). Religion, spirituality & chronic illness: A scoping review and implications for health care practitioners. *Journal of Religion and Spirituality in Social Work*, *37*(1), 24–44. https://doi.org/10.1080/15426432.2017.1386151

[30] Rogers C, B. N. (2015). *Heart Failure: Pathophysiology, Diagnosis, Medical Treatment Guidelines, and Nursing Management. 50*, 787–799.

[31] Rusmini, -, Dramawan, A., & Cembun, -. (2018). The influence of supportive psychotherapy on patient anxiety to pre-hyperbaric therapy. *International Journal of Health Sciences*, *2*(3), 55–64. https://doi.org/10.29332/ijhs.v2n3.219

[32] Skilbeck, J., & Payne, S. (2003). Emotional support and the role of Clinical Nurse specialists in palliative care. *Journal of Advanced Nursing*, *43*(5), 521–530. https://doi.org/10.1046/j.1365-2648.2003.02749.x

[33] Strang, S., Ekberg-Jansson, A., & Henoch, I. (2014). Experience of anxiety among patients with severe COPD: A qualitative, in-depth interview study. *Palliative & supportive care*, *12*(6), 465–472. DOI:10.1017/S1478951513000369

[34] Strine, T. W., Chapman, D. P., Kobau, R., & Balluz, L. (2005). Associations of self-reported anxiety symptoms with health-related quality of life and health behaviors. Social Psychiatry and Psychiatric Epidemiology, 40(6), 432–438. DOI:10.1007/s00127-005-0914-1

[35] Tatukude, C., Rampengan, S., & Panda, A. (2016). Hubungan Tingkat Depresi dan Kualitas Hidup pada Pasien Gagal Jantung Kronik di Poliklinik Jantung RSUP Prof. Dr. R. D. Kandou Manado. Jurnal E-Clinic (ECl), 4(1).

[36] Vongmany, J., Hickman, L. D., Lewis, J., Newton, P. J., & Phillips, J. L. (2016). Anxiety is chronic heart failure and the risk of increased hospitalizations and mortality: A systematic review. *European Journal of Cardiovascular Nursing*, *15*(7), 478–485. https://doi.org/10.1177/1474515116635923

[37] Wetherell, J. L., & Gatz, M. (2005). The Beck Anxiety Inventory in older adults with a generalized anxiety disorder. Journal of Psychopathology and Behavioral Assessment, 27(1), 17–24. doi:10. 1007/s10862-005-3261-3

[38] Wierenga, K. L., Lehto, R. H., & Given, B. (2017). Emotion Regulation in Chronic Disease Populations: An Integrative Review. *Physiology & Behavior*, *176*(1), 139–148. https://doi.org/10.1016/j.physbeh.2017.03.040