

Angina: Symptoms, Causes, and Treatment Options

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Introduction to Angina Beliefs and Illness Representation

Angina beliefs constitute the intricate cognitive frameworks that patients construct to make sense of their diagnosis of angina pectoris, a condition characterized by chest pain or discomfort caused by myocardial ischemia. These beliefs are not merely intellectual facts about the disease but deeply personal, subjective interpretations that dictate how individuals perceive, react to, and manage their chronic health condition. Drawing heavily upon the theoretical underpinnings of the Common Sense Model of Self-Regulation (CSM) proposed by Leventhal and colleagues, the study of angina beliefs moves beyond biomedical markers to explore the patient's internal, lay representation of their illness. This representation, often termed the illness schema or illness perception, functions as a crucial mediator between the objective medical state and the resulting coping behaviors, psychological adjustment, and ultimately, health outcomes. Understanding these subjective frameworks is paramount because beliefs about the nature, severity, and prognosis of angina exert a profound influence on adherence to complex treatment regimens, engagement in necessary lifestyle modifications, and the overall experience of living with chronic heart disease.

The formation of these beliefs is a dynamic process, shaped by a confluence of factors including previous illness experiences, communication with healthcare providers, cultural narratives surrounding heart disease, and the immediate, visceral experience of anginal pain itself. When a patient experiences the sudden, often frightening onset of chest discomfort, they instinctively seek to attribute meaning and predictability to the event. For example, if a patient attributes the pain solely to external stress rather than underlying arterial blockage, their motivation to take prescribed anti-anginal medication might be significantly diminished. Conversely, if the patient views angina as an immediate, life-threatening event requiring absolute rest, they may adopt maladaptive avoidance behaviors, leading to unnecessary functional disability and heightened anxiety. The central tenet here is that the patient's definition of the problem--their set of **angina beliefs**--determines the coping solution they select, regardless of whether that solution aligns with clinical recommendations.

Crucially, the CSM posits that illness representations are structured around five core dimensions: Identity, Timeline, Cause, Consequences, and Cure/Control. When applied to angina, these dimensions allow researchers and clinicians to systematically map the patient's internal model. A coherent and accurate set of beliefs generally facilitates effective self-management, whereas fragmented, inaccurate, or catastrophic beliefs tend to lead to maladaptive coping strategies, such as denial, avoidance, or excessive reliance on others. Therefore, the assessment and potential modification of **angina beliefs** have become a central focus in cardiac psychology and rehabilitation, recognizing that cognitive restructuring is often as vital to long-term prognosis as pharmacological intervention. The psychological burden associated with angina, including fear of recurrence and the constant uncertainty regarding physical capacity, is often more closely tied to the patient's beliefs about the condition than to the objective severity of the coronary artery disease.

itself.

The Cognitive Dimensions of Illness Representation

The first three dimensions of the CSM--Identity, Timeline, and Cause--provide the basic structure through which the patient recognizes and classifies their anginal episodes. **Identity** refers to the signs and symptoms the patient associates with the illness. For angina patients, the identity dimension typically includes chest pain, shortness of breath, and radiating discomfort, but it also encompasses non-specific symptoms like fatigue or anxiety. A critical aspect here is symptom misattribution; patients may fail to identify atypical symptoms (such as jaw pain or nausea) as anginal, leading to delayed treatment seeking, or they may incorrectly attribute benign symptoms (like muscular soreness) to their heart condition, resulting in unnecessary health anxiety and over-monitoring. The clarity and consistency of the patient's perceived symptom profile are strong predictors of their ability to distinguish between a routine episode and an emergency, profoundly influencing the speed and appropriateness of their response.

The **Timeline** dimension relates to the patient's perception of the duration and course of the illness. Angina is fundamentally a chronic condition, but patients often hold varied beliefs about its trajectory. Some perceive it as acute, believing that medication or a procedure (like angioplasty) will result in a complete cure, leading to disappointment and non-adherence if symptoms persist. Others view it as cyclical, characterized by periods of exacerbation and remission, which can foster a sense of learned helplessness during flare-ups. A particularly challenging timeline belief is the perception of unpredictability; if patients believe anginal episodes strike randomly, without identifiable triggers, they may experience higher levels of general anxiety and restrict their activities indiscriminately, fearing that any exertion could provoke a fatal attack. Accurate understanding of the chronic, manageable nature of angina is essential for long-term psychological adjustment and sustained engagement in cardiac rehabilitation programs.

Finally, the **Cause** dimension addresses the patient's attribution of etiology. While medical professionals emphasize biological factors (atherosclerosis, risk factors like hypertension or high cholesterol), patients often rely on psychosocial explanations. Common lay beliefs include attributing the onset of angina primarily to acute stress, sudden shock, or historical overwork. While stress can certainly trigger anginal episodes, overemphasis on psychological causes may lead patients to neglect biological risk factor management, such as dietary changes or smoking cessation, believing that merely managing stress will resolve the underlying pathology. Furthermore, some patients may internalize a sense of personal blame, viewing their angina as punishment for past unhealthy behaviors, which can contribute significantly to feelings of guilt, shame, and depression, thereby complicating the emotional landscape of the illness experience.

Perceived Consequences and Emotional Impact

The **Consequences** dimension of angina beliefs captures the patient's subjective assessment of the impact of the illness on their life. This dimension is often the most emotionally charged and the strongest predictor of psychological distress. Consequences extend far beyond physical limitations, encompassing perceived impacts on career, financial stability, social roles, and independence. Patients who hold highly catastrophic beliefs about the consequences of angina--for instance, believing that any chest pain guarantees an imminent heart attack or immediate death--are likely to experience severe health-related anxiety and panic attacks, often leading to hypervigilance and unnecessary emergency department visits. The perceived severity of consequences drives behavioral responses; if the perceived consequences are devastating, the patient may adopt extreme safety behaviors, such as complete cessation of physical activity, which paradoxically leads to deconditioning and increased functional impairment, reinforcing the very belief that the heart is fragile and failing.

The emotional response associated with angina beliefs is complex and multifaceted. The constant threat of pain and the underlying fear of a fatal cardiac event create a state of chronic uncertainty. Patients often struggle with intense feelings of vulnerability and loss of control over their bodies. If the patient perceives the consequences as highly disruptive and uncontrollable, they are more likely to develop clinically significant levels of depression and anxiety. This emotional distress is not merely a side effect of the physical illness; it is intrinsically linked to the cognitive representation. For example, the belief that angina prevents one from fulfilling spousal or parental duties (a high perceived social consequence) can directly fuel feelings of inadequacy and sadness, leading to withdrawal from social engagement and further deterioration of quality of life.

Research consistently demonstrates that negative perceived consequences are robustly associated with poorer health outcomes, even controlling for objective disease severity. Patients who minimize the long-term consequences, perhaps through denial, may fail to adhere to essential preventive measures, increasing their risk profile. Conversely, patients who catastrophize the consequences may become emotionally overwhelmed, leading to exhaustion of coping resources. Effective clinical management requires addressing these emotional consequences by challenging the underlying cognitive distortions. Helping patients reframe the consequences from absolute disability to manageable limitation is a key therapeutic goal, allowing them to shift their focus from what they have lost to what they can still achieve within the parameters of their condition.

Controllability, Curability, and Self-Efficacy

The final two dimensions, **Controllability** and **Curability**, relate to the patient's perceived efficacy in managing the condition and achieving recovery. Curability addresses the belief in whether the illness can be permanently cured or resolved. For a chronic condition like angina, the objective

reality is typically management rather than cure. However, patients often harbor a strong desire for a permanent fix. If a patient believes angina is curable, they may become frustrated when symptoms persist after initial treatment (e.g., stent placement), leading to a perception of treatment failure and subsequent non-adherence. A more adaptive belief involves accepting that while the underlying disease may not be cured, the symptoms and progression are highly manageable through sustained effort and collaboration with clinicians.

Controllability is arguably the most critical dimension for promoting active self-management. This dimension differentiates between treatment control (the extent to which medical intervention can control the symptoms and disease progression) and personal control (the extent to which the patient believes their own actions--such as diet, exercise, and stress management--can influence the illness). Strong beliefs in personal control are linked to higher levels of self-efficacy and are predictive of engagement in health-promoting behaviors. For instance, a patient who believes they can control the frequency of their anginal episodes through mindful pacing and adherence to their rehabilitation exercise plan is far more likely to maintain physical activity than one who feels entirely passive, relying solely on medication.

The concept of **self-efficacy** is deeply intertwined with controllability beliefs. Self-efficacy refers specifically to the patient's confidence in their ability to execute the behaviors required to manage their condition successfully, particularly during challenging situations, such as managing stress or knowing when to take nitroglycerin during an attack. Low self-efficacy concerning symptom management is a major barrier to functional recovery. Patients with low confidence may avoid physical exertion out of fear, even if medically cleared, thereby perpetuating a cycle of deconditioning and increased symptom sensitivity. Therefore, interventions must focus heavily on bolstering self-efficacy, often through mastery experiences (guided, successful performance of previously feared activities) and verbal persuasion from trusted healthcare providers, reinforcing the patient's agency in managing their chronic illness.

The Role of Angina Beliefs in Health Behavior and Adherence

Angina beliefs serve as powerful cognitive drivers influencing a vast spectrum of health behaviors, ranging from daily compliance with medication to crucial emergency response actions. Adherence to prescribed pharmacological treatments is significantly mediated by beliefs about the necessity and effectiveness of those medications. If a patient perceives their angina as acute and curable, they may stop taking preventative medications once symptoms subside, believing the treatment is no longer necessary. Conversely, if they view the consequences as severe and the treatment as the only effective control mechanism, adherence rates tend to be higher, though this may sometimes tip into over-reliance, neglecting the importance of lifestyle changes. The perceived balance between the costs (side effects, inconvenience) and the benefits (symptom relief, longevity) of treatment is calculated based on the patient's internal illness model.

Beyond pharmacological adherence, beliefs critically influence engagement in demanding lifestyle changes, such as adopting a Mediterranean diet, quitting smoking, and maintaining regular physical activity. A patient must first believe that these actions are causally linked to their cardiac health (Cause dimension) and that they possess the ability to execute these changes (Controllability/Self-Efficacy). For instance, if a patient attributes their angina solely to unchangeable genetic factors, they may rationalize that dietary modifications are futile. Furthermore, exercise behavior in angina patients is particularly sensitive to symptom identity and consequence beliefs. If exercise triggers pain, and the patient believes that pain signals irreversible heart damage, they will inevitably withdraw from rehabilitation, regardless of external medical advice emphasizing the safety and necessity of supervised physical training.

Perhaps the most critical health behavior influenced by angina beliefs is the response during an acute anginal episode, especially the decision to seek emergency care. Patients holding beliefs that minimize the severity or attribute pain to non-cardiac causes (e.g., indigestion) are often prone to significant delays in seeking help for acute coronary syndromes, dramatically increasing mortality risk. Conversely, patients with extreme anxiety and catastrophic consequence beliefs may present frequently to the emergency department for non-serious symptom fluctuations, leading to "somatic preoccupation" and increased healthcare costs. Optimal behavior involves a nuanced understanding of symptom triggers, the appropriate use of nitroglycerin, and the timely recognition of symptoms requiring urgent medical attention--all skills dependent on a balanced, accurate, and non-catastrophic set of **angina beliefs** regarding identity and consequences.

Maladaptive Beliefs and Psychological Distress

Maladaptive angina beliefs are cognitive patterns that impede effective coping and often exacerbate psychological distress, leading to poorer quality of life. One prominent maladaptive pattern is **catastrophizing**, which involves the tendency to magnify the threat of anginal symptoms and outcomes, interpreting every chest twinge as a sign of impending death or severe disability. Catastrophizing significantly amplifies pain perception and increases the frequency and intensity of anxiety and panic related to health. This cognitive distortion creates a negative feedback loop: the fear of pain causes muscle tension and hyperventilation, which themselves mimic cardiac symptoms, reinforcing the catastrophic belief and leading to further anxiety and avoidance behaviors. Addressing catastrophizing through cognitive restructuring is a cornerstone of psychological intervention in cardiac rehabilitation.

Another maladaptive belief pattern involves **illness ambiguity**, where the patient lacks a clear, coherent representation of their illness. This often occurs when medical communication is inconsistent or when symptoms are atypical and difficult to pinpoint. Ambiguity breeds uncertainty, which is highly stressful and often leads to chronic rumination and worry. Patients who feel uncertain about the cause or timeline of their angina struggle to formulate effective coping plans,

resulting in inconsistent health behaviors and emotional volatility. The perceived lack of control resulting from ambiguity can be profoundly debilitating, fostering feelings of helplessness and increasing the risk of developing clinical depression.

Furthermore, beliefs centered around excessive self-blame regarding the cause of angina can be highly detrimental. Patients who believe their illness is solely the result of moral failure or irresponsibility (e.g., "I brought this on myself") often experience intense guilt, which can interfere with the motivation necessary for recovery. While acknowledging the role of risk factors is important for behavioral change, an overly punitive causal attribution can undermine self-compassion and resilience. Overcoming these maladaptive patterns requires targeted psychological interventions that validate the patient's experience while gently challenging the accuracy and utility of their current cognitive models, transitioning the patient towards a more realistic, manageable, and self-compassionate view of their chronic condition.

Measurement and Assessment of Angina Beliefs

The assessment of angina beliefs is primarily conducted using standardized self-report questionnaires rooted in the Common Sense Model. The most widely utilized instrument globally is the **Illness Perception Questionnaire (IPQ)** and its revised form, the **IPQ-R**. The IPQ-R systematically measures the five core dimensions of illness representation (Identity, Timeline, Cause, Consequences, Control/Cure) alongside two additional scales: Illness Coherence (the degree to which the patient understands their condition) and Emotional Representations (the emotional response generated by the illness). These quantitative tools allow clinicians and researchers to generate a profile of the patient's subjective illness model, identifying specific areas of maladaptive belief that require therapeutic attention.

While quantitative measures like the IPQ-R provide reliable scores for comparison, qualitative assessment methods, such as semi-structured interviews, are often employed to gain richer, context-specific insight into the patient's narrative concerning their angina. Qualitative assessment can reveal unique causal attributions (e.g., linking the angina onset to a specific traumatic event) or uncover subtle beliefs about the perceived social stigma associated with heart disease, information that might not be captured by structured scales. Integrating both quantitative and qualitative data provides a comprehensive picture of the patient's cognitive and emotional landscape, enabling highly individualized care planning.

Accurate assessment is crucial because the profile of angina beliefs often dictates the choice of intervention. For instance, a patient scoring high on the Consequences scale and low on the Control scale requires an intervention focused on reducing catastrophic thinking and enhancing self-efficacy. In contrast, a patient scoring low on the Coherence scale requires intensive psychoeducation and clarification regarding the nature of their chronic disease. Systematic

measurement ensures that interventions are precisely targeted to the specific cognitive barriers preventing optimal psychological and behavioral adjustment.

Clinical Interventions Targeting Cognitive Restructuring

Clinical interventions aimed at improving outcomes in angina patients frequently incorporate strategies designed to modify maladaptive illness beliefs, primarily through psychoeducation and Cognitive Behavioral Therapy (CBT). Psychoeducation forms the foundational step, focusing on improving **Illness Coherence**. This involves providing clear, consistent, and jargon-free information about the diagnosis, pathophysiology, typical timeline, and effective management strategies for angina. Effective psychoeducation directly challenges inaccurate beliefs regarding Identity (clarifying which symptoms are truly dangerous) and Timeline (emphasizing the chronic, manageable nature versus an acute, curable state).

Cognitive Behavioral Therapy (CBT) techniques are employed to directly address negative emotional representations and catastrophic beliefs about Consequences. CBT helps patients identify and challenge automatic negative thoughts related to their angina (e.g., "This pain means I am dying"). The therapist guides the patient to evaluate the evidence supporting and contradicting these beliefs, substituting catastrophic interpretations with more realistic and functional appraisals. This process is crucial for reducing health anxiety, improving mood, and breaking the cycle of fear-avoidance behavior that leads to functional decline.

Furthermore, enhancing **Controllability** and **Self-Efficacy** is achieved through behavioral experiments and graded exposure. Patients who fear physical activity due to the belief that exertion is dangerous are gradually exposed to monitored physical challenges, allowing them to experience mastery and gather evidence that their heart is strong enough to tolerate activity. Successful completion of these tasks provides irrefutable evidence that their personal actions can positively influence their condition, directly modifying the belief that the illness is uncontrollable. By systematically restructuring the patient's internal representation of angina, these psychological interventions significantly enhance adherence, reduce distress, and promote long-term engagement in cardiac self-management.