INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

**Bell & Howell Information and Learning
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
800-521-0600**

UMI[®]

Université d'Ottawa • University of Ottawa

**The Recovery Mosaic:
Older Women's Lived Experiences
after a Myocardial Infarction**

by

Evelyn Elizabeth Kerr

Thesis submitted to the School of Graduate Studies and Research
In partial fulfillment of the requirements for the
degree of Master of Science in Nursing

University of Ottawa

March, 1999

© Evelyn Elizabeth Kerr, 1999

**National Library
of Canada**

**Acquisitions and
Bibliographic Services**

**395 Wellington Street
Ottawa ON K1A 0N4
Canada**

**Bibliothèque nationale
du Canada**

**Acquisitions et
services bibliographiques**

**395, rue Wellington
Ottawa ON K1A 0N4
Canada**

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-45229-8

Abstract

Although mortality rates from heart disease and stroke have generally declined over the past decade (Statistics Canada, 1997) they continue to be the number one cause of death for women in Canada and the United States (American Heart Association, 1992; Heart and Stroke Foundation of Canada, 1997). Research has started to focus on women and heart disease, however, there is a paucity of work that identifies the unique needs of women over 65 years of age. The purpose of this study, therefore, was to explore the experiences of recovery in women 65 years of age and older in the first two weeks following a myocardial infarction. The qualitative methods of Heideggerian phenomenology and feminist approaches were used to gain a better understanding of personal reflections of recovery. In depth, semi-structured, audio-taped interviews were conducted with a purposive sample of 7 women. Data analysis revealed that recovery was highly contextual, multivariate and consisted of an active process resembling a mosaic, in which the women described how they "created a new picture for themselves". The data clustered into four substantive themes which included: Life is Scattered; Trying to Make Sense of It; Learning to Live With It and Getting Settled. These themes were compared and contrasted with the broader literature to confirm findings and to highlight existing gaps in therapy and treatment. Specific interventions and strategies have been proposed to address the unique physical, emotional and learning needs of these older women.

Acknowledgments

As this path to discovery draws to a close I wish to acknowledge those people who helped to support and sustain me along the way. This day has always seemed so nebulous; surely, too untenable a feat. Yet the end has arrived at last, a joyous day of celebration, a day to give thanks.

First and foremost, I thank my husband Gord and our children James and Alanna for their love and patience. Thank-you for understanding what this wondrous adventure in learning has meant to me. You are very precious to me and I am truly blessed.

Thank -you Mom and Dad for teaching by example that with hard work and determination, anything can be accomplished. Thanks too for knowing just the right thing to say when I needed it most. To my friends and fellow part-time classmates, Dianne, Cynthia and Lynn, thanks for the shared laughs and the listening ears; what a joy to have learned from you and to have shared with you.

I also wish to extend my gratitude for the enduring support and guidance given to me by my thesis supervisor, Dr. Frances Fothergill-Bourbonnais. I feel privileged to have shared this experience with you. Thank-you to the other members of my committee; Dr. Meryn Stuart, for helping me to seek the truth and to Linda duRocher, for your practical wisdom and added insight.

I am especially grateful for the financial support provided by the Nursing Bursary Committee and the Nursing Research Committee at the Ottawa Civic Hospital.

I also wish to express my appreciation to the extraordinary women who opened their homes and without hesitation, shared their stories with me. I am indeed, honored to have met you.

Lastly to Aunt Mamie, whose star now shines brightly in the heavens, thank you for believing in me. I can almost hear you whisper, " Way to go girl, I knew you could do it"!

TABLE OF CONTENTS

<u>ABSTRACT</u>	i
<u>ACKNOWLEDGMENTS</u>	ii
<u>LIST OF TABLES & FIGURES</u>	v
<u>CHAPTER 1 - INTRODUCTION</u>	1
<u>"WAKE-UP"</u>	1
1.1 <u>BACKGROUND TO THE STUDY</u>	2
1.2 <u>RESEARCH OBJECTIVES</u>	5
1.3 <u>PURPOSE OF THE STUDY</u>	5
1.4 <u>DEFINITION OF TERMS</u>	6
<u>CHAPTER 2 - REVIEW OF THE LITERATURE</u>	7
2.1 <u>INTRODUCTION</u>	7
2.2 <u>LITERATURE REVIEW</u>	8
2.2.1 <i>A Demographic Profile of Older Women</i>	8
2.2.2 <i>Mortality and Morbidity Issues For Older Women With Coronary Heart Disease</i>	10
2.2.3 <i>Gender Differences</i>	11
2.2.4 <i>Gender Bias</i>	14
2.2.5 <i>Psychosocial & Functional Profile Of Women With Cardiac Disease</i>	14
2.3 <u>SUMMARY</u>	17
2.4 <u>ASSUMPTIONS</u>	20
<u>CHAPTER 3 - METHODOLOGY</u>	21
3.1 <u>RESEARCH DESIGN</u>	21
3.2 <u>METHODOLOGICAL ASSUMPTIONS</u>	25
3.3 <u>SAMPLE</u>	25
3.4 <u>SETTING</u>	26
3.5 <u>ELIGIBILITY CRITERIA</u>	30
3.6 <u>ETHICS AND HUMAN RIGHTS</u>	31
3.7 <u>METHOD</u>	31
3.8 <u>THE INTERVIEW PROCESS</u>	33
3.9 <u>DATA COLLECTION PROCEDURE</u>	37
3.9.1 <i>Pilot Study</i>	37
3.9.2 <i>Main Study</i>	38
3.9.3 <i>Characteristics of the Participants</i>	40
3.10 <u>DATA ANALYSIS</u>	45
3.11 <u>ENHANCING METHODOLOGICAL RIGOR</u>	49
<u>CHAPTER 4 - THE PARTICIPANTS' ACCOUNTS- FINDINGS AND DISCUSSION</u>	53
4.1 <u>INTRODUCTION</u>	53
4.2 <u>THE MOSAIC OF RECOVERY- THE SCHEMATA</u>	54
4.3 <u>THE MOSAIC OF RECOVERY</u>	57
4.3.1 <i>Life is Scattered</i>	57

4.3.1.1 Shock and Surprise.....	57
4.3.1.2 Feeling Restricted.....	60
4.3.1.3 Loss of person-hood.....	64
4.3.2 <i>Trying to Make Sense of Their Lives</i>	73
4.3.2.1 Reliving the MI Experience	74
4.3.2.2 Living with Changes In Body Responses.....	77
4.3.2.3 Making Comparisons	81
4.3.3 <i>Learning to Live With It</i>	83
4.3.3.1 Playing By The Rules.....	83
4.3.3.2 Cheating	86
4.3.3.3 Taking Care of Themselves.....	88
4.3.3.4 Receipt of Supportive Measures	93
4.3.4 <i>Getting Settled</i>	102
4.3.4.1 Seeking the Physician's Validation.....	102
4.3.4.2 Beginning to Feel Better	104
4.3.4.3 Moving Forward.....	105
4.5 <u>CONCLUSIONS</u>	108
CHAPTER 5 - <u>CONCLUSIONS</u>	116
5.1 <u>SUMMARY</u>	116
5.2. <u>IMPLICATIONS AND RECOMMENDATIONS</u>	118
5.2.1 <i>Health Promotion and Primary Prevention</i>	118
5.2.2 <i>Discharge Planning</i>	121
5.2.3 <i>Educational Needs of Older Woman</i>	124
5.2.4 <i>Transitional Support</i>	126
5.3 <u>ROLE OF THE ADVANCED PRACTICE NURSE</u>	128
5.4 <u>STUDY LIMITATIONS</u>	134
5.5 <u>ENDING</u>	135
<u>REFERENCE LIST</u>	138
<u>APPENDIX A:CONCEPTUAL MODEL OF HERMENEUTIC CIRCLE FOR DATA ANALYSIS</u>	156
<u>APPENDIX B: PATIENT INFORMATION LETTER AND INFORMED CONSENT</u> ...	157
<u>APPENDIX C: SAMPLE INTERVIEW SCHEDULE</u>	160
<u>APPENDIX D - DEMOGRAPHIC INFORMATION</u>	161
<u>APPENDIX E: CONTACT SUMMARY SHEET</u>	162
<u>APPENDIX F: LETTER TO AGENCY</u>	164
<u>APPENDIX G: THE MOSAIC OF RECOVERY - THE SCHEMATA</u>	165

List of Tables & Figures

Table 1 – Description of Informants	44
Table 2– Theme Clusters	47
Table 3 - Thematic Categories and Supporting Themes.....	48

CHAPTER 1 - Introduction

"Wake-up"

*The pain is intense
I'm locked in it's grip*

*It shows no mercy -
doesn't let-up*

*What is happening to me
Will I get help in time*

- or is it too late?

*Have I done with my life
What I was meant to ?*

*Please Lord, let me live
- there's more I want to do*

*-hospital lights
mercifully, come into view.*

*Never felt so afraid.
So weak and so helpless*

*As angels of mercy
Buzz 'round and 'round me*

*Like a newborn.
My life's in the hands of others*

*A humbling experience-
if ever there was one...*

Reprinted with permission. Dianne W. Oost: "I Couldn't Have Had a Heart Attack !: A Personal Journey, A True Story of Healing". ©1999

1.1 **Background to the Study**

Colazzi (1978) believes the first question the phenomenological researcher should ask is not where to begin or how to proceed, but why the researcher is involved in the phenomenon. This study came about as a result of my experiences and personal observations acquired through some 21 years of nursing clients with cardiac problems. I have worked in adult cardiac critical care units and more recently as an educator of nurses on three cardiology and post-operative cardiac surgery units. These various settings have provided me the opportunity to identify what I perceive as potential "gaps" in our health care delivery with certain client populations, notably women, and particularly older women.

Over the last ten years I have noted a rise in the numbers of women being admitted with the diagnosis of an acute myocardial infarction. These women have typically been older, appeared frail as a result of one or more co-morbid illnesses, lived alone or with an elderly spouse, had few family visiting and frequently were on fixed incomes. I have observed with interest the planning for their eventual discharge to the community and have often wondered what transpired for these women while at home. I have asked myself the following questions: How do these women cope with their recovery with apparently few supports in place? Were the necessary resources provided to facilitate a recovery without incident? Were plans effective to meet their needs? Indeed, were their needs really understood?

In addition, experiential data revealed gendered variables in the discharge process. For instance, male clients who have sustained an acute myocardial infarction were often younger and most had spouses to provide much necessary support on discharge. Women on the other hand, being older and often living alone or having the burden of trying to recover while caring for an aging spouse, had a different set of challenges with which to contend. In addition, with recent health care cutbacks, few supports or reduced hours of support were available.

Furthermore, the researcher's Master's related clinical experiences in the home setting of elderly women post coronary ischemic event revealed shared concerns regarding housework, grocery shopping, laundry, and transportation needs to and from appointments.

Searching for literature to support these experiential data, brought to light Johnson's (1991) work on the process of adjustment post myocardial infarction and acted as the impetus for this current research. Her work clearly identified that men and women recovered in similar and yet very different ways. The following excerpt from her work illustrates a few of these exceptions.

Both the men and women in this study had difficulty accepting the patient role; however, the reasons for this difficulty were different for the male and female informants. Many of the female informants said they preferred to give rather than receive care: " I like to do things for other people, but I've never really wanted to be waited on". The female informants in the study tended to see themselves as caregivers and not as care receivers. Many of the women attempted to protect their mothering roles. They felt particularly uncomfortable when their children attempted to provide

comfort. In order to maintain their mothering roles, the women demonstrated care and concern for their family members by minimizing their own conditions.....Many of the female informants said they spent a great deal of their time in the hospital worrying about how their husbands and children would handle their illness.....The majority of male informants enjoyed the attention of family members while hospitalized: " I liked the attention. It made me feel loved. I mean, it's the clearest signal I've had in our 16 years of marriage that she really loves me". Rather than discourage the attention of family members, most of the male informants, encouraged it. The major aspect of the patient role that the male informants disliked was the threat to their bread-winning role (p42).

The intense differences in terms of recovery for both men and women led this researcher to discover whether this description was isolated or a predominant theme in the literature. Further examination of the literature pointed to additional gender based discrepancies with regard to emotional and physical aspects of recovery. However, few studies had explored the needs of older women with cardiac disease, in particular, recovery from a first time myocardial infarction. It therefore seemed timely to systematically conduct research to identify older women's self described concerns in order to plan specific interventions and strategies based on their perceived needs.

1.2 Research Objectives

1. To understand the experiences of recovery for elderly women post MI within the first two weeks after discharge from hospital.
2. To describe how women perceive their recovery from an emotional and physical perspective.
3. To describe how elderly women's perceptions of recovery affect their health seeking behaviors.
4. To delineate how elderly women's perceptions of recovery affect their participation in health promotion programs.

1.3 Purpose of the Study

The purpose of this research was to explore the experiences of recovery, in the first two weeks following a first time myocardial infarction (MI), in women 65 years of age and older.

1.4 Definition of Terms

Recovery- Recovery is defined by Wilson-Barnett (1981) as a group of complex physical and socio-psychological conditions that influence how individuals respond to major illness or disease. This process is influenced by such factors as financial situation, presence or absence of complications, understanding by the client of the care they have received, patient's emotional stability, previous illness/ surgical experiences, support systems, previous health status and repeat hospitalizations. The ultimate goal of recovery after a cardiac event is to assist the individual to reach an optimal level of psychological and physical functioning and the prevention of disease progression (Fleury & Cameron-Go, 1997).

Myocardial Infarction (MI)- is defined as the death or necrosis of heart muscle resulting from severe, prolonged ischemia, often due to the disruption of blood flow from one or more of the coronary arteries to specific areas of the left ventricle, namely anterior, anteroseptal, lateral and posteroinferior wall. MI's are further designated according to the depth of tissue necrosis, with subendocardial (Non-Q-wave) being necrosis limited to the inner half of the ventricular wall and transmural (Q-wave), when the necrosis exists across the full thickness of the ventricular wall (Buja, & McAllister, 1995).

CHAPTER 2 - Review of the Literature

2.1 Introduction

Although mortality rates from heart disease and stroke have generally declined over the past decade (Statistics Canada, 1997) they continue to be the number one cause of death for women in Canada and the United States (American Heart Association, 1992; Heart & Stroke Foundation of Canada, 1997). Eaker, Packard, and Thom (1989) estimate approximately 500,000 women, compared to 450,000 men, die of cardiovascular disease each year in the United States. In Canada, the incidence of death for women due to cardiovascular disease is no less startling, at a rate of 39,023 per year (Heart & Stroke Foundation of Canada, 1997).

As well, Wenger (1994) reports that 60% of patients being hospitalized in the United States for acute myocardial infarction (MI) are older than 65 years. Similar trends are seen in Canada, as coronary heart disease is the leading cause of death and hospitalization for persons older than 65 years (Stokes & Lindsay, 1996). Moreover, of the 9557 deaths in women annually from acute MI, 90% of these are 65 years of age or older (Statistics Canada, 1997).

The review of the literature has been formulated to encompass the many factors that impact the lives of elder women. Having a perspective of the profile of older women, including context, demographic information and the prevalence and association of heart disease, highlights gaps in the literature and provides focus to the research topic. As well, adhering to

the tenets of qualitative research, only a selective review was done prior to data collection in order to formulate questions for the study.

2.2 Literature Review

2.2.1 A Demographic Profile of Older Women

The age demographics of the North American population are shifting. The Canadian Study of Health and Aging Working Group (1994) estimates that the proportion of the Canadian population 65 years and older is expected to rise to 14.5% in 2011 and to 21.8% by 2031. Rosenberg and Moore (1997) report that by 2011, 16% of women in Canada will be over 65 and of these more than 32% will be over 80 years of age. Furthermore, according to a study of 759 randomly sampled seniors performed by Murphy and Hepworth (1996), increased age leads to increased use of acute care services, hospital admissions, inpatient physician visits and emergency room visits.

Specific gender and age related demographics from a Statistics Canada document titled, A Portrait of Seniors in Canada (1995), demonstrate that women make up 58% of the population over 65 years, and 70% of the population over 85 years. Fifty three percent (53%) of seniors over 65 live alone, and indeed, 53% of women older than 85 years live alone in a private household. Senior women over 65 years can also anticipate living longer than men by four years, and of these years only one will be disability free. A majority of seniors (62%) living at home seek aid in household work and personal

chores from their family members, with spouses being the number one choice. Senior women however, who are often single or widowed, seek assistance from their children, often a daughter (40%), or friends, neighbors or volunteer groups.

Rosenberg and Moore (1997) extracted data from the National Population Health Survey (NPHS) (Statistics Canada, 1995), which provides additional demographic information on the health status of senior women in Canada. They investigated 3 sets of measures: 1) the ability to carry out activities of daily living (ADL's), such as reading the newspaper, climbing stairs, walking a specific distance) and instrumental activities of daily living (IADL's), such as meal preparation, shopping, housework; 2) the presence of chronic medical conditions; and 3) the self perceptions of seniors as to their overall health status. The findings were categorized into two age ranges, 65-74 and 75 years and older.

They found that limitations in health and functional abilities increased with age. Older women reported their ability to perform ADL's and IADL's was limited due to vision and mobility problems. More women over 75 required help with shopping and heavy housework compared to those in the 65-74 age range, and compared to men 75 and older. Arthritis, or rheumatism, high blood pressure and back problems were the most frequent self-reported chronic illnesses in women 65-74 years. Heart disease and cataracts were the next most common illnesses, with all these diseases increasing in prevalence in the over 75 age group. The frequency of health visits by senior women to

their family physician was increased due to chronic conditions such as diabetes, heart disease, cancer, high blood pressure, bronchitis or emphysema. Surprisingly, although many senior women had chronic illnesses, they rated their health status overall as generally good to excellent. Furthermore, fifty per cent of women surveyed who were over 75 years, accepted that certain disabilities and health limitations resulted from the aging process.

Other research highlights that unattached women over 65 are more likely to live in a low income situation (Statistics Canada, 1995). In addition, women over 75 years are more likely to live alone on a low income, be disabled from chronic health problems and require assistance with ADL's and IADL's (Rosenberg, Moore & McGuinness, 1997).

These findings emphasize how senior women, particularly those with low income or those older than 75, have great potential to impact the use of health care resources.

2.2.2 Mortality and Morbidity Issues For Older Women With Coronary Heart Disease

Much research has been conducted with respect to the mortality and morbidity trajectory for women with cardiovascular disease. Bickell et al., (1992), in an historical cohort study from 1964-1984, of 1088 females and 4707 males, concluded that women with cardiovascular disease are older, have more functional limitations and present with a more aggressive symptom course compared to men. Ayanian and Epstein, (1991), citing the Framingham study, suggest that once women have suffered an acute

MI they are at increased risk of re-infarction and death as a result of advanced age and severity of the coronary heart disease. A more recent cohort study (Becker et al., 1994) with data gained from the TIMI-II trial (Thrombolysis in Myocardial Infarction Phase II), confirmed these findings. Women were often older and had associated incidence of previous congestive heart failure, systemic hypertension, and diabetes mellitus.

Other factors impact the mortality risk for women. Case, Moss, Case, McDermott and Eberly (1992) performed a longitudinal cohort study with 1234 men and women between the ages of 25-75. They identified that women who lived alone had a greater potential for recurrent cardiac event and death. In a similar study design, Berkman, Leo-Summers and Horowitz (1992) found that women who had experienced low emotional support prior to their MI, had higher mortality rates within 6 months of their MI.

2.2.3 Gender Differences

Gender differences exist for women with respect to the anatomy, physiology, symptom presentation and coronary risk factors in relation to coronary heart disease (CHD). Women's hearts are smaller, lighter and have smaller coronary vasculature (Romeo, 1995) compared with men. Physiologically, the female heart has higher stroke volumes, ejection fractions, resting heart rates, as well as lower blood volumes, oxygen carrying capacity and left ventricular end -diastolic volumes (Flavell, 1994). Women's abnormal responses to exercise testing appear to be related to lower hematocrit levels, higher systemic and

pulmonary pressure responses and higher circulating estrogen levels (Wingate, 1997).

In addition, the manifestation of CHD for women often differs from that of men. Women frequently first present with symptoms of angina while men may experience an acute MI (Lerner & Kannel, 1986). Douglas and Ginsberg (1996) report that women often exhibit symptoms of atypical pain due to less common forms of ischemia such as vasospastic and microvascular angina. They noted that women experience more nausea and vomiting, neck and shoulder pain, fatigue or dyspnea, and those women with chronic stable angina frequently experienced pain while at rest, or asleep or following times of mental stress. In addition, more silent myocardial ischemia occurs in women than men (Wenger, Speroff & Packard, 1993).

There are gender differences in coronary risk factors. For example, females are typically 5 to 10 years older than men before the onset of symptoms of CHD. The loss of supposed protective qualities of estrogen on women's lipid profile makes them more vulnerable to heart disease post menopause. Bush (1991), as cited by MacPherson (1992), raised concerns relating to interpretation of lipid results for women versus men. Bush commented that the level of cholesterol at which women are at risk is 265 mg/dL versus 235mg/dL for men. Women are at even greater jeopardy if they have low levels of high density lipoproteins (HDL's) in relation to their total cholesterol levels.

Co-morbid illnesses, such as diabetes and hypertension, impact women differently than men. Research shows that diabetes is a powerful predictor of CHD. For example, diabetic females have a three to seven times greater likelihood of mortality from CHD than non-diabetic females, while diabetic males have two to four times the mortality risk from CHD than non-diabetic males (Manson, Colditz & Stampfer, 1991). In addition, Rich-Edwards, Manson, Hennekens & Buring (1996), cite results of the Systolic Hypertension in Elderly Program which found elderly women's treatment of hypertension, through pharmacological management, led to a beneficial 36% reduction in the incidence of stroke and a 25% reduction in CHD. Modifiable risk factors such as smoking, obesity and sedentary life styles also impact the incidence of CHD in women. The occurrence of CHD in women who smoked more than 20 cigarettes per day is 2 to 4 times that of non smokers (Fried & Becker, 1993). Obesity and waist-to-hip ratios of higher than 0.8 are positively correlated to CHD. Middle aged females with body mass indexes (BMI) of greater than 29 are found to have a three times higher risk of CHD than lean women (Rich-Edwards et al., 1996). Lastly, exercising may have long term benefits for women. Blair et al. (1989), in an eight year prospective study of 3120 healthy women, found associations between physical fitness and a reduction in cardiovascular mortality.

2.2.4 Gender Bias

The relationship between gender and the quality of medical treatment is an area of concern for women. This group has consistently been underrepresented in clinical trials and undertreated in comparison to males (Beery, 1995; Douglas & Ginsburg, 1996; Healy, 1991; Wenger, 1990, 1992; Wenger et al., 1993). Current medical therapies for women are based on data obtained from trials with predominately male subjects. For example, a meta-analysis of the literature from 1960-1991 which reviewed drug trials for treatment of acute MI, found that fewer than 20% of the randomized subjects could be identified as women (Gurwitz, Col & Avorn, 1992)

Earlier studies indicated women, especially elderly women, received less medical interventions such as coronary angiogram (Ayanian & Epstein, 1991; Steingart et al., 1991) and fewer coronary bypass surgery referrals (Kahn et al., 1990). In a recent study, McLaughlin et al. (1996), reviewed the adherence to national guidelines for drug treatment for suspected acute MI, and noted that women and the elderly were consistently undertreated with thrombolytic agents, Beta blockers and Aspirin.

2.2.5 Psychosocial & Functional Profile Of Women With Cardiac Disease

A variety of studies have addressed several psychosocial and functional aspects of recovery from a MI. MacKenzie (1993), studied 19 women with ischemic heart disease, 13 of whom were 4-6 weeks post-MI, and discovered that women felt a loss of control, had a reduced level of positive affect and carried on in their

previous roles as homemaker even when their stamina was reduced. Young and Kahana (1993), performed a longitudinal study at 6 weeks and one year post MI, to explore the health and care giving support of older men and women post MI. They found that women had more functional disability, were less likely to be referred to rehabilitation programs, received less help in meal preparation and laundry and reported more symptoms than men. Riegel and Gocka (1995), in a descriptive correlational study looking at psychosocial adjustment, return to work and functional class, found that at one and 4 months post MI, women wanted more social support, particularly emotional support and received it most often from their spouses. Primary support for widowed women was received from their daughters. Unfortunately, socioeconomic status, income, and marital status, identified elsewhere in the literature (Greenwood, Packham, Muir & Madeley, 1995) as important gendered variables, were not comparable between the matched pairs in this study.

Johnson and Morse (1990) reported that individuals who perceived they did not have enough support to meet their needs felt "isolated and abandoned" and found that women tended to "bend the rules" and engaged in activities which were prohibited in order to feel less dependent upon others (p.131). Women did not like to feel "indebted" to others. This finding is similar to that of Boogaard (1984) who discovered that women "resisted being helped by others" and felt guilt in not performing housework (p. 438). She also noted that women did not enter structured rehabilitation programs. This latter fact was

similarly discovered by Hamilton & Seidman (1993). They reported that 50% of the women they studied did not receive cardiac rehabilitation nor was it discussed with them by their physicians.

Hawthorne (1994) examined both men's and women's perception of the cardiac surgical experience using a qualitative ethnographic approach. She discovered that women communicated differently with their male physicians, in that they "consistently displayed passivity and deference" (p.79). In addition, women received less counseling due to an inability to communicate with their male physicians (Hawthorne, 1994).

The quality of the marriage and the support of family were also considered important factors by women. Primomo, Yates and Woods (1990), interviewed 3 groups of women with chronic illness in a descriptive correlational study design discovered that the greater the reported marital quality the lower the reported illness and depression. Beach et al.(1992) in a longitudinal descriptive study with repeated measures at three weeks, three months and six months post MI found that the spouse's marital satisfaction was significantly related to the patient's recovery at three weeks post discharge. Young and Kahana (1993) noted that older married women were more likely to die post MI, the reason cited being minimal caregiving assistance by the spouse. They speculated that the spouse's advanced age, ill health and lack of socialization to the role of caregiver may have resulted in diminished levels of after care for older women on discharge.

2.3 Summary

This review of the literature demonstrates that the proportion of older women in the general population is growing and will continue to grow. Elderly women live longer than men, are more frequently single or widowed and therefore more likely to live alone, usually in their own homes. Cardiovascular morbidity and mortality issues predominate for women post menopause. Women's mortality trajectory post MI is significant, with women being sicker and having higher mortality rates than men and often having associated co-morbid illnesses. In addition, women are not provided available medical treatment offered to their male counterparts.

Recovery post MI differs in women and men. Women tend to resume household activities early in the recovery period, do not attend rehabilitation programs, find it difficult to communicate effectively with male physicians, experience feelings of guilt, and report more symptoms and reduced functional capacity.

Gaps in the literature demonstrate that few studies performed on women have attempted to stratify data according to age specific needs (Conn, Taylor & Abele, 1993; Friedman, 1993; Rankin, 1988; Sharpe, Clark & Janz, 1991). It is difficult to identify the needs of older women due to a paucity of research on subjects over 65 years of age (Gilliss et al., 1993; Gulinik, 1991; Gurwartz et al., 1992). For example, little is known about the physical and emotional experiences of women over 65 years of age who are recovering from a myocardial infarction while

managing multiple household responsibilities. In addition, little evidence exists regarding the usefulness of current community programs offered by organizations like the Heart and Stroke Foundation for this specific client group. Other comparative studies have disproportionate numbers of men to women in their sample, making data interpretation for the needs of women cumbersome (Artinian & Duggan, 1995; Bennett, 1992, 1993; Gillis, et al., 1993). As well, few studies in the nursing literature differentiate the needs of the MI client, as this diagnoses is grouped with other subjects with CHD (MacKenzie, 1993; Nyamathi, Jacoby, Constancia & Ruvevich, 1992; Sharpe et al., 1991).

It is also significant that several authors (Bramwell, 1986; Gilliss et al. 1993; Jacobson, 1986; MacKenzie, 1993) suggest that the first two weeks of recovery are difficult, yet little research has been performed to discern the needs identified by clients, in particular elderly women, during this time period. Finally, many studies (Beach et al., 1992; Hilbert, 1993; Jacobsen, Lowrey & McCauley, 1992; Markle-Reid, 1989) have been quantitative in design and have tended to focus on singular responses such as family satisfaction, coping, and support. Thus these studies lack insight into the context, process, values and beliefs of elderly individuals experiencing a life-threatening event (Fleury, Kimbrell & Kruszewski, 1995; Morse & Field, 1995a). Only a few qualitative studies exist which specifically address the needs of women post myocardial infarction. Johnson and Morse (1990) employed grounded theory methodology to examine

the recovery period of women post-MI. However, the needs of elderly clients were not differentiated.

This study will explore older women's experiences with recovery from a first time MI. It will investigate their emotional and physical responses within the first two weeks from discharge. Additionally, the context of their home environment will be considered in relation to these women's perceptions of their recovery experience. Increased understanding of the unique experiences of recovery in elderly women, will assist health care providers to design and implement strategies and interventions which reflect the age and gender based needs of these clients.

2.4 Assumptions

Assumptions derived from the literature review and experience of the researcher must now be delineated so as not to bias interpretation of the meaning of recovery gained from an analysis of the lived experiences of older women.

The following list outlines the assumptions held to be true for the purposes of the proposed study:

1. Gender bias has existed for women in relation to inclusion in cardiovascular research studies.
2. The profile of women who present with myocardial infarctions differs from that of men.
3. Women recover in different ways from men, yet interventions to date are based upon a health care system that has focused on interventions related to men.
4. Women do not tend to attend cardiac rehabilitation programs.
5. Older women are more likely to live alone, have more chronic illness and functional limitations.

CHAPTER 3 - Methodology

3.1 Research Design

There are many qualitative research methods that inductively explore human interaction within a naturalistic environment that ultimately shape a person's values and beliefs (Lincoln & Guba, 1985). However, the methodological approaches and purposes of each differ (Morse & Field, 1995a). Phenomenology, specifically Heideggerian phenomenology, is founded on the principles of existential philosophy (Benner, 1994; Heidegger, 1992; Jasper, 1994) and attempts to derive greater understanding of a particular lived experience as it is "interested in the origin of knowledge embedded in our everyday activities" (Walters, 1995b, p.793). It is an inductive, descriptive research method (Omery, 1983) whose purpose is not to generate nor create theory (Leonard, 1994; Omery, 1983; Sorrell & Redmond, 1995), but rather to simply understand and draw from the participant "a vivid picture of the lived experience, complete with the richness of detail and context that shape the experience" (Sorrell & Redmond, 1995). Gullickson (1993) adds that meaning is drawn from the transaction of the participant in their world situation which leads to new discoveries in what may have previously been unrecognized.

In addition, Heideggerian phenomenological method acknowledges that the researcher arrives at the field of study with certain prescribed norms and values that can not be distanced from the area of interest (Koch, 1995; Walters, 1995b).

This prior knowledge and experience is viewed as a strength and this combination of old and new knowledge and experiences allows for greater insight and understanding into the phenomenon under study.

Therefore phenomenological methodology was deemed a suitable approach to generate the deepest and richest meaning of the experience of recovery from an acute MI for older women through the exploration of their subjective experiences within the context of their home environment and their personal reality.

It is also important to recognize that feminist researchers support the use of qualitative methodology such as phenomenology to explore the essence of women's issues and concerns (DeVault, 1990). Indeed, such authors as Gilligan (1982) have explored women's interpretation of their psychological growth and advocate for qualitative research methodology for women's studies. The underlying premise for using qualitative methods with women is to gain knowledge of "the language that they use and the connections they make [to] reveal the world they see and in which they act" (p.2). In addition, feminist research methods attempt to legitimize a scientific line of enquiry in women's research which is descriptive, qualitative, equality driven, subjective, value-laden and woman centered (Campbell & Bunting, 1991). In fact, feminist research methods are grounded in phenomenology, reciprocity (Anderson, 1991) and reflexivity (Hedin & Duffy, 1991) and lead to the valuing of women's lived experiences. Feminist method assumes inter-subjectivity between the researcher and participant as they co-participate in the creation of data.

Olesen (1994) states, "in a certain sense, participants are always 'doing' research, for they, along with the researchers, construct the meanings that become the data for later interpretation by the researcher" (p.166). Other philosophical tenets of feminist method are the non-exploitation of women as research "subjects" and the empowerment of women by affording them the opportunity to share or voice their concerns. Importantly, outcomes from feminist research seek to improve the state of women in society (MacPherson,1983).

The methodological approach to this investigation consists of three basic steps as outlined by Boyd (1993). These steps are founded on the tradition of hermeneutic analysis which is inherent to Heideggerian phenomenological investigation (Benner, 1994; Koch, 1995, Leonard, 1994; Walters,1995b). Koch (1995) comments that other streams of phenomenology, such as Husserlian, advocate "bracketing" of preconceived notions or biases as an essential first step. Heideggerian hermeneutic methods, on the other hand, accepts that the researcher has pre-understanding of the phenomena and it "is not something we can eliminate, or bracket, it is already with us in the world" (Koch,p.831). Pre-understanding is termed fore-structure by Heidegger, and consists of three essential components. First, fore-having, or that understanding which is taken for granted; second, fore-sight or a point of view or a lens through which we orient our interpretation of the phenomenon; and third, fore-conception, which is the preliminary sense or intuition of what questions need to be asked and what that potential answer is (Leonard,

1994, Appendix A). To this end, the first step in this research process was to acknowledge the researcher's fore-structure. Chapter 1 outlined the researcher's knowledge and experience that had potential to influence the interpretation of the phenomena under study. Additionally, the review of the literature in Chapter 2 outlined the gaps in the literature that guided the formulation of objectives addressed in this study. The review of the literature as interpreted by the researcher also defined certain assumptions (as identified in Chapter 2) acknowledged as aspects of the phenomenon and were understood to be true.

The second step, data collection, involved gathering detailed descriptions from older women about their experiences with recovery from a MI, through in-depth interviews, observational notes and journal reflections. The third step consisted of three interrelated interactive processes of hermeneutic analysis to identify: common themes; exemplars which captured the meaning of the participant's situation; and paradigm cases which provided the description necessary to derive greater understanding of a participant's actions and interpretations within their own context (Boyd, 1993). Lastly, the research findings that evolved from the interpretive processes were obtained from a description of the phenomenon of recovery by the informants and were recounted in terms of meaning for them.

3.2 Methodological Assumptions

The choice of phenomenological method was conceived from the assumptions that:

- (1) the process of recovery has meaning for older women;
- (2) women informants are articulate and able to describe their experience;
- (3) older women who have sustained a first time MI would be willing to share their experiences with the researcher;
- (4) both the informant and the researcher are co-participants in this research process (Gullickson, 1993); and
- (5) new meaning or greater understanding of recovery for older women may be discovered.

3.3 Sample

A purposeful sample of participants were chosen who were willing to talk about their recovery experiences as gauged by the ease of conversation with the researcher while in hospital. Those who offered different perspectives based upon the context of their recovery were also selected to participate. For instance, women who were single or widowed, those living with elderly spouses, and those with co-morbid illnesses were sampled to gain knowledge of their recovery.

Adequacy of the sample was reviewed through the ongoing data analysis process. In other words, the "relevance, completeness,

and amount of information obtained" (Morse, 1989, p. 135) as these are used in Heideggerian phenomenological methods to determine an appropriate and adequate sample. This resulted in the richest description of the phenomenon of interest (Annels, 1996; Koch, 1995; Morse & Field, 1995a; Walters, 1995b).

Sandelowski (1986) points out that sample size is difficult to predict as "it is dependent on the nature of the data collected and where those data take the investigator" (p.31). However, Morse (1994), has proposed the use of six participants in the study of phenomena.

This study had a sample of seven, including one participant from a pilot interview and six others. Redundancy of themes was noted by the sixth interview and by the seventh interview, data saturation was determined and therefore adequate sampling procedures were considered complete (Morse & Field, 1995a).

3.4 Setting

Heideggerian phenomenology "recognizes the human-world interrelationship as a unified phenomenon" or in effect, how the context, including environment, shapes how an individual views their world (Walters, 1995a). As such, this section will provide an accurate description of the two settings which had the potential to influence the participant's perceptions of their life experiences after an acute MI. Two settings were required to conduct this research study, one for recruitment and the other for interviews that took place in the participant's homes.

Hospital- Participants were recruited from two cardiology units

located in a large metropolitan teaching hospital. This hospital was selected as it is an acute tertiary care referral center for interventional and non-interventional treatment of cardiac illness, overseeing approximately 6,400 procedures per year. The following description of the hospital setting was obtained from a short interview with the two nurse managers of the units from which participants were enrolled.

These units serve clients from a variety of different cultural and socioeconomic backgrounds with a multitude of cardiovascular medical problems. Medical services offered included such procedures as angiograms, electrophysiological studies (EP studies), pre-percutaneous transluminal angioplasty (PTCA) procedures, treatment for unstable angina, congestive heart failure, arrhythmias, pre-heart transplant and pacemaker implantation. Admissions to the units for the diagnosis of acute MI numbered 20 on a monthly basis. The medical treatment for clients who had sustained a MI was consistent, as both units were covered by identical staff physicians and residents. A Cardiology Resident was available 24 hours a day. The average length of stay for clients who had sustained an acute MI was 7-10 days.

Combined bed capacity for both units totaled 57 with a total staff of 80 fulltime, part-time and casual status R.N.s who worked predominately 12 hour shifts. Each unit had a central nursing station wherein a 16 channel telemetry monitoring system was housed. The rooms were mostly private and semi-private in layout with only one 4 bedded general ward room.

Although two different nursing managers administered the units, the underlying nursing philosophies for both units were similar. The goals of nursing care for the newly diagnosed client with acute MI were described as follows: to assist the client to understand their new diagnosis; to allow them control and the ability to make decisions regarding their future life style; to teach prevention strategies; and to ensure supportive measures were available to these clients at the time of discharge.

Patient education was a predominant theme in the discussions with both nurse managers. MI classes were conducted on a bi-weekly and in a needs based manner in either group settings or individually with a nurse. The Nursing Care Coordinator (NCC), who had approximately 30 years of cardiovascular experience, conducted the classes that were approximately one to one-and-a-half hours in length and semi-structured in format. The class consisted of a slide show of educational content that included causes of atherosclerosis, diet, exercise, medications and emotional well being. Class content was supplemented by a discharge education booklet which allowed clients to make notes. Time was allotted for questions and answers from clients. The MI discharge booklet gave detailed descriptions of activity and exercise restrictions, including energy expenditure, rest requirements, medication and diet information, resumption of sexual activity and psychological needs during the recovery time period. In addition, the NCC addressed individual concerns of the class participants as the need arose. R.N.'s on the units were

expected to supplement and reinforce with the clients any content areas or concerns they might raise.

Allied health professionals affiliated with the unit consisted of: one social worker, whose role was to assist nursing staff with clients and their families when practical, emotional, adjustment and discharge issues were a concern. In addition, a dietitian and physiotherapist were consulted as required.

Home- Home settings were the site for interviews of the 7 participants. Data from the field notes, transcripts of the interviews and personal reflections following each interview, supplemented the following descriptions of the participant's home environments. The settings included two bungalows, one two storied duplex, and four apartments. Of these apartments, one was a rented condominium in a socially affluent neighborhood, 2 were located in senior citizen's rent-to-income buildings and one was located in a high rise building. Five of the participants lived within the region of Ottawa Carleton. One lived in Hull, Quebec and another in a rural setting within a 30 minute drive of Ottawa. Three of the participants, since discharge from hospital, appeared to live principally in three rooms of their homes, the living room, the bedroom and the kitchen. Three of the participants had set up "sick beds" in one room of the house, usually the living room.

Two of the participants suffered from mobility limitations (one required a motorized wheelchair and the other a walker) and had Home Care provided to them due to their limitations of illness, specifically, diabetes and arthritis. They both spoke

of using ParaTranspo as a means of transportation. The remaining informants used public transit or private cars.

All participants' homes were found to be extremely tidy, although several of the participants shared that they were uncomfortable with the "messiness" of their homes.

3.5 Eligibility Criteria

The sample included women who had sustained a MI within the previous two to three day time period. The criteria for participant inclusion in this research study were as follows:

1. to have sustained a first time myocardial infarction.
2. to be able to converse comfortably in English.
3. to be 65 years of age or older.
4. to live within a 20 mile radius of the Ottawa Carleton region.

The first criterion was established to ensure that a previous history of a MI would not confound these women's current reflections on their experience. The second criterion was necessary for the researcher to detect nuances in the language that might not be discovered, as this researcher is not bilingual. The age range was chosen as few previous studies had delineated age specific needs of women with MI.

3.6 Ethics and Human Rights

Permission was sought to conduct this study from the University of Ottawa Faculty of Health Sciences Human Research Ethics Committee and the appropriate research committees from the target hospital. Prior to inclusion of any one of the participants into this study, the purpose of the study was reviewed and a written informed consent was obtained (Appendix B). The written consent served as verification that the participant had been instructed about the nature of the project, understood what was involved, the purposes of the study and any possible risks. The taped interviews were numbered and the participants given pseudonyms to ensure anonymity and confidentiality. They knew that quotes might be used if findings were published.

3.7 Method

Interviews were conducted in the participants homes to ensure a naturalistic environment which has been found conducive for study participants and the gathering of meaningful data (Lincoln & Guba, 1985; Morse & Field, 1995a; Weiss, 1994). The interviews were unstructured, interactive and guided by general questions (Appendix C). The questions were grounded from those issues derived from the literature review and the researcher's experience as requiring further study and more in-depth exploration. These questions were broad and open in nature in order to "gain in the coherence, depth, and density of the material each respondent provides" (Weiss, 1994, p.2). The

participants were given time to reflect on each of the questions and had the opportunity to express in their own words those thoughts which were of significance to them. For the most part, the informants guided the interview, which is in keeping with the phenomenological interview as it seeks to describe the world as experienced by the participants with the assumption that they will describe what is meaningful and of importance in their lives (Kvale, 1996). In doing so, all participants were asked the same general question to begin the interview but thereafter, each interview was guided by those topics raised by the informants. Probes were used by the researcher during the course of the interview to elicit more information about certain items or concepts under discussion (Polit & Hungler, 1995).

Each of the informants participated in one, face-to-face, in-depth interview. The average length of the interview was 104 minutes but ranged from 63 to 115 minutes. The participants were asked to share with the researcher what it had been like both emotionally and physically in their first two weeks at home. It was through this process of sharing that the nature of their experiences post discharge became better understood to the researcher. Sorrell and Redmond (1995) comment,

" Thus phenomenological interviews are not 'conducted' but rather are 'participated in' by both the interviewer and the respondent. Both may experience a 'healing' or catharsis from the storytelling, as they are empowered through awareness of new meanings in lived experiences" (p.1120).

The interview tool was piloted and the opening question was reworded to reflect a more empathetic communication style

considered more conducive to eliciting descriptive responses (Kvale, 1996). For example the new question read, " I would like to learn from you about your experience since you have been home from the hospital. How you have felt emotionally and physically and any challenges you may have experienced. I want you to be my teacher, so that I might learn from you." (See below for detailed description of the interview process which outlines the feminist application of method).

In addition, demographic information was obtained from each participant prior to the start of the interview (Appendix D). The interviews were audio-taped and transcribed verbatim. Field notes and summary contact sheets (Appendix E) were completed immediately following the interviews. Journal notes were also written by the researcher following each interview and throughout the research process. The journal notes differed from field notes in that they included the researcher's personal reflections and were used to substantiate specific choices made throughout the research process in relation to analysis and method (Koch, 1994). Follow-up interviews were conducted with selected participants once analysis was complete.

3.8 The Interview Process

There is a belief among qualitative researchers that the interview process is tantamount to the acquisition of valuable data (Kvale, 1996; Weiss, 1994). Therefore aspects of the interview process will first be presented in order to highlight the feminist method used by the researcher to facilitate the

participants in sharing their unique experiences. The following description also represents the degree of introspection and analysis given by the researcher to the text of the narratives that subsequently furthered the depth of the interpretation.

All participants welcomed the researcher into their respective homes and seemed slightly ill at ease at the start of the interview. They became more relaxed however, as the researcher initially inquired about their state of well being and then reiterated the purpose of the interview. Each woman appeared willing to share her story of recovery with the emphasis being that the researcher would learn from their valued personal experiences. It was hoped that at the outset of the interviews, the participants would realize that their words and experiences mattered to the researcher and that by using the researcher as a conduit, their experience might be of significance to other women. "Feminist research starts from the lived experiences of women and does not deny or denigrate the personal, but seeks to validate the private, emotional, and interior worlds of individuals" (Hedin & Duffy, 1991, p.228).

In keeping with feminist methodology, the researcher viewed these women as participants, not as subjects. Thus, a shared reciprocal relationship was developed between the researcher and the participant and this relationship was instrumental in capturing the essence of the participant's lived experiences (Anderson, 1991). It was noted that as the interviews proceeded, two of the women both verbally and visibly expressed worry that they were not providing anything noteworthy from their lives.

They seemed clearly relieved when the researcher reassured them that what they were sharing was of great importance to the researcher and a contribution to other women.

The interviews flowed readily and at times the informants asked questions of the researcher regarding their dietary and exercise routines or raised concerns pertaining to their ongoing progress in comparison to others. This form of enquiry, referred to as "asking back", is advocated by feminist researchers as it promotes research as a shared experience between participant and the researcher (Kirby & McKenna, 1989). As the researcher relayed information to the participants or provided reassurance to them, they again visibly appeared more relaxed and at ease.

With regard to feminist approach, the researcher maintained vigilance on the issue of appropriation of the participant's voices as described by Opie (1992). Thus participants were empowered and the meaningfulness of their own words was heightened. For example, throughout the interviews, periods of hesitation, short and long pauses and the use of the words, "you know" were noted prior to the informants relaying information of importance. The latter were noted when the informants paused to mentally recapture memories or were taking time to choose words to describe scenarios which had occurred and had been meaningful to them. Devault (1990) highlights the importance of phrases such as "you know" in that they appear "to signal a request for understanding" seen often in dialogue between women (p.103).

Tone and volume of their voices often lowered as the participants expressed private personal thoughts about themselves

or their families. In contrast, tone and volume of their voices increased in those participants who expressed the greatest degree of frustration with activity and dietary restrictions. For example there were tones of a command as they described what they shouldn't or couldn't do according to the teaching handout given to them upon discharge. Increased emphasis was noted when they described the degree of tiredness they had felt or how their mood had improved, in relation to being able to do more, both physically and socially. Voices were shaky and tremulous, when they appeared puzzled regarding their progress or had questions to ask of the researcher. Several of the women spoke affectionately of family members, in particular sons, daughters, granddaughters, brothers and sisters.

The retelling of the chest pain episode, which had resulted in their hospitalization, was very detailed and descriptive. In fact, several participants used body language such as a rocking motion or rubbing an area on the chest and back to emphasize the degree, location and nature of their pain.

Only one participant, Claire, became emotionally distressed and cried several times during the interview. The crying occurred when she recounted her experience in the hospital and the fact that there appeared to be several days when she had no recollection of what had occurred. Although she did not acknowledge to the researcher that she had been frightened that she had nearly died, she made several references throughout the interview that she was fortunate to be alive. Claire said,

" I don't know if it was just a heart attack, that one and I was lucky. I **was** lucky, (said with emphasis), you know."

In addition, Claire shared the fact that one of her son's had died at an early age from cancer and that the anniversary of his death had just recently passed. It became apparent to the researcher that this informant's personal experience with a life threatening illness precipitated an emotional reliving of her son's tragic death. The conversation continued, with frequent pauses. When the researcher offered to turn off the tape, she declined.

Lastly, the researcher made a conscious effort not to tire the participants and looked actively for symptoms of tiredness. In doing so the informants were not exploited as " objects of research or mere providers of data" (Hedin & Duffy, 1991,p.228). As a result, indicators such as yawning, coughing or shortness of breath, led eventually to the conclusion of the interview.

3.9 Data Collection Procedure

3.9.1 Pilot Study

A pilot study was conducted before the main project for two reasons: (1) to provide the novice researcher with more experience in the techniques of qualitative interviewing and (2) to test the interview guide and format. In phenomenological research, the ability of the researcher to elicit the greatest depth of discussion, determines validity (Morse & Field, 1995b).

The participant for the pilot was recruited from the same hospital setting where the main study was conducted. A letter of

introduction outlining the nature of this investigation was given in advance to the medical and nursing staff (Appendix F). Once eligibility requirements were met, the participant was approached and gave consent. The interview was subsequently held in the participant's home two weeks after the time of discharge. This interview lasted 63 minutes. The audio-taped interview was transcribed and checked for accuracy against the tape. Field notes and reflective journal notes were written immediately post interview. Within one week of the interview, the researcher's qualitative methodologists reviewed the transcripts and offered feedback on areas for improvement. These included: a change to the format of the opening question to provide a more empathetic approach by the researcher, one felt to be more conducive to qualitative methods; alternate choices of probes and enquiry to be used which reflected the pattern of thoughts as they emerged from the interview; strategies to differentiate therapeutic versus research interview techniques; and lastly, advice on establishing rapport with participants prior to the recruitment phase. The main study proceeded following this pilot study as the interview questions were found to be sound and had generated data which appeared to address several aspects of this pilot participant's experience with recovery from a MI.

3.9.2 Main Study

Six participants were recruited to the main study through the use of daily census reports which identified eligible participants. A total of ten women met the eligibility criteria and were approached by the researcher. However, two declined for

personal reasons and another's diagnosis was changed by the physician, making her ineligible. The researcher approached the participants on day three or four from their date of admission with a letter outlining the nature of the study (Appendix B). Only those persons deemed well enough to meet with the researcher, as determined by the participant's nurse, were approached by the researcher. In this initial meeting, the researcher outlined, in a general sense, the purpose of the study. Following this discussion, a copy of the informational letter/consent was left for the participant to read, with plans made for the researcher to return in a few hours to inquire regarding their willingness to participate. Six of the women readily agreed to participate in the study with most stating that they wished to contribute in some way to helping other women who might experience this condition. They reviewed and signed the written consent form (Appendix B).

These women were subsequently telephoned at home two weeks after the date of their discharge. Out of the six, only one of the participants met with the researcher within two weeks of the date of discharge. Two participants were scheduled three weeks post discharge, due to their stay at either a convalescent home or with family members. In these cases, the interviews were postponed by a week, as it was felt by the researcher that it would be better to interview the participants in their own home environment and thereby gain a more accurate view of their reality. One participant, who had sustained a very severe MI and had suffered several complicating circumstances while in

hospital, chose not to be interviewed until week four, citing ill health and fatigue. Lastly, two of the participants were readmitted to the hospital within 2 weeks of discharge and remained hospitalized for a further three to four days. They were subsequently interviewed in the fourth and fifth weeks from the time of their initial MI. The enrollment phase took from October 1997 to the end of March 1998, with the last interview conducted in April, 1998. This length of time was the result of bed closures for 3 months on one of the study units. In addition, the age of the women to be recruited was originally set at 70 years, and was subsequently changed through the Human Ethics Committee of the site hospital to 65 years due to difficulty experienced by the researcher in obtaining a sample.

Redundancy of themes was noted with the sixth participant. A seventh interview was conducted which confirmed this trend in the analysis. Data collection was terminated in April, 1998 following discussion with the members of the researcher's thesis committee.

3.9.3 Characteristics of the Participants

Just as the setting is of value to an understanding of the context of the lived experience of the participants, so too is a description of the participants. All participants were female and ranged in age from 67 to 86 years, with a mean age of 74 years. All were Caucasian and three spoke English as a second language. All had sustained a first time myocardial infarction (MI). The types of myocardial infarction found in the study participants included, subendocardial or Non-Q wave (2), Anterior- Lateral(1), Inferior Wall (3) and Inferior- Lateral(1). Romeo (1995), in

reference to the anatomy of the female heart, notes that the right coronary artery is often dominant in females and therefore when blockage occurs, increases the likelihood of Inferior wall MI.

Length of hospital stay ranged from 5 to 18 days with a median stay of 10 days. Two of the participants had concomitant illnesses of arthritis and diabetes and were subsequently re-hospitalized within one to two weeks of discharge. Their second hospitalization stay ranged from three to four days.

Each of the participants had been married at one time in their lives. Only one continued to live with her spouse. Two had divorced from their husbands 20 to 30 years previously. Four of the women had been married for many years and these same women had been widowed for 7 to 20 years. One of these, currently lived with a male partner.

Four of the participants described having worked outside their homes but not since being retired. Occupations reflected opportunities for women of this generation without secondary education and included secretarial work, medical records librarian, cloak check clerk and house cleaner for private homes. Only one of the informants had been working until her MI, for 3 hours per week in a local hospital's house keeping department.

Although income status was not discussed, each participant shared socioeconomic information with the researcher. Only one informant appeared to be affluent. She was the only participant to convalesce in a private retirement home. She also reported

having a maid come into her home every second week to do laundry and housekeeping duties.

Three other participants owned cars and lived in private dwellings including a home in a trailer park, a bungalow and a semi-detached duplex. Three women did not own cars, rented apartments in senior citizen's complexes, which may or may not have been subsidized, and spoke of being unable to afford private home care support.

The family structures of these participants were equally unique. Four women described having had children. Of these four, three spoke warmly of their offspring and described in detail how they had been supported in their first few weeks post-hospitalization. One participant convalesced with her son and daughter-in-law during the first two weeks post discharge. She also described the phone calls and outings she had taken with her other children. Another relayed how her son, daughter-in-law and granddaughter had helped her to settle into her apartment when she was initially released. Only one informant did not speak affectionately about her offspring but made references filled with warmth and humor about her granddaughter, while another one focused on her niece.

A summary of the demographic characteristics of the pilot and main study sample are outlined in Table 1. Of interest is the resemblance of these participants demographics with the national norms, in particular the proportion of women who were single or widowed (5), co-morbid illness (7) and who lived alone (5). Every participant had at least one concomitant medical diagnosis and

several had more than one. Co-morbid factors included diabetes, arthritis, hypertension, dysrhythmias, asthma, emphysema and hypothyroidism. A thorough analysis of the demographics can not be performed due to the small numbers in this sample. However, there were definite comparable trends in this sample with those nationally. Pseudonyms were provided for each of the participants.

Table 1 – Description of Informants

Names	Alice	Luisa	Claire	Ruth	Marie	Anne	Sophie
Age	70yrs	67 yrs	69 yrs	86 yrs	80 yrs	72 yrs	74 yrs
Language	Anglo-phone	Italian	Franco-phone	Anglo-phone	Franco-phone	Anglo-phone	Franco-phone
Length of hospital stay	10 days	5 days	10 days	11 days	7 days	6 days	18 days
Repeat hosp.	No	No	No	No	Yes, home 2 wks re-admitted 3 days	No	Yes, home 12 days, re-admitted 4 days
Type of MI	Inferior	Inferior	Inferior Lateral	Non Q wave	Inferior	Anterior Lateral	Non Q wave
Co-morbid factors	Hypertension High cholesterol	Asthma	Arthritis	Emphysema, Hypothyroid, mild mitral & aortic stenosis	Arthritis x 32 yrs	Atrial Fibrillation	Diabetes
Marital status	Divorced	Married	Widowed	Widowed	Widowed	Divorced	Widowed
Dwelling	Single home, in trailer park	Bungalow, Middle class locale	Duplex, Middle class locale	Luxury condominium	Senior's building	Senior's building	Senior's Building
Family members	No children 2 brothers & sister-in-law	Son, daughter-in-law, granddaughter, brother and sister	Son out of province, brother & sister	No children, sisters who live distance away, nieces & nephews	Son, daughter-in-law, granddaughter, sisters	5 children, 1 son very close, many grandchildren	1 brother, 1 sister, niece
Friends	Several in trailer park	Several	Male Partner	Several in locale	Several in social club	Several in social club in building	A few in building
Work	Retired clerk	House-cleaner, 3 hrs /wk	No mention	Former law secretary, home-maker	Retired hair-dresser	Retired house cleaner	Retired medical records librarian
Living Arrangement	Alone	Spouse	Male Partner	Alone	Alone	Alone	Alone

3.10 Data Analysis

Thematic data analysis was undertaken using the iterative processes of hermeneutics. The researcher chose this methodology as it is an inductive method used with Heideggerian phenomenology and has as its goal to derive increased understanding of the phenomenon of interest as experienced by the participants in the research. This inductive process assists the researcher to view the world from the "emic" perspective, that is, the view of the client's world as she sees it and describes it within her social and cultural context (Schutz, 1994). Consequently, it was anticipated that the researcher would develop increased understanding of the participants' beliefs regarding their life experiences through the exploration of their everyday practices (Plager, 1994).

In addition, as the participants were female, the researcher referred to feminist methodology to help guide and heighten her awareness of women's issues and concerns. The researcher found that hermeneutic and feminist methods blended naturally to assist both in the interview with the participants and through the analysis process to derive greater meaning from these women's spoken words.

As soon as possible following each interview, each tape was transcribed verbatim with inclusion of all pauses, exclamations, laughter and crying which were separated from the text by the use of brackets. It was felt that the inclusion of these nonlinguistic features would reduce misrepresentation and misinterpretation of the data when analyzed (Sandelowski, 1994).

Each tape was replayed to check for transcription accuracy. The data set consisted of 350 pages of typed text. As well, demographic information (Appendix C), field notes and contact summary sheets (Appendix D) were used to supplement the transcribed data. Morse & Field (1995a) comment that these observational data "assist in validating and interpreting information provided by the participants" (p.107).

The data were read and reread several times. A circular fashion of hermeneutic analysis was used whereby the researcher moved back and forth between an examination of the text of the transcripts as a whole, and then in an examination of them piece by piece (Leonard, 1994). In so doing, this process assisted the researcher to create a deeper and more authentic analysis of the data (Leonard, 1994; Koch, 1995) (Appendix A).

A manual method of color coding and file folders was used to manage and sort data (Morse & Field, 1995a). The interviews were transcribed with two-inch margins on both sides of the record to allow for coding, critique and comments by the researcher regarding the content. Each page of every interview transcript was number coded in the left-hand margin. Line by line the transcripts were analyzed for key words and phrases which were then coded using colored markers. Then relevant sections were cut and pasted onto a full sheet of paper and placed into a file folder that represented specific themes. Each interview transcript was analyzed in this manner which resulted in several sorted files. Those phrases or key words that did not recur or

appeared irrelevant were discarded. (See Table 2 for details regarding the initial themes).

Table 2– Theme Clusters

Themes	Key words or Phrases
Emotional Responses	Shock, anger, disbelief, "feeling useless", bored, "fed up"
Physical Responses	Fatigue, comparing symptoms, awaiting physician's approval, home care and perceived lack of support
Support Issues	Emotional, Tangible, Informational, Family and Friends, Information Seeking, Seeking Physician's Approval
Pain Experience	descriptions, who helped, when did they seek help
Life Adjustments	Recovery, Reflection on Recovery and how life has changed, meal preparation, "cut backs", "learning to live with it"
Playing by the rules	emotional responses of anger, being out of control, loss of independence, live with the restrictions and things will progress
Spirituality	Survivorship, lucky to be alive, getting on with life
Health seeking behaviors	frequency of seeing physician or other health team member

These files were again analyzed, and new "theme" file folders were developed that appeared to link the concepts together into relevant major thematic categories with supporting themes. (See Table 3)

Table 3 - Thematic Categories and Supporting Themes

Life is Scattered	Trying to make sense of the MI	Learning to Live with it	Pieces fall into place
<ul style="list-style-type: none"> • Shock and disbelief, nervous, shaky • Can't believe they survived • Relive pain experience • Life no longer in their control • Family hyper-vigilant • Loss of independence, makes them feel "nuts" • Have to live with lesser standard in house-keeping 	<ul style="list-style-type: none"> • Try to regain control • Comparison of present life to usual life before MI • recognize symptoms- e.g. more tired, falling asleep easily • validating symptoms through comparisons • trying to accept diagnosis in order to move onwards • living within restrictions • Questioning, "why me", mortality 	<ul style="list-style-type: none"> • Feel life is on hold • Making life style adjustments, e.g. diet, no smoking, new medications, activity levels • Plan how to conserve energy, through "cut backs", learn to do things more slowly • Play by the rules leads to progress, but sometimes difficult to live with restrictions, results in feeling useless and bored • Positive support from family and friends • Negative aspects of support 	<ul style="list-style-type: none"> • Measure progress by symptoms • Seek physician's approval to "get on with life" e.g. can they travel, drive car • Feel better emotionally as physical symptoms subside • Looking to the future • Socializing is important to resuming normal life patterns

All supporting themes for each category were further analyzed for redundancy and relatedness and were subsequently discarded or moved into a more appropriate category. From this final analysis a conceptual model of recovery was developed and will be discussed in Chapter 4.

In addition, specific episodes or incidents discussed by the participants were further analyzed to capture the "exemplars" or stories of significance. The rich descriptive data were examined to fully understand the participants' actions and feelings within the context of their situation (Leonard, 1994; Boyd, 1993).

3.11 Enhancing Methodological Rigor

Debate continues about the determinants of reliability and validity in qualitative research. However Sandleowski, (1986,1993) citing the seminal works of Lincoln & Guba (1981), describes four components to institute rigor in qualitative research. These four aspects include credibility (truth value), fittingness (applicability), auditability (consistency) and confirmability (neutrality) and these were used in this research study to determine trustworthiness of the data and the analysis.

Credibility was established via return visits to three participants. It must be noted that there is inconsistency in the interpretation of the phenomenological method with respect to the number of participants required for return visits (Gullickson, 1993; Nelms, 1996; Tanner, Benner, & Gordon, 1993).

However, seeking verification from the participants of the study is implicit to the validation process in qualitative research (Janesik, 1996). The researcher returned to three participants with the analysis of the findings to ask if the themes represented their experiences with recovery from a MI. The follow-up interviews were 90 minutes in length and took place in the participants' homes. The interviews were conducted on

average 8 months post initial interview and ranged from 6 to 11 months post discharge. Each participant was encouraged to confirm, negate or add her own perspective to the findings. All three participants confirmed that the themes represented a picture of their experiences with recovery. Each had specific themes with which they could more closely relate that were noted by the researcher when they nodded in agreement or verbalized agreement. One of the participants cried throughout the follow-up interview as the researcher shared the findings with her. Two sections of the findings had particular significance for her and she commented repeatedly that these were the true feelings she had experienced. Participants shared the following comments. One said, "Yes that makes sense to me. Overall it makes sense to me". Another commented, " Yes, it makes sense, that's the real thing, what you said, that passed". Lastly, one other stated, "It's as if you are in my body, knowing me".

According to Sandelowski (1986), " A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience immediately recognize it as their own" (p.30). In this regard, these findings were considered confirmed as all three participants agreed to the description of their recovery experience presented by the researcher.

Walters (1995b) also proposes providing the participants with "excerpts" from their narratives as a means of validation. Therefore, this researcher provided each participant with exemplars from their own narratives to validate the themes found

in the transcripts. Of interest to the researcher during the validation process was that on several occasions when the participants seemed to derive greater emotional or intuitive closeness to a particular theme, the participants would share the same story that the researcher had chosen to support the findings. Again validation was achieved.

Credibility was also maintained through a review of the themes and categories performed by a qualitative methodologist who compared, discussed and finally established consensus with the researcher. Lastly, a Master's prepared nurse familiar with qualitative methodology, independently reviewed two clean copies of the transcripts of two participants to determine whether any new themes could be found or whether there was concordance in the themes. No new themes were found, although new perspectives were gained from this reviewer's comments that added new dimensions to the richness of the interpretation. The acquisition of a new perspective, coincides with the plurality of interpretations which is one tenet of hermeneutic analysis, in that no one interpretation can be deemed correct (Leonard, 1994).

Fittingness was sustained through the use of theoretical sampling. In other words, women living in different contexts, (those who were single or widowed, divorced, living with spouses) were sought in the sampling procedures to validate the similarity of the themes found within the interview data. The participants subsequently validated these thematic findings.

Auditability, was extended through the use of a field journal as an audit tool. In addition, the use of tape recorded

interviews, verbatim transcription, supplemented by field notes and summary contact sheets were used to increase the truth value of the data.

Neutrality was achieved when auditability, truth value, and applicability were established" (Sandelowski, 1986,p.33). Freedom from bias was maintained by checking for thoroughness and representativeness of the data with a qualitative methodologist, through the validation of the themes with the research participants and by verification with the thesis committee of conclusions drawn from data (Sandelowski, 1986).

CHAPTER 4 - The Participants' Accounts- Findings and Discussion

4.1 Introduction

This chapter describes the essential elements of recovery from first time MI for elderly women two to five weeks after discharge. Recovery includes a period of convalescence defined as the phase of "illness when treatment ends or becomes predictable and the patient begins to reestablish patterns of daily living" (Hawthorne, 1994, p.76). The current research offers an in depth view of the complexity of the recovery pattern within this convalescent period.

These informants described a desire to return to a semblance of normality. For the majority of participants, normality implied regaining control of their household, having the ability to drive as well as socializing with family and friends. Each participant's account of the recovery experience was unique, highly contextual, and multivariate. In-depth comparative analysis of the transcripts unveiled a multidimensional and complex framework called a 'mosaic of recovery'. The inspiration for the image of a mosaic of recovery grew from one participant's comments. Alice said, "I find it's been like a jig saw puzzle and all the pieces are falling into place". The mosaic of recovery captures the essence of what these women experienced as they tried to regain a pattern to their lives, all the while recognizing that they would never again be the same. The journeys of these women were ones of creation, a formulation of newness.

Hence the term mosaic of recovery, which depicts how the pieces of their lives fused together during the process of recovery, thereby creating a new picture for themselves.

4.2 The Mosaic of Recovery- The Schemata

Textual analysis revealed that the data clustered into four broad themes, each with supporting themes (Appendix G). These themes equate to pieces or phases in recovery and are analogous to the creation of a mosaic. The following section will present this analogy.

Mosaic by definition means to build a picture or design by inlaying small bits of glass or stone (Webster, 1974). The process of building a mosaic entails four steps.

- 1) One gathers small pieces of debris, usually pieces of stone, clay or glass and throws the pieces onto a working surface. The pieces lie there in a scattered and often chaotic manner. Likewise, these women described a broad theme the researcher has titled, **Live is Scattered** as they related how their lives were totally disrupted with the diagnosis of a MI. Sub-themes which linked to the broad theme were i) shock and surprise, ii) feeling restricted, and iii) loss of person-hood.
- 2) Pieces are examined in order to make sense of them in relation to what one has in mind as an outline of what is to be created. Similarly these women described a theme referred to as **Trying to Make Sense of Their Lives** as they began to examine their current life situation in relation to what they considered their normal pattern of living. Sub-themes that

connected with the broad theme were i) reliving the MI experience, ii) living with changes in body responses, and iii) making comparisons.

- 3) The pieces are categorized according to color, texture, edges and the fittingness necessary to create the design. Thus, order and some degree of control over the chaos is achieved. These categories then serve as reference points or guidelines from which action can be taken and the true piecing together of the mosaic begins. In addition, these reference points provide markers upon which progress in building the mosaic can be gauged. At times in this third phase, the individual building the mosaic may become frustrated, as pieces do not always fit into place as the person thought they should. Time is again needed to reflect on the emerging design and this reflection can prolong the building process. One may have to go back a step and search for a missing piece. These women described similar patterns of thinking found in the broad theme titled **Learning to Live With It**. This theme captured the essence of life style adjustments expected by these women and their ensuing psycho-social and physical responses to these. Several sub-themes were linked to this broad theme including: i) playing by the rules, ii) cheating, iii) taking care of themselves, and iv) receipt of supportive measures.
- 4) In the last stage, the pieces begin to mesh together and the mosaic takes shape as a discernable picture or pattern, or indeed, is completed in total. In the same manner, these women described a broad theme titled, **Getting Settled**, as they began

to feel that they were again in control and had a structure or routine in their lives. Sub-themes that related to this broad theme include i) seeking the physician's validation, ii) beginning to feel better and iii) moving forward. It is important to note that the building of a new picture of their lives, for most of these women, did not occur sequentially but was a movement back and forth through these various stages as they reflected daily and measured their progress.

The process of recovery will be presented and supported by the use of the participants own words as a comprehensive depiction of their lived experiences following an acute MI.

4.3 The Mosaic of Recovery

4.3.1 Life is Scattered

These women revealed overwhelming feelings of chaos as they reflected on their first few weeks at home. All pieces of normalcy in their lives were scattered upon receipt of the news they had experienced a MI. The everyday routines of their lives such as preparing meals, shopping, doing laundry, cleaning their homes and spending time on recreational activities, were disrupted with their diagnosis. 'Life is Scattered' consisted of three sub-themes including: i) Shock and Surprise; ii) Feeling Restricted; and iii) Loss of Person-hood and each will be delineated in the following section.

4.3.1.1 Shock and Surprise

The diagnosis of an acute MI elicited the response of 'shock and surprise' and was a consistent theme among these women. They seemed incredulous that they could possibly have sustained an acute MI. They appeared to seek answers to the question, "Why me?" Most felt they had observed their diets and had lived healthy life styles. Therefore, they found their current situation unbelievable. In the following illustration, Sophie describes her feelings at the knowledge of having had a MI as being surreal, something unfathomable. Sophie commented,

Sophie: "I don't know. It t'was strange. It t'was, as if I was living something, very unusual. Cause I never **dreamed** (said with emphasis) that I would be the victim of a heart attack. I never had a very salty diet. I never had a fatty diet and I was watching my diet because I was a diabetic. So I was watching my diet and I was trying to keep to the health rules and I never **dreamed**, (said with emphasis) and I was **so surprised** (raises voice) and I was so surprised and [feeling] strange and trying to convince myself that it was there. That I had suffered a heart attack, you know."

Luisa also shared feelings of puzzlement as to the reasons for her MI, as she too, had attempted to live a healthy lifestyle. She attempted to rationalize how she had sustained an acute MI.

Luisa: "One thing I feel is that, I don't know how come. (referring to her MI) I watch lot's myself. Because I have my grandfather, have many years ago. So then I watch. Before I was watch the liver, what I eat, worry about something for the heart or something much gas, and I'll watch for that. And me I watch for the caffeine, and once and a while I'll take. So I don't know how come they came that [MI] for me."

Both women attempted to connect their diagnosis of MI to some causative factor. This form of reasoning is highlighted in the literature in relation to adjustment and coping. Jacobsen et al. (1992) conducted interviews with 42 post MI patients to discover links between causal thinking, coping and adjustment. They noted that although no significant association was found between these factors, those people who had not thought 'why me' had more positive affect 3 to 5 months following their MI and suggested that not thinking about the cause of the MI leads to better adjustment. Contrarily, a qualitative study conducted by Johnson and Morse (1990) with 14 patients post MI, found causal

thinking occurred in relation to a person's seeking an explanation for their heart attack so that they might develop a sense of direction as they adjusted to their MI. Given the conflicting nature of these two findings it is difficult to surmise the rationale for this questioning behavior among the study participants and requires further investigation, especially in relation to long term adjustment.

However, it is significant that all participants shared some story of surprise, most often disbelief, that they, a woman, could possibly have had a heart attack. Most of the participants appeared amazed to learn of the hereditary nature of the disease and had never made a connection between the heart attack and their family history. Johnson and Morse (1990) recounted similar findings and shared, "some of the female informants had trouble identifying the cause of their heart attacks, because they believed that the stressors that typically contribute to a heart attack are primarily experienced by men" (p.129). Dempsey, Dracup & Moser (1995) also noted that women delay seeking treatment for acute MI as they minimize their symptoms or deny the possibility of the symptoms being cardiac in nature. The present findings have significance, for although much advertising has been established over the past 5 years targeted at women and heart disease, older women continue to believe that heart disease is gendered male or lack understanding of certain causative factors.

4.3.1.2 Feeling Restricted

Feeling their lives were scattered so too, these women felt restricted as they began to realize that life would not continue as they knew it. Activity restrictions imposed by medical personnel or by their own physical symptoms, in particular fatigue, led these women to describe a variety of emotional responses. These included expressions which reflected frustration, loss of independence, powerlessness, feeling "like a kid" and indecision. Some participants spoke of the imposed restrictions in relation to their inability to drive their car for one month following an acute MI with a resulting perception of loss of independence. Ruth shared these feelings.

Ruth: "the **biggest** (raises voice) complaint I have about the whole damn thing [MI] is that I can't drive (laughs).....So I'm not supposed to go...until I can drive next week. Being dependent on people for groceries and things like that. I'm tired. No, other than that, I have, I don't as...I say it's not being able to get out and be independent, is the biggest complaint."

Likewise Varvaro (1991), when measuring role function adaptation in 83 women who had experienced a coronary event within the previous year, found that "dependence on others was reported as bothersome" (p.34).

Other participants felt frustrated at not being permitted to continue with their daily routines due to the restrictions, particularly activity related, imposed upon them by others as part of their medical management. The following example illustrates Alice's feeling of annoyance as she is made to feel like a "kid". She has in essence, lost a measure of control over her life.

Alice: "It makes me feel cross...(short pause). It makes me feel like a kid. I can't do this, I mustn't do that... I have to get somebody else to do it if I want it done."

In addition, Anne shared the following feelings as result of her friends restricting her participation in her social club. In turn, she felt bored, useless, and devalued as a person at not being able to contribute. Ultimately, her relationship with her peers altered as a result of her activity restrictions.

Anne: "Well, you see I've been President of a social club here, so I was organizing things like...every Friday we had soup and sandwiches. I'd help set the tables, put the chairs around, do a lot of lifting ... Wednesday nights it's Bingo. Like last night I went down, but they wouldn't let me do anything (sounds frustrated). They... I just handled the money and called back the numbers. But it was boring! (voice raised) You know to me, to sit.To me...I like be on the go all the time, organizing things... I like to be involved in certain things.

EK: And when you're not involved...How do you feel?

Anne: Like I say, useless. I'm bored."

Moser and Dracup (1995) mention the importance of control in psychosocial recovery. They found in a study of 176 patients, 6 months after a cardiac event, that a high perception of control resulted in significant differences in psychosocial recovery including less anxiety, depression and hostility. King and Jensen (1994) noted in a qualitative study post coronary bypass surgery, the theme of women trying to preserve the self. They found that women went through a process of being out of control (manifested by floundering for control or losing it to someone else) and in some instances choosing to relinquish control to someone else and eventually attaining/ regaining control. They found that older women in their study had less difficulty in relinquishing

control. In the present study, those individuals who had fewer symptoms, experienced the greatest difficulty with control. These women's perceptions of not being in control and feeling restricted by others explain why they felt bored, useless and "like a kid".

In addition, one participant expressed difficulty with her family's continued watchfulness which made her feel like an invalid. The following occurred while Anne was convalescing at her son's within two weeks post discharge.

Anne: "Like the first night I was **there** (said with emphasis) I had this dry cough and I coughed and coughed, and I turned around and there was the three of them at the door. My son, his wife, my youngest daughter and I said, " Hope you're not going to be there every time I move in the bed or cough, or if I get up." I said, " I'm not an invalid."

The literature supports the fact that individuals adjusting to an acute MI are often the recipients of unwanted attention with ensuing feelings of stress or lost independence. Dracup, Meleis, Baker and Edlefsen(1984), reporting on a study with family focused rehabilitation participants, noted that placing a spouse in a "watch dog" role can increase relationship stress. Similarly, Johnson and Morse (1990) discovered that "sometimes the overanxious helpers had to be "fought off" to regain independence" (p.131). Clark, Janz, Dodge and Garrity(1994) noted in a combination survey and focus group discussion with older women with heart disease, that families of older women with heart disease are " likely to recommend cutting down (or eliminating) physical activities, and to treat the women as invalids" (p. 205) .

Many of the informants felt restricted simply as a result of their own physical symptoms and general health that did not permit them to leave their homes. Sophie experienced many physical limitations within her first few weeks post discharge resulting in symptoms of shortness of breath and syncope. Her concomitant diabetes contributed to descriptions of weakness and fatigue. She was subsequently readmitted to hospital after only 3 days at home. She described feeling frustrated at her inability to leave her home.

Sophie: "And then, I felt myself **so restricted**, (said with emphasis) you know. Like, I haven't been out much since I came back at all I think. And so I, I thought it t'was so restraining (raises tone of voice), to be cooped in, how do you say, to be in the house, you know. Not being able to get dressed to go out, ah, I wanted to really. So that, I felt, that was restraining, really, frustrating."

Most of the participants shared narratives wherein they placed great value on their ability to leave their homes in order to shop and or socialize with friends. Women in this study led very active social lives with all women speaking of participation in some form of activity such as card groups, social clubs, playing golf, attending church and going shopping with family and friends. These demographics are consistent with Statistics Canada's (1995) survey on lifestyle demographics of seniors. They found that among seniors, women who lived alone spent the most time in active leisure pursuits, devoting approximately 1.8 hours per day. The report cited activities similar to those reported by women in the current study.

As with Sophie, all participants shared how their inability to socialize led not only to feeling restricted, but depressed and frustrated. These findings have significance for older women and their psychological adjustment post cardiac event as this loss of independence and social interaction may lead to social isolation, thus adding potential stress in their lives. Clark et al., (1994) likewise noted that social interactions and relationships between family members, particularly the spouse, adult children and physicians had a major influence on women's ability to manage post cardiac event. For participants in the present study, being able to leave their home was seen as a measure of returning to normal.

4.3.1.3 Loss of person-hood

Since these women's lives were scattered as a result of the MI, they described a theme referred to as loss of person-hood. They spoke of a sense of loss at their ability to perform domestic activities and to carry on with responsibilities within their home and with their families. Loss of person-hood is similar to aspects of role re-definition noted in the literature in relation to in women's recovery post cardiac event (Benson, Arthur & Rideout, 1997; Boogaard, 1984; Fleury et al., 1995; Johnson & Morse, 1990; King & Jensen, 1994; LaCharity, 1997; Sharpe et al., 1991; Varvaro, 1991).

Varvaro (1991) discovered that women post MI felt isolated and useless at being unable to complete daily chores and a loss of role in the family "was expressed strongly" by these women. They were also frustrated with chores being left undone or not

completed as they would have liked. Sharpe et al. (1991), in a study with 323 men and women, found that older women with heart disease had higher levels of stress related to household matters as measured with the Sickness Impact Profile. They postulated that the rationale for this higher score in elderly women could be attributed to not wishing to relinquish the role of homemaker. MacKenzie (1993,) confirmed these emotional responses as a result of role pattern changes in a study examining role patterns and emotional and physical responses. Using a mixed sample of women with acute MI and acute coronary syndrome 4 to 6 weeks post discharge from hospital, the results indicated that women experienced significant levels of low affect and loss of control (measured by the General Well-Being Schedule (GWBS)). MacKenzie (1993) states, " trends in the data suggest women highly valued homemaking and family roles, and did not relinquish these roles in the early discharge period" (p.14). Likewise LaCharity (1997), using a qualitative descriptive method to study 12 postmenopausal women with coronary artery disease, found that women's inability to perform care provider roles in the family caused feelings of stress. Additionally, women felt guilt due to an inability to complete household duties. Lastly, Benson et al. (1997) discovered similar responses among 14 women in a phenomenological study conducted within 6 months post MI. They noted that the most difficult adjustment for women post MI was related to role expectations. They state, " Our results suggest that women feel frustrated and diminished when they are unable to resume their prior roles; in fact, their descriptions reflect a partial sense

of helplessness about their abilities to relinquish these parts of their identities" (p.22). Similarly, King and Jensen(1994)found that women post cardiac surgery went through a process of self preservation linked to domestic role expectations, role performance and associations with others. They described how women's sense of self is imbedded in what they do and their relationships with others. In summary, these earlier studies in women found that role re-definition led to perceptions of loss of control and were often accompanied by feelings of frustration and uselessness.

Participants in the present study similarly described a pattern of losing control of their home situation and appeared to equate this loss of role functioning with their value as a person. They expressed feelings of diminishment when unable to perform these roles. The theme, loss of person-hood attempts to capture what these women described as a loss of self- worth, more akin to loss of self- esteem. They also shared feelings of loss of person-hood (self worth) resulting from their inability to perform their work routines.

It is significant to note that in the Statistics Canada General Society Survey (1994), of Canadian seniors surveyed, 86% of all men over the age of 65 compared to 46% of women in this age range considered themselves retirees. The largest share of women, (48%), reported that keeping a house was their main activity and they therefore did not consider themselves to be retired. These statistics are valuable as they allude to the fact that older women perceive housework as real and ongoing work

that must be completed. When women recover post MI, they return home and their work routines await them. Being asked to restrict what they do in their "job" causes role conflict and a sense of being less valued as a person. Wingate(1995) confirms this finding. She noted that returning to previous employment status in women post MI resulted in higher levels of self-esteem and a perception of better quality of life.

To further clarify these feelings shared by older women, examination of their social context is warranted. Women in this study were raised in an environment of patriarchy in the first few decades of the twentieth century. They lived through and were influenced by several major events, including an economic depression, World Wars and a Cold War. In addition, many political, economic and social forces helped to shape them. Government and the media played a role in the transformation of societal norms that in turn forged these women's personal expectations and in particular, what society expected of them with respect to marriage, work life and child care. For instance, few women with children worked outside the home as child rearing and household management were considered women's traditional roles and responsibilities. Indeed, most participants in this study talked of working outside the home solely prior to marriage, in stereotypical occupations of their generation including legal secretary, medical records librarian, house cleaner, and office clerk.

Societal pressure, in the form of media advertisements and magazine articles, daily extolled the virtues of staying at home.

As Prentice et al. (1996) point out, " it was domestic duties that were the central feature of the idealized woman's life. For the most part, the Canadian media stereotyped women in the post-war years as happy homemakers who were dedicated stay-at-home mothers" (p.383). As a result of these influences, most married women of this generation were socialized to look upon household duties and child rearing as their "raison d'être", their value and meaning in the world, their power base, their legitimate role. The homemaker role was taught to young women by their mothers or in home economic classes and included such key tasks as meal planning and preparation, purchasing groceries, cleaning the house, laundry and budgeting (Prentice et al.,1996). In fact, this role carried with it a certain degree of power and influence. As Ashley Montagu (as cited by Chafe, 1972) wrote in the Saturday Review,

"Being a good wife, a good mother, in short a good homemaker, is the most important of all occupations in the world...I put it down as an axiom that no woman with a husband and small children can hold a full-time job and be a good homemaker at one and the same time" (p.207).

Women's work is also significant to the context of these women and requires further exploration. Several authors have investigated women's work and have differentiated between the actual tasks involved versus the nebulous or co-ordinative aspects of the work (DeVault,1991; Hochschild,1989; Luxton,1986; Oakely, 1974). Oakely (1974) described six core tasks of housework as "cleaning, shopping, cooking, washing up, washing and ironing"(p.49). DeVault (1991) however, took this examination one step further. Her research highlights a

dichotomy that exists when women describe the work they perform in the home. For instance, many women trivialize their work as straightforward and simple and seemingly invisible, yet value the importance of such things as provision of meals in the family as a means of providing sustenance and maintenance of family culture. Many women equate sustenance with nurturing and life. DeVault (1991) aptly describes the invisible work that women render as consisting not only of the performance of physical tasks, but, "the planning and co-ordination involved in household work, as well as the constant juggling and strategizing behind the physical tasks" (p.56).

In view of this social context, it is not surprising that participants in this study were found to be resilient and careful planners. They had a keen interest in their household responsibilities and expressed great desire to re-establish themselves in their home work routines. Nor is it unreasonable that losing a measure of control over their work environment, including performing household functions like laundry, ironing, dusting, bed making and vacuuming, led to expressions of frustration, resentment, sadness, boredom and uselessness by participants.

For instance, Anne described feelings of loss of person-hood regarding her normal status in her son's household in which she regularly babysat, cooked, ironed and cleaned. She expressed irritation at her son and family due to their increased concern with her welfare since her return home. The following illustration refers to her time spent convalescing at her son's

home during the first two weeks post hospital discharge. She expressed annoyance at not being permitted to perform the activities that gave her pleasure as a mother and grandmother. In essence she had to curtail activities that had meaning in her life, and felt a sense of loss of who she was as human being, a person.

Anne: "I've tried to live a normal life, only there (referring to her son's home), they didn't want me doing ironing. They didn't want me doing the laundry. They didn't want me running the vacuum."

Some of the participants lost a measure of person-hood in having to rely on others, like spouses or Home Care Workers, to perform household duties. Lusia shared stories that gave an impression of losing a sense of control as her husband began to assume responsibility for many of the household duties. In the following illustration, she described feelings of annoyance that his standard of housekeeping did not meet her expectations.

Luisa: "So this morning I said, I know, what have you got to do? What you have to do. Pull the sheets." So I showed it to him. Because he never bothered with the beds. I mean, I been a lot of, a lot of places. Two, three, four times or five times to Italy by myself, he won't come. So I don't see what he do (more emotion in tone of voice) He just covered the bed, that's it. That's a man."

Women's research validates women's difficulty with relinquishing control of their home responsibilities to spouses. Luxton (1984) in a study conducted in a rural mining community in Flin Flon Manitoba, discovered that as women began working outside their homes, they experienced mixed feelings with regard to their husband's participation in the housework. Luxton stated,

" When men start doing domestic labour, women begin to lose control. Domestic labour has traditionally been the one sphere of female control and power. For most women, the kitchen is the closest they ever come to having a 'room of their own'. It is difficult for women to relinquish this" (p26).

In addition, Luxton noted that many of the women in her study found training their unskilled spouse, time consuming and in itself an additional job. Older women in Clark et al.'s (1994) study expressed concerns that having their retired spouses at home while they recovered, would in fact increase their stress and create work. Similarly, Luisa's work increased as she mentored her husband to do laundry which led to expressions of frustration and stress.

Luisa: "The only things he can't do, to wash. I have to wash it. That's about how many times you going to tell the washing machine, the way you do. He forget. The dryer, not too bad, now the dryer not too bad. But the wash, the wash, he don't. So I went downstairs myself. I tell him what to do. But I put the clothes in and then I told him the dryer...But he like to do things. But you got to tell him you know."

Others have also noted that older women who are married are more likely to die one year after a MI, citing the older age of the spouse, poor skill level with caregiving and ill health as potential reasons (Young & Kahana, 1993).

Sophie also shared feelings of frustration at not having control over her environment and having to accept a lesser standard in the quality of the workmanship. Sophie described how the Homemaker did not clean Sophie's apartment in the manner that she wished nor did she follow Sophie's instructions. Sophie eventually decided to accept a lesser standard as the aggravation of trying to train the homemaker was not worth the stress.

Sophie: " She means well, but she doesn't seem to know exactly how to work, at least not the way I've been trained by my mother to do, do housework, you know. Like she takes a broom, and she goes like this (motions with her arms as sweeping). She sweeps too, too, too high. And I said, " you keep the broom, close to the floor". And you just. She says, "It would take all day for that". And then, she, she doesn't seem to understand me and so I have to repeat and I have to explain. So, another time I said, "all my inside clothes, well, well all my ready to wear clothes, you please, bring some hangers down and put them on hangers, buttoning up say the first button or something to make sure they don't fall off and bring them up and put them away instead of folding them. So it will be already something that I don't have to do. But she took all, all the clothes back up on her arm (said with tone of frustration). And she put **even** (said with emphasis) my nighties on her arm and my underclothing on a hanger (laughs).... I didn't say you don't have to put my nighties on hangers. So what's the point, it doesn't really harm anyways...
... Well, it's frustrating)."

The shared feelings of loss of person-hood expressed by the participants in this study are congruent with previous research and highlight that women over 65 have similar value systems and beliefs about home responsibilities as women in other age groups. However, women of this generation appear to equate the loss of homemaker role, as equivalent to job loss.

4.3.2 Trying to Make Sense of Their Lives

The second broad theme in the pattern of recovery is termed, **Trying to Make Sense of Their Lives** and comprises the three supporting themes: i) Reliving the MI Experience; ii) Living with Changes in Body Responses; and iii) Making Comparisons. Each supporting theme will be described in detail in the following section.

At this point in their recovery the participants sifted through the disruption in their lives to find meaning in their experience of having sustained a MI. In doing so they appeared to be making attempts to understand what had happened to them. Inherent differences were found among the participants in relation to how they "responded" to and were "impacted" by the MI. They also shared how they felt both emotionally and physically with the diagnosis of MI and wanted to make sense of their lives with the inclusion of a MI. It is interesting to note that of all women interviewed only one appeared emotionally distraught at the time of interview. Indeed, most appeared complacent with the fact they had sustained a MI and gave an impression of life handing them just one more problem with which they must contend. This lack of emotion may in part be due to the socialization of these women during an era of many life crises, such as the Depression and world Wars, with the resultant perception that the MI was yet another "challenge" to overcome.

4.3.2.1 Reliving the MI Experience

In order to make sense of the MI, each participant reflected upon the initial experience that resulted in her seeking medical help. The retelling of their stories appeared to be an important and often cathartic experience. Of the seven women interviewed, four spontaneously started the discussion of their MI experience which lends credence to the belief that the experience of initially seeking help was of importance. It appeared that the participants, through their story telling, retraced their steps to reexamine what had occurred. They shared how they had managed the situation and in certain cases, dealt with their own mortality and how they had survived. For instance Claire commented,

Claire: "I shouldn't cry. I should thank God, that I'm alive. Cause I wouldn't be here if it wasn't for the hospital. I would've died, I think, you know. Because I was close."

During the interview, many of the participants returned several times to the story of their initial MI experience. This fact adds to the importance of this story telling being a piece of their trying to understand. These narratives were often lengthy and filled with detailed and vivid descriptions of the time of day, the persons involved, the nature and quality of the pain, the thoughts they experienced during the episode and their perceptions of their medical care. The following examples focus predominately on the pain experience.

For example, Lusia spontaneously relived her MI experience and shared the following detailed descriptions of her pain.

Luisa: " My pain was **terrible**, (face grimaces, said with emphasis). It start on the front, here, (motions to front of her chest) and the first pain I have was like a jab. And then after they do like, they sit on my chest and they go into my heart. And then I said to myself, " Ah, where is, where is my heart? On this side or the other way?" I analyze where is, where is my heart? So they still have pain, still have, still have pain (gestures with her fist over her chest, and moves back and forth in seat with a rocking motion) My pain, I feel like when you open a book and my spine all crack out, that's what my spine and **that pain** (said with emphasis) it was very, very bad that I have."

Many of the women appeared surprised or uncertain about their MI episode not fitting the "text book" depiction of chest pain. In retelling their stories to a health care person, it seemed they were seeking validation for the emotions and the uncertainty they had experienced particularly with respect to the symptoms of their MI. For instance Ruth commented,

Ruth: " And I had these terrible pains in my chest. I thought it was indigestion (moves hand over upper chest). I think I had spring rolls or something for lunch.. but it wasn't so...(short pause) Well I, phoned the doctor's office and they said get an ambulance and go to the ..it was terrible pain (point's to chest). And I phoned the doctor's office and they said get an ambulance and go to the Emergency. And I phoned friends to take me there...It was funny, I didn't even have any pain in my arm. So...(short pause).... Oh. I thought I had indigestion. No, I didn't have any arm pain."

Benson et al. (1997) confirm the need by women to seek validation for their MI experience through sharing stories with other women. They found, during focus groups with women post MI, that study participants valued the opportunity to discuss and compare stories with other participants.

Lastly, three of the informants mentioned a spiritual component when reliving their MI experience. Of these women, two

had lost consciousness and life saving measures such as intubation or the insertion of a pacemaker were instituted. Their narratives were interspersed with mention of 'faith and survival'. They talked of thanking God that they were still alive and seemed amazed that they were. One participant in the present study commented,

Alice: "You have to believe...(short pause) Thank God you're alive. And this is my best Thanksgiving yet, because I was still alive.(long pause) (looks downward, appears reflective)...(and later) But I have a lot of faith...(short pause). I believe in God. ...I feel when my time is up, it's up. Oh, you know, that time wasn't the time. He still has plans for me."

Participants spoke of the faith they had in God that helped sustain them through their recovery and assisted in their acceptance of the diagnosis. The following narrative illustrates this point.

Sophie: "Now, well I've accepted it and I am aware that I've had a heart attack and I've accepted it cause I'm really rather religious, not a fanatic. But, and I thought, well you know, ' Father knows best'."

Several authors note the importance of spirituality and religious faith in the recovery period (Clark et al., 1994; King & Jensen, 1994 ;Varvaro, 1991). Johnson and Morse (1990) found that women spoke of coming to terms with their MI as they faced their own mortality after surviving a MI. Similarly, LaCharity (1997) noted that women stressed the importance of spirituality when coping or adapting emotionally with their diagnosis of coronary artery disease.

4.3.2.2 Living with Changes In Body Responses

One aspect of these women making sense of their lives included the theme living with changes in body responses. By knowing their body responses (via increased symptom awareness) to daily routines, the participants in turn made sense of how they were adapting to the MI and measured their progress. The symptoms frequently described by the participants were feelings of weakness, tiredness and fatigue. Several authors have noted increased symptom reporting among females versus males with heart disease (Sharpe et al., 1991; Young & Kahana, 1993). Sharpe et al. (1991) explain these differences through women having, "greater awareness of their body signals, greater willingness to report symptoms, a more diffuse view of illness, and biological differences in the impact of some diseases" (p.37).

For some of the women the feeling of tiredness was overwhelming and incapacitating. Indeed, only 2 of the participant's were interviewed at the two week point and extreme fatigue was cited most frequently as the cause for delaying the interviews. The women appeared surprised at the intensity of the tiredness they experienced and how it affected their normal routines. One can assume then, that the first two weeks of recovery is a difficult time frame for elderly women post MI as they struggle with the adjustments in their physical symptoms. Certain participants shared however, how they made changes in their lifestyles to accommodate this level of fatigue. Claire, Luisa and Ruth talked of sleeping on the couch in the living room due to their tendency to fall asleep without warning. Claire in

particular, mentioned sleeping in the living room as she found it too difficult to go downstairs to her room. The following narratives demonstrate the intensity of the level of fatigue experienced by these participants.

Claire: " Well, the first two weeks I forced myself to eat because you know I take lots of pills and I was always, always (said with emphasis) tired. **Always, always** (emphasis) sleeping. I don't know if it's natural but I was always sleeping. You know. And I didn't take any pills like to make me sleep...Because I was sleeping and my boyfriend, say, "Claire, you sleep too much. Walk a little bit". I say, Albert, "Leave me alone, I'm tired, I'm sleeping."

Claire's words denote the degree of tiredness she experienced and how she knew she could not attribute the fatigue simply to sleeping pills. She wondered if this was a usual symptom post MI. Similarly, Marie gave an impression of exhaustion while living with the scheduling of appointments in her first few days at home.

Marie: "When I came out I was very shaky. Of course I am an older person and probably it didn't help. And when I got home I thought I was smarter, which I really was, and did what I could. But the day after, I came home Monday night and Tuesday I tried to manage but was shaky and upset. But Wednesday I got very afraid that maybe I was going to fall or something. I was nervous. So I called my daughter in law and my own granddaughter and they came over, and straightened out a bit. There was some straightening out I couldn't manage. And I was so weak I guess and shaky and nervous. And anyway they gave me a help and made supper. That made me feel better and it was OK. The next day I just managed with what I could and since then the thing is, it keeps coming back. I'm **tired, tiredness** (raises voices with expression of dismay). I've been busy with appointments, have to go back and forth for the doctors because the blood. And the lab keeps calling me. So I'm disturbed all the time. I haven't had the chance really, to me, to have a good rest."

These findings are confirmed in the literature. Excessive fatigue was noted previously by Varvaro (1991) wherein the subjects reported becoming easily tired and having decreased energy levels. Young & Kahana (1993) also noted more cardiac distress symptoms in older women post MI, which included shortness of breath, coughing, angina and more functional limitations in instrumental activities of daily living. Conn et al. (1991), in exploring the differences in age and gender in physical health, psychosocial state and regimen adherence, noted that older women had significantly more days of reduced activity, spent more time in bed and had more chronic illnesses than older men.

Importantly, participants with co-morbid illnesses such as diabetes or arthritis did not discuss their symptoms of MI in relation to the pre-existence of another chronic illness. Instead, they spoke exclusively about their MI and tried to understand their symptoms relative to the MI. For example, when Marie was asked what illness she was referring to when she spoke of being tired and not knowing if it was a side effect of her illness, commented,

Marie: "Well, arthritis has been with me since the age of 32 years old. It's a thing I have to cope with all the time. No, I'm thinking of the heart, of angina, hope to not get anymore of those attacks."

This finding has significance as it raises the need for further investigation of the physical and psychological impact of chronic illness coupled with a newly diagnosed illness.

Another finding related to those participants who experienced few, if any symptoms post MI. They spoke of increased frustration in relation to the imposed activity restrictions. They, in turn, were the most likely to test their limits within these activity restrictions. In the following, Alice had to think before continuing with her daily routines.

Alice: "Uh, I don't really think of it or recall having the attack until I go to do something that I know I shouldn't do, like lifting something without thinking. If you have an operation, you have an incision and every time you move you know you have an incision. Whereas with a heart attack, I don't think about it.....it doesn't hurt when I move and this is the one thing I find...(short pause) I sort of have to think about it."

Anne described a similar response to the lack of symptoms. She commented,

Anne: "Because like I say, I feel as though there's [nothing] wrong with my body. ...(short pause). Maybe if there was a steady ache, or, maybe if I would see a picture that said. You know, there and there is where you've hurt yourself, you know, you've hurt your heart. Then maybe I'd realize, but, because I can't see anything, you know, there's no cut, there's no, no, bruising, there's nothing (said quietly). I feel, well, OK..."

These narratives illustrate how Alice and Anne's lack of tangible evidence of their MI as measured by symptoms, led to feelings of uncertainty about their MI. The lack of symptoms contributed to these women feeling a degree of frustration with their activity restrictions. Previous research by Friedman (1993a) had similar findings with older women and heart failure. She found that women who measured their affect as high, also measured their stress level as higher. She speculated that these two variables were linked, because, " subjects who were more

alert, energetic, and active could also have rated their experience with heart disease as more stressful because it interfered with their usual activities" (p.28).

4.3.2.3 Making Comparisons

The third sub-theme in trying to make sense of it refers to making comparisons between their present life style and associated symptoms from the MI, to their previous level of well being relative to their typical daily routines and patterns. Many of the participants reflected on their progress, which resulted in worry or self-questioning, especially as to whether their progress was appropriate and usual following a MI. Lack of shortness of breath and fatigue were used as cues for resumption of activities such as light dusting, washing the dishes, shopping or going for walks. Comparisons were made between level of symptoms prior to the MI and afterward. Measuring and making comparisons of recovery based upon symptom presentation is confirmed by Hawthorne (1994) who noted that women used level of fatigue to guide their activity and rehabilitation.

In the following narrative Sophie describes her symptoms of tiredness and compares them in relation to her life before the MI. She also refers to being tired just weeks before the MI which has been noted in the literature (Douglas & Ginsberg, 1996) as a symptom for women. Sophie commented,

Sophie: "Because I was used to go, come and go, do my own thing, my own meals, do my bed and do just... And I always had a homemaker but there was a lot of things that I would do myself. Now, if I try to do a little bit of housework, straightening up or doing this and that, I, ah, find that I get tired.... I feel much more tired than I was before. It started a couple of weeks

before I went to, before I had the heart attack. It was really strange. I couldn't even hang up my clothes, because I was so tired (said with emphasis), physically tired...And I was pushing my walker and I felt so tired, it t'was, it was something I never experienced in my life. And then well, having the heart attack has left me physically tired. And I get tired much easier, much more easier than I used to. I used to be able to do quite a few things without getting overly tired."

They also used body cues to determine whether they had overexerted and needed to rest as is illustrated in the following narrative with Anne.

Anne: "I did a little bit of ironing, when I came up and I'm one of these people that iron towels and pillow cases (laughs) and you know things that I really don't need to iron. But anyway, I was a little bit tired when I was finished and it said (discharge manual), you should sit down when you're ironing. But I figured, if it started pulling or you know, paining me. I would have quit."

In addition, many symptoms these women experienced changed their ability to socialize in their usual manner. The following is an illustration of how Ruth's life has changed as she makes comparisons to her current versus her previous lifestyle. Ruth commented,

Ruth: "...and I find I'm tired (emphasis on word) more than I used to be (has a pensive look). I put my head down practically near every afternoon and (voice changes to a whisper). It's not what I'd like to do (laughing).....It's not what I do ordinarily....I'd be out doing something. You know. Like shopping or playing bridge or something. And I haven't had anybody in because I just can't."

4.3.3 Learning to Live With It

The third theme in the pattern of recovery is termed Learning to Live With It and consists of four supporting themes including: i) Playing By The Rules; ii) Cheating; iii) Taking Care of Themselves and iv) Receipt of Supportive Measures. Each of these will be further elaborated in this section.

Subsequent to trying to make sense of the MI experience, the participants began to mobilize themselves in order to create some semblance of normality. "Learning to live with it" occurred as the participants began to live with the restrictions set by the medical and nursing community, their families and friends. However, living with these restrictions became more acceptable to these women when they personally planned and organized interventions, thus gaining a measure of control within their environment.

4.3.3.1 Playing By The Rules

The sub-theme playing by the rules refers to the point at which many of the participants began to accept their diagnosis and realized the need to follow instructions given by the medical and nursing community. The term playing by the rules resulted from reflection on the words used in the narratives that implied authority and command. For example, such words as "told not to", "shouldn't", "can't", and "mustn't" imply power and can be found throughout the dialogue of these women. In most instances, the participants adjusted to living within the rules and came to accept and acknowledge that by doing so they might create a new

picture for themselves. Each participant reflected on and responded differently to situations. For example Sophie likened her struggle with acceptance as a battle that she had to face.

Sophie: " Well, I more or less became reconciled with the idea that I had a heart condition, you know, and I had a blockage and had to put up with that....(later) It t'was always something that, that I, I couldn't accept you know, that I had difficulty to accept. But as I say, progressively I came to accept it, you know. That was a good battle my same one that I won because if you don't accept a condition, you cannot cope with one, you know. If you accept it, well, then you take the precautions, you do the exercises you've been told you can do, you take the medications that you're on and ah, you try to live as normally as possible with, (laughs) with your condition."

Playing by the rules included learning to live with the activity restrictions, medication regime and dietary adjustments set out by the medical and nursing community following their MI. In fact, it encompassed for many of the women, a need to make many life style changes. In the next example Alice shared how she was following the activity instructions and had not done laundry. The sigh indicated that she was not particularly pleased at having to refrain from doing so.

Alice: "Oh, the laundry, poor laundry. (laughs). I have a friend who was supposed to come over and do my laundry and the vacuuming but she's had a bad cold. She won't come near me, but she'll come. The laundry, well, I do a little hand washing, every now and then. The small pieces.... I was told not to do the laundry so I don't do it. So I (sigh)....."

Many participants shared how they had made dietary adjustments. The following narrative illustrates how Anne was learning to follow a low salt diet.

Anne: "But it's hard, you know, to do without these things (referring to salt). But I've, I'll be honest. I've not touched the salt and ...(short pause), so I am

kind of watching it... I am definitely cutting out the salt so, I am trying to do what's right...."

The next narrative demonstrates the life style changes being made by Alice to manage her stress.

Alice: "I try to keep free of worries now. Because they don't do you any good... Well, I don't need that. If I can keep cool, calm and collected then I feel that my blood pressure will stay where it should. If I get upset, then my blood pressure goes up. And I don't need that. I try to do, I try not to worry about things anymore. It doesn't get you anywhere."

Anne recognized her need to change her life style with regard to daily activities especially as they pertained to household duties and letting others help. She is however, filled with indecision due to the lack of symptoms. She put it this way,

Anne: "With that book, I've read it, and read it and you know you do say to yourself, " Well, no I can't do those things" or "I shouldn't (said with emphasis) be doing those things". But ... (short pause) like you're learning to live with it. Even though I'm saying to myself (laughs) , "Well, I feel fine". Yet in the back of my mind, I am saying, you know , " I've got to slow down, you know, I've got to let other people do things for me". But that's hard when you've always done it yourself."

Playing by the rules has been noted in other studies but has been titled differently. For example, King and Jenson (1994) described the need for women to learn "new rules, limits and norms" (p.102) as a phase called 'being there'. Johnson and Morse (1990) described a phase of adjustment wherein the participant's established guidelines for living that included modifying life styles. LaCharity (1997) noted a theme called "Managing Life Style Changes" which included similar findings with life style adjustments.

4.3.3.2 Cheating

Another sub-theme found in learning to live with it is titled 'cheating'. The term cheating was chosen as it lent a subtlety to those occasions when these women did not follow the rules. There were several instances when participants both consciously or unconsciously did not follow instructions. Inadvertent cheating with respect to activity level occurred when no one in the home could complete a specific household duty such as when the spouse or partner lacked both knowledge and skill to perform a certain task. As was mentioned previously, Luisa decided to instruct her husband how to do the laundry and the bed making and as a result, over exercised. Claire made a choice to assist her partner with the task of performing the laundry that resulted in her overextending her activity restrictions. The following illustrates how Claire and her partner resolved the laundry situation.

Claire: " I do a bunch when I have a load there. Albert puts it downstairs. I do the rest. I put in the sheets and I fold them, you know. Sometimes I put them in the back."

Conversely, Ruth described instances when she intentionally did not follow dietary restrictions. The following is an example of Ruth's decision to not follow the low salt diet restrictions.

Ruth: "I find I'm not supposed to be having salt which is a (makes a face of distaste). I'm eating cheese which I don't think I should or shouldn't have..../The book says I shouldn't but if I want a grilled cheese sandwich for lunch I'm going to have one."

Interestingly, LaCharity (1997) noted that as women adapted and coped with their CAD diagnosis through changes in dietary

habits, they commented how they had, "cheated once and awhile" (p.595). She dubbed these episodes of cheating 'planned exceptions' as the subjects in her study rewarded themselves with food they craved after carefully adhering to dietary changes.

Anne experienced indecision regarding her activity restrictions and thus cheated by vacuuming. The following is an example of the conflict she felt at not having symptoms and yet knowing that she might cause herself harm if she over taxed herself.

Anne: "And if there's a little bit of dirt, fine it can stay there, but, you can only have it there a certain length of time, that's the way I'm beginning to feel, you know. Well, you can have dust, but then come Saturday, I may say, "Oh, I've got to get this place clean. I've got to vacuum" And yeah, in a way, you know, I shouldn't (said with emphasis) be really vacuuming, from the book....But, I try....it makes me feel really undecided (said with emphasis).... Like I feel it was only a warning... And yet one part of me is telling me there is nothing wrong. You can do that (said with emphasis), you know. So you're caught between the devil and the deep blue sea, you know."

All participants spoke of attempting to follow the activity, medication and dietary restrictions as set in the discharge booklet. However, those women who experienced few symptoms, spoke of performing prohibited activities. The literature confirms that women do not follow exercise limitations and are found to "bend the rules" and assume housework within 4 weeks post MI as a result of needing to assume domestic role responsibilities to reduce their feelings of stress (Johnson & Morse, 1990; King & Jensen, 1994; Sharpe et al., 1991; Varvaro, 1991). It did not differentiate however, between women who frequently reported symptoms versus those who did not. Of interest to the present

study, is the participants' frequent referral to the discharge booklet as "the book", and the impression of great deference being paid by older women to the information in the booklet. This finding has implications for practice as it points to the fact that older women incorporate discharge information when making decisions regarding activity and diet while at home and for the most part, appear to follow the rules as they have been socialized to do. Further research may be necessary to compare these findings with those of men and younger women with a MI.

4.3.3.3 Taking Care of Themselves

Another sub-theme in learning to live with it refers to how these informant's were in essence 'taking care of themselves' through resourceful planning and strategizing. To put this into perspective one must again refer to the context of these women who were accustomed to being in charge of their home environment, their place of work. The MI, and the restrictions placed on them by the medical and nursing community, essentially thwarted their ability to have control in their home environment and to be in control of their lives. 'Taking care of themselves', describes the many ways these women used their skills of planning and coordination, to plan for their recovery. They implemented many interventions to conserve energy and facilitate their recovery. These interventions included cutting back on the energy expended in meal preparation, restricting visiting by family and friends, cutting back on household work or completing the work in stages and lastly, developing an exercise regime. These women repeatedly

described how they organized and planned for their recovery. They spent much mental time in what Devault (1991) refers to as the invisible aspects of domestic work, planning and coordination. Once they had learned of their diagnoses they were planning their eventual discharge and they began asking themselves several questions. Where would they stay and with whom? How would they get home? What food would they eat once they were at home? Many mental processes were at play as they planned for their recovery. In the following narrative, Alice was extremely proud of how she has used frozen vegetables and reduced the number of pots required to make dinner from three to one. Thus she had managed to save herself time and energy, and has accomplished what she set out to do, to cut back on her work. In fact, all of the women discussed meal planning and seemed to derive some degree of satisfaction knowing that their basic nutritional needs were being met.

Alice: "Whereas you buy all these things frozen, cut up and mixed together in a bag and all you have to do is open a bag and put some in a pot. Terrific. And you don't waste any because you just tie up the bag again and put it in the freezer.... I think it's great. I'm making, a big job, a small one...(short pause) Cutting back(said with pride) Cut backs (laughs) Great."

Sophie described plans to have a caterer supply her meals as she was finding it difficult to find low salt diabetic meals. In some instances the interventions implemented by these women were actually measures to regain control over their home environment. For instance, both Claire and Luisa had restricted their visitors in order to ensure they received adequate rest. Luisa commented,

Luisa : "The first three days I was like, no, I prefer no visitors. You know. Because I had a lot of visitors in the hospital. I don't sleep at all, not, I no rest at all, not even the day time and not the night time."

Marie sought help from her family to organize her kitchen table with items she needed at hand to reduce unnecessary trips in her apartment, thereby saving energy. She commented,

Marie: " Well, it makes [things] organized. Put away things. Things I've got. Everything in my hands. So that I can reach around here.... (table has many items on it, a hair brush, comb, telephone, newspaper). But for me I don't have to keep going to the bathroom or go to [bedroom] and get what I need. It's messy that, table, but the rest I try to keep in order."

Anne described how she had altered her house cleaning routine by limiting the extent of the cleaning. In addition, she had attempted to alter the strategy by which she performed her laundry as evidenced by the use of the buggy. She had essentially, implemented an energy conservation intervention.

Anne: "Saturday, I ran the vacuum, and I dusted, but all of me, I didn't take any of this(points to plates and pottery on the walls) junk off, the hutch or you know, and I haven't...and I haven't You know and I've run the vacuum. I washed the sink and the toilet, but not the bath tub because I figured bending over the bathtub wouldn't be good.(short pause) I did my laundry Saturday night. And like I said, I usually carry it in the basket but I carried it in the ah, buggy, so I didn't really carry it. I dragged it."

The aspect of self intervention was noted by Benson et al. (1997) wherein women managed the challenges of living with their heart attack through reductions in expectations for housekeeping. Additionally, LaCharity (1997) noted that women with CAD developed strategies to divide chores into "manageable segments

while incorporating frequent rest breaks" (p. 597). Many of the women planned activity regimes to take care of themselves. Anne talked of taking walks and becoming more active. Alice spoke of daily walks to keep herself in shape. As these interviews were conducted in the late fall and early spring, many of the participants described how they were taking alternate measures within their homes due to the fear of falling on ice. Claire spoke of being afraid to go for walks outside for fear of falling, but added that she had a pattern of walks within the house. She also mentioned swimming.

Claire: "I want to do something. If it wasn't winter I'd go swimming, you know, go swimming. Cause it's good for you. But I don't know. I'll have to ask, you know. I still have some papers (flyers from University) there, cause there's swimming there at the University."

Similarly, Ruth described being afraid to fall on icy days although she routinely exercised in her apartment.

Ruth: " I know I'm to walk. I walked 20 minutes this morning, just in the kitchen..... But I've always have, I've done, I've done that for years. The other day I was out. But oh, I'm scared to death I will fall, on some of those icy days. I can go down, there's a big garage here so I can go downstairs and walk if I have to. Which I've done a couple of times."

The two participants with previous mobility problems did not allude to exercise although they had implemented other life style adjustments like diet. As was mentioned earlier, an aspect of self-intervention was these women's innate ability to plan and coordinate their care.

In addition, these findings may elucidate some of the reasons for women's non-attendance in rehabilitation programs. During the interviews, although the women spoke avidly about their self-administered activity and diet regimes, only one introduced the subject of rehabilitation programs. Most showed little evidence of knowledge of rehabilitation programs. In addition, those women who were functionally capable of exercising commented that they had their own activity schedule and gave an impression of not needing to be a part of a rehabilitation program as they were personally partaking of some form of exercise. Anne in particular had been referred to rehabilitation, but spoke that she had forgotten to follow-up with the doctor and commented that she might look into it at a later date. She went on to discuss how she planned to go walking as was usual for her, when the weather improved. The researcher was left with the impression that Anne would exercise on her own and had no intention attending. Lastly, both Ruth and Claire mentioned they feared falling on ice, with Ruth stating the ice might prevent her from attending a program.

Several factors in the literature have been implicated in older women's non-attendance at cardiac rehabilitation programs including lack of available transport, non-referral by physicians and the presence of co-morbid illness which may affect elder women's eligibility in programs (Ginzel, 1996). Lacharity (1997) noted that older women have higher drop-out rates and are less likely to adhere to post- MI regimes. The present study suggests that older women do not understand nor do they appear to perceive

attendance at a rehabilitation program as a priority. These findings have implications as they suggest that older women's perceptions of rehabilitation are not fully understood.

4.3.3.4 Receipt of Supportive Measures

The final sub-theme in learning to live with it, pertains to supportive measures received by these women. Social support has long been considered an essential element of recovery. Social support has been found to ameliorate the recovery process by improving physical and emotional aspects of everyday living (Bennet, 1993; Dhooper, 1984; Riegel & Dracup, 1992). Conversely lack of support can increase mortality, especially in those individuals who are socially isolated (Berkman & Breslow, 1983).

House and Kahn (1985) define social support as a combination of the relationships one has with persons or groups (social integration), the size of that group (social network) and the function of the support that includes the quality and type of support provided. Social support consists of three types: emotional, informational and instrumental or tangible. All participants spoke of the receipt of emotional, informational and tangible support and alluded to their social networks and the degree of reciprocity or give and take in these relationships. In addition, the timing of support was alluded to during the interviews. Each of these will be discussed and pertinent narratives will be used to highlight the significance of these factors to the informant's adjustment to the MI.

Emotional support was a major support component for these women. Many spoke about how their family members were calling

from great distances, nearly every night which gave them pleasure and a sense of security and reassurance. Alice spoke of her family 's and friend's phone calls in the following manner,

Alice: "Oh, my sister out of town. She calls me, she was calling me every day(said with surprise). And my brother and his wife, who live in Quebec... They phone me every night, from there. I said, "You're trying to buy the Bell? I'ts not necessary, call me every second or third night". You know. Call every night, "Just to hear your voice". So fine. And my other friends do call...(short pause) long distance. It doesn't matter if it was on the weekend, they call during the week because they were worried...(short pause) and that was fine. That's when you know you have true friends. When you're sick...(long pause)."

Claire received emotional support from her partner Albert as he assisted her to overcome her fear of leaving her home. The following is an example of how Albert, took the initiative and led her out of the home to make this major transition.

Claire: " It was nice you know, when we went out for dinner. I didn't want to say no. He called me from work. He said, " You better get dressed. You're going to go out..." .
 EK (later in the conversation) What does Albert say to you when you say, "I'm afraid". What does he say?
 Claire: Ah, "Don't be afraid" (said with tenderness). And he knows. He, he dropped me right at the door of the restaurant. He ah, left the car and took me inside and he said, "Stay here. I'll go and park". And God, you know, he was so unbelievable."

Informants described receipt of informational support via a discharge pamphlet on MI and from nurses who provided explanations regarding their illness. In addition, those women who had previous contact with health care providers, made calls to them for information and cited how they had reviewed the booklet together.

The following was Alice's opinion regarding the value of informational support on discharge.

Alice: "Fantastic. Everything I wanted..... Yes. I thought it was great. And it helps, it helps patients to understand what they should and what they shouldn't do. And I think it's a great pamphlet for all of us. I've heard people on the street say the same thing."

However, two of the participants commented that some sort of illustration in the discharge booklet reviewed by a nurse or physician to clearly visualize the damaged area of the heart would be useful to confirm that they indeed had sustained a heart attack. Anne commented:

Anne: " If I would have seen a picture that said. You know, there and there is where you've hurt your heart. Then, maybe I'd realize."

Tangible support was also discussed by the participants and included such items as assistance with meals, transportation and domestic duties. It became evident that family members and various friends were providing considerable tangible support. Luisa spoke of the assistance she received from her husband:

Lusia: "But he happy, he happy I come home...He do everything. He washes the dishes sometimes ...He do so many things."

Tangible support came in the form of meals made by sisters, family friends and spouses. Family members and friends also supplied transportation to doctor's appointments. For example, Marie who commented about the help her son had given her,

Marie: "My son, he travels and on Friday, he's home. So he's been taking me to the doctor and he's very interested and helpful. He wants to do all he can to help."

Tangible support was also given through the health care community, via Home Care, to the two women with serious disabilities due to concomitant illnesses.

In addition, many of the informants had small but extremely effective networks upon which they relied for tangible and emotional support. Social networks comprise such aspects as the size of the network, the number of contacts with individuals, the formal or informal nature of these contacts such as family or friends versus health professionals and the degree of reciprocity or give and take in a relationship (Yates, Skaggs & Parker, 1994). The participants had social networks that included family members and friends. Even those who did not have relatives nearby had a variety of friends and close neighbors in their apartment buildings or nearby homes upon whom they called for help. It is also interesting that those women who lived in senior's complexes and therefore had greater potential to be socially isolated, had in fact a highly supportive network of friends who kept contact daily by phone or through visiting in their apartments. In the following illustration, Sophie described her friend's frequent visits.

Sophie: "Well she's a taking charge type...You know, without being overpowering or anything like that... But she was, she's been very caring because she came everyday to check on me. And ah, asking me, if there were any errands she could do for me. And she did a lot of errands, you know."

In a study investigating the psychological well being of older women with chronic illnesses, Heidrich (1996) reported that the existence of highly effective social networks was linked to

higher levels of psychological well being, even with the existence of physical limitations. This fact has significance as it implies the need for greater attention to the amount and quality of older women's social networks to maintain or improve a sense of well being in recovery.

This study suggests that the network was often mobilized at the time of their initial symptoms of an acute MI. At some point during their chest pain episode all of the informants asked friends or family members to assist them with validation of symptoms. Similar to previous research (Dracup et al., 1995) which explored reasons women delay seeking help with MI 's, those participants who consulted family members delayed seeking help longer than those who sought counsel from friends. The following is an example of how Alice received support from her network of friends on the night that she suffered her MI.

Alice: " So I went to the bathroom and threw up...(short pause) just the once. And on my way back to the living room I thought, " Oh, I **don't feel well**" (emphasis by the client on these words) . So I unlocked the door and I phoned my neighbor across the street and she came over. And whenever she saw me she said, " I'm gonna call 911, you're having a heart attack". She knew because her mother has had two or three heart attacks."

Reciprocity was another aspect of support mentioned by the informants. Reciprocity implies the give and take in a relationship and the feeling that there is mutual and equal contribution. If persons feel a relationship is not equitable, the support may be "perceived as unhelpful, particularly when it

undermines self-esteem" (Stewart, 1989, p.271). Both Ruth and Anne, who described themselves as independent persons, spoke of being pleased at not having to rely on others. The following example gives the impression that Ruth felt pleased to have maintained her independence.

Ruth: "They've offered...(short pause). I haven't had to call to ask anybody to do anything so far. And I've definitely been lucky that way. But I've just done (laugh) so much on, all my life learning on my own."

Equally, Anne discussed how asking others for help will be a difficult change as she was accustomed to exclusively dealing with matters. She commented,

Anne: "When there's things to do, I like to do it myself, I don't expect other people to do it, and that's been one of my downfalls down here. Because I wouldn't ask people to do the things, you know. So, ah, I wouldn't ask people to do the things, you know. So ah, I know I've got to learn to ask other people to do the things but I still prefer to do it on my own."

Reciprocity of support has likewise been noted in the literature as a particular concern for women. Johnson and Morse(1990) discovered that women do not wish to feel indebted to others as a result of their inability to perform household duties. Boogaard (1984) noted that women felt "quilty" at having others help.

Several participants acknowledged negative aspects of support that included inadequate assistance from home care providers. Sophie described negative perceptions of Home Care support and shared her frustration at trying to teach the home care worker her household routines, who chose, in turn, to ignore

her requests. Sophie described feeling physically and emotionally tired on days when the home care worker came. She commented:

Sophie: " Well, it's frustrating. You know, I think anyone would feel frustrated...(short pause). It's physically tiring...(later). If I have somebody...(short pause, choosing a word)who's contradicting me or doing something which doesn't agree with me or doesn't agree with my way of doing things. I get tired."

This finding has implications for assumptions made by many health care workers with regard to the issue of home care support. Often Home Care support is ordered for individuals at the time of discharge with the intent to assist the client in their home environment. This example illustrates that not all home support is helpful and can in fact, add a dimension of stress to the client on discharge.

One final area noted in the narratives related to the **timing of support**. Jacobsen (1986) highlights the significance of the timing of support in the trajectory of crisis or illness recovery. He stresses the importance of emotional support in the early phases of a crisis, as emotional arousal (anxiety, fear, emotional distress) is the most predominant factor in this early stage. Thereafter, individuals need informational support and tangible support to assist them in the transition through the crisis event.

This sequencing of support was apparent in this study although several instances of mistiming of the support were noted. For the most part, emotional support was timed to the early phase of their recovery as participants seemed to recollect

the many instances of receipt of emotional support from family and friends while in hospital and at home and prioritized these in importance during their conversation. With respect to informational support, most participants shared that they had not read the discharge booklet until they had been home for several days. In addition, at the time of the interview, although it was evident that all participants had read the MI pamphlet, some appeared unclear about the nature and extent of their MI. Many of the informants raised questions in relation to activity levels and symptoms and sought clarification from the researcher. They spoke of wanting answers from their physicians but that they had to wait for their follow-up appointment. For example, Claire commented:

Claire: "But I never, never, I never asked, I never asked...But I'm going to ask some questions when I see the doctor, you know. How much heart was damaged...well I never asked before, what kind of heart attack I had. You know how serious it was."

Anne wanted to know more about her MI. She commented,

Anne: "... I would like to know if it was just a 'mild' (said with emphasis) attack, or may be when I go back to [the Doctor] I can ask him, you know, what kind of heart attack it was... So, when I do (said with emphasis)...I'll try and ask him all these different things."

These comments by the participants denote mistimed informational support. Parkes (1982) suggests that timing informational support to satisfy the needs of the individual is critical. Attempting to meet informational needs that are not a priority for patients, because they are preoccupied with other

issues, will result in information being ignored or misunderstood. Thus, while in hospital, participants were managing the shock of having a MI and were not emotionally prepared to learn about their MI. Later, while at home, they wanted to learn more about their condition and at that time required the informational support.

Lastly, the timing of tangible support is critical to recovery. Marie described how she felt her home care requirements were underestimated and poorly timed by the Home Care Coordinator with ensuing stress for both Marie and her family at the time of discharge.

Marie: "But, I think that once the Home Care, they don't realize just how disoriented you feel for awhile. I couldn't face all that had to be done. I didn't have the **energy** (said with emphasis) and the strength... Everything to put away and maybe there's some dishes there that's dirty. But coming back to the lady with the Home Care, I don't know, unless you have an illness, at one time or another, if you realize you can't just get up and do the things that you should. There's work. When you come home and it's there looking at you. It's got to be done. I needed somebody there, for help."

This study highlights discrepancies with respect to the timing of informational and tangible support for older women and has implications for how and when clients are educated and tangibly supported prior to and following discharge. It would appear that additional informational and tangible support may be needed during the first few weeks at home.

4.3.4 Getting Settled

The fourth and final theme in the recovery process is referred to as "getting settled" and consists of three sub-themes including: i) Seeking the Physician's Validation; ii) Beginning to Feel Better; and iii) Moving forward. Each of these supporting themes will be discussed in detail in the following section.

During this phase of recovery, the informants spoke of trying to regain a sense of normalcy as the pieces of their lives began to take shape and a sense of wholeness evolved. Although many of these women's lives had not totally returned to normal, they described a sense of getting settled with their MI and moving onwards with the creation of a new picture for themselves. They were in essence fitting together the final pieces of their recovery mosaic. As Alice so aptly put it " It's like the leaves falling from the trees. They all find a place where they land. That's all".

4.3.4.1 Seeking the Physician's Validation

An important element in these women getting settled, related to their seeking the physician's validation. Some participants spoke of their intent to seek validation that they were progressing normally post MI, in the follow-up appointment with their physician. As was mentioned previously, many wanted questions answered. For instance, Ruth wanted to know her cholesterol level.

Ruth: "I don't even know whether my cholesterol is high or low. I don't think I have ever been told... Well, I think I'll see him [physician] on the ninth of the month...and that's what I've been wondering."

All informants referred to seeking the physician's permission to move onwards. Alice awaited her scheduled appointment to determine whether she would undergo tests. The following is an example describing how Alice's life was essentially 'on hold' while she waited to see the physician.

Alice: "I'll be glad when it's over so I'll know what's what...Well I'd like to know if they found something they have to correct. Ah, with the angioplasty and if they can't correct it with that, they think it may be another bypass. And that's what I want to know. One way or another...Well, I mean if it's going to make me feel better, I want it. Because this year, I love playing golf and this year I didn't get to golf. I missed the whole summer. So hopefully, if I'm more fixed up than 100% of them, then I can go. I miss that a lot...(later in conversation) I just don't want to do anything that I'm not supposed to do or haven't found out about. I'll get all those answers when I see the doctor...."

For many of the informants, the physician's permission appeared critical to their making future plans as they had kept their lives in abeyance until they received approval to move forwards. Two of the informants sought confirmation of their ability to travel. For example, Claire commented:

Claire: "You know, that's what I'm gonna ask the doctor. If I could travel. If I could go to Alberta for Christmas...."

This health seeking behavior on the part of the participants is congruent with a generation of women who were socialized to show deference to persons in authority, in particular the physician and has significance as little previous research has explored this aspect. Hawthorne(1994) examined gender differences

in recovery post coronary artery surgery and noted that women "deferred the monitoring of their risk factors to their physician, whereas men tended to follow their own 'numbers' religiously" (p. 79). She explained this difference to women being socialized to a passive approach to life. Ashton (1997) in a study comparing the perceived learning needs of men and women after a MI, noted that women preferred to learn from physicians. This aspect of women deferring major decisions to the physician warrants further exploration.

4.3.4.2 Beginning to Feel Better

As women spoke of getting settled they described beginning to feel better. Most of the informants looked for symptom cues, such as less tiredness, to indicate a return to normal. Marie made the following comment when asked how she was feeling at the time of the interview in comparison to the first two weeks at home.

Marie: "Much stronger now. Oh, yah, more in control every minute."

Likewise, Alice commented,

Alice: "Everyday I feel a little bit better, a little bit stronger. Ah, in the evenings I tend to feel a little more tired than I would like, but I guess that's normal. Ah, having a first heart attack you really don't know exactly what to expect but you sort of accept how you feel in the evenings. After a while I guess my, every evening I will feel a little bit better."

Similar findings were documented by Riegel and Gocka(1995) who found that from one month to four months after acute MI, women described their health as improved. However, other studies

contradict these findings. Conn et al. (1991) noted that although older women 1 to 2 years post MI felt highly supported as a measure of social support, they generally rated their health as poorer as indicated by a subjective rating and larger numbers of chronic illnesses. The fact remains that further research on the health perceptions of older women needs addressing.

4.3.4.3 Moving Forward

The final sub-theme in the broad theme 'getting settled' refers to 'moving forward'. This was a phase in which the participants shared how they were making progress and were beginning to feel improved both emotionally and physically. An aspect of moving forward was the re-establishment of their daily routines which included banking or shopping, venturing outdoors and in particular, socializing with friends and family. Moving forward implied regaining a measure of independence that appeared to have a positive effect on their emotions and on their overall sense of well being. For instance, Ruth was looking forward to driving which would afford her the opportunity to regain independence and enable her to do those things that she might never consider asking others to do. When asked what having the car meant to her she commented,

Ruth: "So I think I'm making progress. Until I get the car I don't do too much.....Well the things I want to do, like, that I can't ask other people to do for me.....Well, I need new face powder and I (with emphasis)don't even know the color. And I want to go and do that. Yah. Things that aren't essential."

Several of the participants spoke of looking forward to venturing out from the confines of their homes as a result of feeling stronger physically. This led to an eventual improvement in their emotional state. The following illustrates Luisa's emotional improvement as she became able to sit on her verandah as was her usual pattern.

Luisa: "I feel I miss to go out. Just really, I feel I go out because usually, everyday, everyday, I got to go out. Even for a half an hour. If I stay in, because later I get a headache, at start....But yesterday I was a little bit on the verandah. It was so nice. I was up, I dress myself and then I been there a little bit, about ten minutes. It was **great** (said with emphasis). That's the way I feel, I can go out."

Likewise, Claire described similar feelings on one of her first outings with Albert. She said she had been "fed up, locked up in the house".

Claire: "Oh, and one night, Saturday night, he took me for dinner (voice, tone sounds excited, face is smiling, appears happier).....I was so afraid. I was like that eh, when I came out. (shows me how her fists were clenched) We left here around 6:30 "Oh, oh, Albert, I'm so afraid". (voice has tone of fear). "Oh, no" (said in a calm voice imitating Albert). ...So uh, we took my car and we went to dinner and we talked, talked, talked. **Gee my gosh. I felt so good** (said with emphasis) you know. That's all I need, change. Get out."

The participant's ability to socialize was linked to feelings of well being and emotional improvement and was used as a marker for their return to a sense of normalcy. Sophie was looking forward to a busy social calendar of Christmas dinners and card games. When asked what getting out and meeting people socially meant to her she commented, " Well, it makes me feel

better, because I like to talk to people". The following illustration highlights the importance of social interactions to Marie. What was also significant in Marie's case, was that although she had severe mobility limitations due to her arthritis (uses motorized wheelchair for transportation), she continued to actively seek social involvement. The following was Marie's description of her busy social calendar. She had been unable to participate in several social events due to medical appointments.

Marie: " But this coming Monday, I'm hoping to go play cards on Monday. It's a small group there, but ah, it's nice. I like the people. I like the people. I like talking to people. So uhm, I'll try to make it Monday. This week I was too busy.....But I hope to start next Monday. Sunday, I have to call for my bus, for Monday. Sometimes it takes me there late, but it doesn't matter. I still go out. And then on Thursday, next week, those two dates I have for next week, Monday and Thursday. That'd be the Christmas one on Thursday. Christmas dinner. So well, anyway, you can plan, but maybe the plans won't go. You don't know. But ah, you can't go by that. You have to try..."

These findings are consistent with others who have noted the importance of social interactions (Clark et al., 1994) as a major influence on how older women manage with heart disease. In addition, Ryff, (1989) utilized life span development to explore dimensions of well being in older adults (mean age 74.9) and concluded that the interpersonal dimension has meaning for woman and is paramount to their having a positive affect. As well, Statistic's Canada (1994) highlights the fact that seniors spend a considerable part of their day socializing. These findings provide rationale for these participants' emotional responses to being socially limited during their convalescence and the

heightened sense of positive mood they described on being able to subsequently socialize.

4.5 Conclusions

The findings of this study were consistent with what is already documented with respect to women of all age categories recovering from a cardiac event. For instance, most women appeared to experience great emotional difficulty with role re-definition following an acute MI due to the activity restrictions placed on them. They continued to "bend the rules" in order to meet their own and household responsibilities. Support was provided by family and a network of friends but was lacking in certain key home management duties, like laundry and vacuuming. Spirituality appeared to play a role in recovery as some of these women tried to make sense of their MI. Demographics were similar to national trends in women 65 years and older, in that most lived alone and had several chronic illnesses.

However, the current study differs from earlier works as the focus pertained to the unique needs of older clients. The present study participants shared insights that helped to form a distinct picture of who they were as individuals and why they responded as they did to their MI.

Older women underestimated their susceptibility to having MI's. They continued to hold onto the stereotypical male presentation of chest pain and seem shocked and surprised by their diagnosis. They continued to be unaware of the hereditary

nature of heart disease and the relationship of co-morbid factors like diabetes and hypertension as risk factors.

These older women were avid planners and began coordinating their plans for discharge soon after they were admitted. In addition, they planned and implemented strategies for self-intervention as soon as they arrived home. These characteristics of older women need to be considered when planning interventions for discharge.

For many older women, the loss of the homemaker role, due to activity restrictions, whether as a result of medical therapy or due to lack of functional capacity, led to several emotional responses. Requesting that they restrict their activities proved particularly difficult for these older women who had been socialized to the role of the "homemaker". Restriction of this role was tantamount to losing a job which led to feelings of frustration, boredom and diminishment as a person. Essentially, their ability to personally perform household duties was inextricably linked to their feelings of self worth. These women needed to be informed of the usual emotional and physical responses experienced by older women after a MI so that they could better evaluate their progress.

Furthermore, this study supported the reality that many women lacked support to perform daily household duties such as laundry, vacuuming and dusting and continued to complete these duties outside the expected activity restrictions. Many of these women did not wish to ask others for help. In effect, discharging older women home with the expectation that they will strictly

follow activity rules in relation to household management appears unrealistic. In households where women live alone and must assume total responsibility for performing these functions, there is simply no one but themselves who can complete these tasks. In addition, the assumption that a partner or husband will assist them in these household duties is equally fraught with challenges. Spouses or partners of older women have also been socialized to roles in which they lack knowledge and skills to perform household duties such as ironing and laundry. Consequently, they require mentoring by the spouse or partner which creates its own stress. Indeed, several participants were unable to limit their activities for these reasons.

Study findings suggested that women who experienced fewer symptoms described more feelings of frustration and uncertainty with regard to their inability to resume normal activities and were more likely to 'cheat' in relation to activity and diet.

Participants in this study were highly supported by family, friends and health care providers. However, timing, amount and certain aspects of informational and tangible support did not always meet the early convalescent needs of older women. For example, tangible support for certain domestic tasks, like laundry and ironing was unavailable to some of the participants. As well, informational support was less than satisfactory with respect to illustrations depicting the type, degree and location of heart damage. Minimal informational support was available to alleviate the stress and uncertainty these women experienced

while awaiting answers to questions about their progress from their physicians at the 4-6 week follow-up appointment.

Older women deferred to their physician regarding their ability to move forward in their lives. Of interest however, is that the two participants who especially raised the need to ask several questions of their physicians, subsequently informed the researcher during the confirmation interview that, in fact, they had not spoken to their physicians with their concerns because they appeared too busy to bother with what these women now believed were inconsequential questions. These findings support the need for further research to clarify the process of interaction between older women and health care providers.

Older women's ability to socialize was key to feeling a sense of improved emotional state and overall sense of well being. Limitations post discharge led to 'feeling restricted' and frustrated. Increasing women's awareness of the normality of these feelings may serve to reduce stress in the recovery period.

Participants with concomitant illnesses described more symptoms and a more complicated recovery trajectory. However, they focused their illness perceptions, including symptom reporting, on the current illness. Rosenberg and Moore (1997) report that seniors accept certain limitations and chronic illnesses as part of the aging process. In addition, persons living with chronic illness can become "normalized" to the chronic illness in what Wellard(1998) describes as a different set of acceptable norms for the chronic illness state. How

individuals manage acute episodes with concomitant chronic illnesses remains an area for further research.

Noteworthy in this study's findings, was the participants' lack of discussion regarding rehabilitation programs. Of the seven women interviewed, two had been referred for rehabilitation and of these two, one spoke of attending while the other remained non-committal. However, the informants spoke of a variety of activity interventions they personally implemented such as walking within their apartments. This study raised several concerns and questions regarding older women and rehabilitation programs. Others have examined older women's referral and compliance with cardiac rehabilitation programs and discovered that older women have fewer referrals than elderly men and that as the age of women increases, the compliance with attendance decreases (Ginzel, 1996). Conceivably, women in the present study were not knowledgeable regarding rehabilitation programs due to lack of information from their physicians or other health care personnel and therefore did not mention the topic. Alternatively, these women perhaps, did not perceive rehabilitation as valuable nor a priority and thus did not discuss the topic with the researcher. Physicians were possibly ill informed regarding older person's ability to participate in rehabilitation programs. For instance, the two participants' with concomitant illnesses may not have been referred to a rehabilitation program, as their functional ability may have been thought to preclude their participation. If this was indeed the rationale for exclusion, then physician education is warranted to

highlight the success of home based and "gero-fit" programs for seniors, especially those with co-morbid illnesses, in maintaining functional ability (Miller, Warren, & Myers, 1996; Morey, Crowley, Robbins, Cowper & Sullivan, 1994; Wenger, 1994). Further research is required to elucidate older women's self-perceived needs regarding rehabilitation, particularly prior to spending scarce health care dollars in the establishment of programs targeted at older women.

The researcher found the 2 week post discharge interview difficult to coordinate. Only 2 informants were interviewed within this time frame. The two participants with co-morbid chronic illnesses were re-hospitalized within one week of discharge. One participant postponed the interview on three occasions, citing fatigue and finally, one informant convalesced with her son for the first two weeks and wished to be interviewed at home. These findings highlight that the two-week convalescent period was an emotionally and physically vulnerable time for older women as they managed their home responsibilities while struggling with the uncertainty of their progress in relation to their new diagnosis. In addition, the re-hospitalization of older women with chronic illnesses points to the need for closer monitoring by health care personnel in the first two weeks post discharge.

Finally, the confirmation interviews conducted with participants at 6-11 months post MI were noteworthy. Anne had experienced a minor cerebral vascular accident (CVA) within 3 months of the MI and at 5 months required a permanent pacemaker

implant for heart rhythm disturbances. These findings are in keeping with the problematic morbidity trajectory of older women post MI (Becker et al., 1994). Anne, at the time of the original interview, had shared great uncertainty regarding her activity restrictions due to lack of symptoms from the MI and a belief that her MI was "just a mild attack". At the 6 month post MI confirmation interview, she appeared to be more apprehensive about what the future would hold. She had stopped her participation in the social club stating her ill health had restricted her ability to attend.

Sophie was interviewed 6 months post MI. She claimed her diabetes was causing problems and contributing to her feeling weak and fatigued. She cried throughout the follow-up interview especially when discussing loss of person-hood. She felt this aspect of her recovery post MI had the most impact, as her inability to perform duties like housework and to socialize left her feeling "diminished as a person". She lamented her lack of ability to attend social events at the local arts community center and cited poor health and few network resources, such as persons to accompany her, as reasons. She also shared that the friend who had been a great support throughout the first few months had been unavailable lately to help as she had felt burdened by Sophie's need for assistance. The loss of her friendship appeared to have touched Sophie deeply and the researcher was left wondering how Sophie would manage in the months ahead as lack of care giving assistance has been noted previously as a contributor to increased mortality in older women

post MI (Young & Kahana, 1993). This finding is significant as it demonstrates how the nature, timing and duration of network support can alter a person's perception of adjustment and coping at different end points post MI and therefore merits further research to discover differences.

Claire was interviewed 11 months post MI and stated she felt better both mentally and physically. She had stopped smoking and had lost weight and appeared proud of these life style changes. She appeared the "most settled" of all the participants and the most at ease with her adjustment to the MI. The fact that she was interviewed 11 months post MI versus 6 months may have provided the time necessary for her to feel more adjusted.

The variety of responses and issues noted with each of these participants at 6 months to one-year post MI, highlights the need for further research to investigate long term adjustment to MI of older women.

In the final chapter, the implications for nursing will be examined and recommendations will be put forth.

Chapter 5 - Conclusions

This chapter begins with a summary of the findings in relation to the study objectives, followed by implications for nursing practice and the roles of the advanced practice nurse, such as research. It concludes with study limitations.

5.1 Summary

This study set out to discover a better understanding of the experiences of recovery for older women. The four research objectives were as follows:

1. To understand of the experiences of recovery for elder women within the first two weeks after discharge from hospital.
2. To describe how women perceive their recovery from an emotional and physical perspective.
3. To describe how older women's perceptions of recovery affect their health seeking behaviors.
4. To delineate how older women's perceptions of recovery affect participation in health promotion programs.

Although only two women were actually interviewed within the first two weeks after discharge from hospital, all women were interviewed within 5 weeks of discharge and their descriptions of recovery continued to be a tangible and accurate depiction of their lived experiences. The narratives shared by these women point to a mosaic of recovery in which their lives became scattered with the diagnosis of a MI followed by a reassembling

of the pieces as they created a new picture of themselves. They experienced many emotional and physical responses to the diagnosis of MI. The predominant physical response was described as extreme fatigue or tiredness, with resultant emotions of feeling restricted in their own life routines. They also described feeling diminished in their "homemaker role" due to their limited ability to perform certain household responsibilities. They experienced frustration at having to accept a lesser standard of household cleanliness while others took on these responsibilities.

This study queried older women's health seeking behaviors within the timeframe of recovery. They spoke of the many questions they had accumulated within the first weeks at home and sought answers to these from the physician at the 4 to 6 week follow-up appointments. Their many questions pertained to activity restrictions, physical symptoms and the normality of these symptoms in relation to their MI and the degree of damage to their hearts. Their narratives were filled with uncertainty in relation to many of these questions and they greatly anticipated their appointment with the physician as they sought the physician's validation to move forward, or to confirm that their progress was usual and expected. Thus many older women deferred decisions to the physician, although some, as was mentioned earlier, did not ask questions if they perceived the physician was too busy.

This study also set out to delineate how women's perceptions of their recovery might affect their participation in health

promotion programs. The researcher concluded that health promotion campaigns, as they currently exist, do not target, nor do they meet the needs of this older group of women.

5.2. Implications and Recommendations

Although the findings from this study were gathered from a small sample and are therefore deemed non-generalizable by logical positivist standards, they do imply the need for action and further investigation to address the needs of older women post MI. Indeed, Baker, Wuest and Stern (1992) citing Lincoln and Guba (1985), note that in qualitative inquiry, it is not whether the data interpretation can be replicated by consecutive researchers but the extent to which the findings of an inquiry are worth paying attention to. The findings from this study provide valuable insight into many concerns for older women's recovery after an acute MI and suggest that implications and recommendations for nursing practice be forwarded. These will be discussed in the following section.

5.2.1 Health Promotion and Primary Prevention

This study suggests that older women require a health promotion campaign targeted to their specific needs as they persist in underestimating their susceptibility for having MI's. Women in this study continued to hold to the stereotypical male presentation of chest pain, which resulted in delays in seeking medical help. They often appeared shocked and surprised by their

diagnosis and had little knowledge with respect to hereditary and co-morbid illnesses like diabetes and hypertension as risk factors. Although many appeared to have knowledge of healthy life style habits, such as low fat and salt diet and the need to exercise, many were not actively pursuing these choices.

Thus, it is recommended that primary prevention campaigns run by organizations like the Heart and Stroke Foundation, include more detailed descriptions regarding the value of making healthy life choices, the nature of chest pain for women and risk factors for older women. Informational pamphlets should include more specific information in regard to atypical chest pain. Atypical pain descriptions should highlight the specific differences women experience in relation to: precipitating factors (at rest, or during mental stress); nature of the pain (often more gastric in nature, more nausea and vomiting, neck and shoulder pain); and the associated symptoms (more fatigue or dyspnea) (Douglas & Ginsberg, 1996). In addition, subsequent primary prevention advertising campaigns should portray an accurate picture of women having MI's, that is, they are typically 65 to 75 years of age in roles as active and busy homemakers, mothers and grandmothers. Thus, the women most vulnerable and most likely to sustain a MI can relate to these advertisements as they are more likely to recognize a picture of themselves and their reality.

Likewise, advertisers may maximize distribution of health promotion information to the target audience through identification of their lifestyles and habits. For instance, in

the Statistics Canada (1994) report on trends in senior's lifestyles, senior women were found to spend on average 3.2 hours viewing television and much of this viewing time was devoted to drama, news and public affairs broadcasts. Targeting health promotional campaigns to these key time frames may capture the interest of the audience. In addition, promoting primary prevention activities in shopping malls frequented by senior women, in particular, grocery stores, might prove beneficial to heighten their awareness of heart disease.

Also, as older women in this study were found to be very social, as defined by their participation in church groups, card clubs and social clubs, knowledge of the importance of these social interactions to older women may assist with primary prevention and health promotion education. For instance, these social outings might serve as a venue to organize educational programs for this specific group. These events would differ from support groups, which have been suggested (Benson et al., 1997), as they would be more social in nature and offer an educational component. This recommendation is made because women in this study responded negatively when asked about their interest in joining a support group. Indeed, they mentioned they had their own groups with whom they socialized. This differing response may be age related as Benson et al.'s (1997) sample was younger (mean, median age of 61), while women in this study were older (mean 74, median age of 72). Most importantly, it points to the fact that the social context of these women is inextricably linked to what they value and perceive as important. Excluding

what they perceive as important from any interventional strategy may be wasteful of precious health care resources.

5.2.2 Discharge Planning

It is well recognized that discharge planning is key to reducing readmission rates and stress in clients and their families particularly in the gerontological population (Bull & Jervis, 1997; Jackson, 1994). This study suggests that discharge planners in the acute tertiary setting consider the unique profile of not only women with heart disease, but senior women with heart disease. This research revealed that older women are avid planners and coordinators and from the time they are admitted to the acute care center, are planning for their eventual discharge. This fact alone necessitates the inclusion of senior women in the discharge planning process as this inclusion may lessen their feelings of "being restricted" on return home.

It is recommended that a discharge assessment tool be constructed and implemented to highlight the individual needs of older women with heart disease. This discharge tool can serve as a consistent method for information gathering by the nurse and as a communication mechanism for nursing staff, the client and family or friends. The nature and quality of women's support, including emotional, informational and tangible support would be highlighted in this discharge document. An assessment of the social network including family members, the number and location of friends and the quality of the friendships is a necessity as these persons can be integral to women's managing at home. It is

imperative that discharge assessment identify whether these women live alone, as living alone is associated with higher incidence of death (Case et al., 1992; Young & Kahana, 1993) and the increased likelihood of receiving fewer community services than those who have family members who can advocate for better service (Jackson, 1994). In addition, women who are not emotionally supported, have higher mortality rates within 6 months of discharge (Berkman et al., 1992). It is also important to include family members or a key individual in this discharge plan to optimize the transition from hospital to home.

It is recommended that the discharge document cue the nurse to assess the frequency of co-morbid illness, the length of time the client has had this chronic illness and their coping ability with this illness. These factors may predict how well a person will manage at home and may necessitate further follow-up in the transitional period from the hospital to the community. In addition, these individuals may require consistent home care and nursing support. These recommendations are put forward because this study suggests that women with limiting co-morbid illnesses such as angina or heart failure symptoms were re-hospitalized within days of discharge.

Song and Lee (1996) found that a predictive model of functional capacity, that includes factors such as behavior, environment, and personal competence, aids in the planning of nursing interventions. Thus inclusion of a functional and cognitive assessment on the discharge document might assist in determining the requirement for additional home support. As well,

in performing a functional assessment, potential candidates for either home or community based exercise programs can be identified. Rehabilitation programs have been developed for older populations with co-morbid illnesses and certain functional limitations. Inclusion of a physiotherapist in the assessment process would be helpful to direct the patient to the appropriate level of program, should they wish to attend. However, caution is advised with respect to rehabilitation referrals until older women's beliefs regarding rehabilitation are more fully understood. If older women do not value rehabilitation programs or have limited accessibility due to transportation difficulties or lack of available social network support, the likelihood of attendance may be limited. Indeed, development of rehabilitation programs for these older women must include factors relevant to their social context. Further research is needed to validate health care workers' and older women's perceptions of the role of rehabilitation in their recovery process.

Finally, the discharge document could assist older women to better plan for home care support, if its required. For instance, prior to discharge, these senior women could formulate a list of tasks they wish completed thus enabling them to plan and organize for their eventual discharge. This strategy of preparedness may also alleviate a degree of the stress and tiredness felt by the clients when the homemaker arrives seeking instructions.

5.2.3 Educational Needs of Older Woman

The findings from this study suggest that older women for the most part read and re-read their discharge teaching booklet and were generally satisfied with the content of the booklet. They subsequently attempted to follow their activity and diet restrictions and appeared to give great deference to the content of the "book". The study also noted, however, that those women who had few symptoms reported the most uncertainty in relation to these activity restrictions and mentioned the need for supplemental illustrations. Nursing should therefore focus attention on women's need to rest and modify activity even when few symptoms are felt. Perhaps if illustrations depicting the degree of damage to the heart were included in a discharge booklet, women could refer to this picture to validate the existence of the MI and to caution themselves with respect to overexertion with household duties.

Theis and Merritt (1994), in a study investigating the learning styles of elder clients, noted that seniors prefer listening to a presentation supported by visual aids. This fact supports the need to further supplement any in hospital education with visual assistance, especially for older clients who will refer to the material at a later date.

Pre-discharge educational classes require a full discussion of the expected recovery trajectory for women, including the expected emotional responses, such as frustration, boredom, feeling useless as a result of role loss, physical symptoms, and feelings of restriction due to activity limitations. It must be

emphasized that these feelings should pass in time as their bodies heal and as activity restrictions are lifted. In addition, physical responses such as intense fatigue should be outlined and strategies to alleviate it, such as doing tasks in manageable pieces or taking frequent naps, should be encouraged. These facts should be included in a discharge booklet and housed in a section specifically for women.

The booklet should also outline the amount of energy expended with certain household tasks. Women should be encouraged to discuss their plans and strategies regarding household work, with full knowledge that these women will be performing some of the tasks when at home. King and Jensen (1994) noted that telling women not to do housework was counterproductive as housework is central to their self concept. Therefore, women need to plan self-intervention strategies in relation to household duties that may eventually alleviate the feelings of loss of person-hood when at home. Women should also be motivated to share their concerns and questions pre-discharge with other women as this sharing may assist in improved emotional well being and a more informed recovery period. Others have noted that older women prefer to learn in group settings, particularly with peers (Theis & Merritt, 1994). This fact should also be considered when establishing rehabilitation programs for older women.

Spousal and family education should focus on the recovery trajectory with special emphasis on the differences in emotional and physical responses women may experience while at home. In addition, family members or friends should be included in

discharge planning to help develop strategies of support particularly with home duties like ironing, vacuuming, laundry and meals.

5.2.4 Transitional Support

This study suggests that older women have many questions and concerns in their first few weeks at home. These include questions regarding activity progression in relation to symptoms and the extent and location of damage to the heart. They expressed the need to relive the MI experience and to "fill in the blanks" in the sections they could not remember. They sought validation that their progress was normal. They anxiously awaited their follow-up appointment with the physician and appeared stressed and uncertain.

In order to alleviate some of the stress and uncertainty it is recommended that some form of telephone support be made, by either a nurse either in the discharging hospital, or in the community, to answer questions and provide support as needed. This strategy is suggested within 48 hours of discharge particularly to those women with co-morbid illnesses to ensure they have the necessary support and are managing while at home, thereby reducing the potential for re-admissions. Telephone follow-up from a nurse within 2 weeks of discharge could assist those women with pertinent questions regarding exercise and symptoms, thereby alleviating stress while they await their physician's appointment. In cases where the health of the client warrants medical attention, the nurse liaison could access the

appropriate support, thereby reducing the likelihood of misuse of the health care system.

In addition, others (Angus, 1996) have suggested that access to a resource person following discharge is valuable for women. Therefore, 6 month support from a community based nurse might be helpful to ensure women are adjusting appropriately to their MI, in particular those women who had previous limiting chronic illnesses.

5.3 Role of the Advanced Practice Nurse

The study findings have implications for the nurse in an advanced practice role. Hamric, Spross & Hanson (1996) suggest that the advanced practice nurse (APN) can be found in a variety of practice roles and has specific core competencies that define the role. These core competencies include: expert clinical practice; coaching for patients, families and other health care providers; consultation; research skills; leadership abilities; collaboration; change agent skills and decision making skills. Findings from this study suggest that the APN Case Manager (CM) could facilitate recovery post MI for older women. According to Hamric et al. (1996) the APN CM is "accountable for managing a group of clinically complex or resource-intensive patients in order to optimize clinical and cost outcomes" (p.448). These outcomes are achieved through partnering with nurses, patients and their families and the use of coordination, communication and collaborative skills. Ideally, the APN CM in the tertiary setting can function as a central coordinator of care to this select group of women. In the following section, the enactment of this role will be highlighted in relation to the study implications and recommendations.

The APN CM in direct practice has numerous opportunities to impact the provision of care to older women with heart disease. Study results can be shared with nurses and other members of the health care team to facilitate their appreciation of older women's perceptions of their recovery trajectory and the problems

they encounter. Thus, health care members may proactively plan for discharge and subsequently identify those women at risk for readmission. In addition, the APN CM can advocate for older women through change in the process of discharge planning and education. Priority should be given to the fact that these older women are avid planners and may benefit from inclusion in discharge planning. The APN CM can assist in the development of a discharge assessment tool with special attention to such factors as support issues, living alone, functional and cognitive ability of the client and the existence of concomitant illnesses.

In the CM position, the APN can assist nurses to identify those clients with multi-factorial problems and to seek interventions for problem resolution. The APN CM can perform the assessment of cognitive and functional capacity to identify clients with limitations and subsequently plan and coordinate appropriate consults to the various health team members such as social work and physiotherapy. From these assessments, it is possible to proactively lobby for referral to rehabilitation programs or specialized exercise. They may communicate with the client and family members to ascertain challenges specific to home support and, with their input, plan appropriate interventions. As key contact persons with whom the client, family members, or community nurse can impart problems while in the home environment, they can ameliorate the client's transition from the hospital to the community. Furthermore, they can assist to develop and implement a telephone support protocol to be used

for both informational and emotional support to the client when at home.

The findings can be amalgamated into the educational content of a discharge class and booklet with attention given to the unique needs of older women's recovery. The APN CM may also ensure the educational content of classes and booklets are reflective of senior's learning style preferences and needs. In particular, the educational content can include reference to the loss of homemaker role, loss of person-hood and the varied emotional and physical responses these women may anticipate when at home. The APN CM may coach these women in energy conservation strategies and in the planning of self-interventions in relation to housework. They may also guide these women with respect to healthy life style choices in relation to diet and the benefits of exercise. Rehabilitation programs can be promoted to both clients and physicians alike and encouraged based on individual ability and most importantly, willingness to attend. In addition, the APN CM can educate the nursing and allied health community at large through publication of these findings and in sharing these results at local, national and international conferences.

The study findings hold implications for the APN CM through consultation. These findings suggest that the APN CM in the acute care setting can consult to inter-hospital multidisciplinary health care teams to advocate for and implement change in health care practices with older women, particularly as they relate to rehabilitation referral, biases with functional ability and discharge planning. Likewise, they can consult with

both publicly and privately funded community based organizations in the development of health promotion and primary prevention policies that benefit older women. For instance, they can lobby for change to information provided in fund raising brochures developed by the Heart and Stroke Foundation. The ANP CM may also use their leadership skills to lobby inter-sectarian government agencies with the intent to profile the unique needs of elder women with heart disease. They may consult to the Regional Municipality of Ottawa Carleton Public Health Department to suggest alternative methods to target educational programs for this client group. In addition, they can consult with community based nursing organizations like the VON to educate nurses with respect to older women's recovery needs and collaborate in developing interventions that aid older women in the transition from hospital to home. They may become involved in transitional care committees with representation from both tertiary and community facilities organized to develop standards for discharge planning.

The APN CM can facilitate research with women and heart disease through joint involvement at local and national levels and in a variety of acute care and community settings. They can motivate nurses in general to consider everyday nursing practices that have excluded gender and age as variables.

They can advocate for studies with women as participants that differentiate the health promotion needs and illness trajectories in these client groups both in acute care settings and the community. They can conduct further research to

distinguish the impact of age, gender and social context on women's recovery post-cardiac event. For instance, they may question how older women compare to younger women with respect to type and degree of emotional distress or physical symptoms. They may compare or contrast the nature, timing and duration of support systems (including informational, tangible and emotional) between women or men of differing ages who live alone versus those with family, to determine how these differing variables affect their recovery process post cardiac event.

Additionally, they may focus research towards the impact of spousal support on stress in older and younger women in relation to coronary heart disease. They may explore the impact of several co-morbid illnesses with the addition of an acute illness on older women's recovery pattern, specifically, to identify how older women cope with an added stressor.

The APN CM is in an advantageous position to pursue research to identify older women's beliefs regarding the value of and willingness to attend rehabilitation programs. They may also wish to explore the physician's perception's and role in referral to rehabilitation programs. In addition, they may investigate the process of interactions between older women and health care providers both in the acute care setting and in the community as little is documented in this area (Angus, 1996).

Furthermore, they may wish to research the utility of telephone follow-up support for older women, particularly in regard to reducing readmission rate and in understanding their needs and concerns as they impact health care costs and the

utilization of health care resources following discharge. They may investigate older women's long term adjustment to a MI at differing endpoints using a variety of measurement variables. Most importantly, they may conduct research to identify self-perceived needs of older women, to develop interventional strategies that reflect these older women's values and beliefs.

5.4 Study Limitations

The study has several limitations. First, the majority of women who participated in this study were white, English speaking and middle class and therefore do not necessarily represent women with first time MI over 65 years of age in the general population. Three participants spoke English as their second language and as such, the researcher may have misunderstood certain nuances of the language.

The study results are further limited due to sample size. The sample size, in keeping with qualitative research methods, is small and therefore precludes the generalizability of these results. In addition, the sample was obtained from one major cardiac referral center with a credible and well established cardiac program. Thus this sample may not be representative of other health care facilities in smaller or rural settings, in terms of education and support resources provided to this population of older women.

A further limitation lies in the extent to which the researcher employed Heideggerian hermeneutic methodology. As a novice researcher, the depth and breadth of the analysis may be wanting as the researcher struggled simultaneously with learning a new research method and conducting research. Thus, this study is bound by these methodological limitations.

5.5 Ending

As was stated previously in Chapter 3, the use of phenomenological method may result in a 'catharsis' or a 'healing' and may lead to the empowerment of the researcher through an increased awareness of new meanings in the phenomena of interest (Sorrell & Redmond, 1995). Indeed, the use of phenomenology has affected me both professionally and personally. It has provided me with valuable insight into the daily lives of these women and to view first hand, their challenges and their strengths. It has privileged me to "know" these women as I had never "known" them before and has shaped how I will view older women in the future. From a personal perspective, the process of conducting phenomenological research left me at times feeling "out of control" and "vulnerable", particularly in relation to the unstructured interviewing process. On the other hand, the use of hermeneutic analysis was a particularly gratifying experience from which I derived great creative satisfaction. Overall, the use of phenomenology as a research method was a wonderfully empowering experience, leaving me to feel confident and proud of my accomplishment and with a heightened sense of urgency to assist older women to "take care of themselves".

Lastly, as this journey of discovery draws to a close I would like to share with each reader a story extended to me by Dianne Oost (1999). She too experienced a MI. However, the MI occurred while she was in her early 40's. She spoke to me of how

she was a woman exceeding her limits through multiple roles, in a fast paced world. She compares to many of us as we endeavor to succeed in our worlds. Dianne wrote this narrative as a part of her personal journey in healing from a heart attack. May her message have meaning for you.

Last night I had a curious dream. Rarely do I remember my dreams with any clarity- rarer still that I carry the memory of it around long after having stumbled from my warm bed into the cold reality of the waiting day.

So simple a dream, yet something about it struck me and stayed. I couldn't help sharing it with my husband at breakfast that morning....
"I was watching a man setting-out chairs in a large room, as if in preparation for a meeting or a show. He very slowly walked across the room to where he wanted it placed...why didn't he carry more chairs at one time, why didn't he move faster, I wondered-but just then I woke up."

As we said good bye to each other at the door that morning. "have a nice day" my husband said cheerfully. " I'll try, but I've got a thousand things to do" I replied. "Remember, one chair at a time. eh." he chided, as he got into the car.

Turning to walk back into the house. I thought- that's right! yes, this is a wonderful day, and I'm going to take my time and enjoy it. After all, I'm one of the lucky ones. I've been given a second chance- and it's great to be alive!

The End

Reference List

Anderson, J.M.(1991). Reflexivity in fieldwork: Toward a feminist epistemology. IMAGE: Journal of Nursing Scholarship, 23(32), 115-118..

Angus, J.(1996). Women and recovery from myocardial infarction and coronary bypass surgery part II: A review of the cardiovascular literature. Canadian Journal of Cardiovascular Nursing, 7(4), 15-22.

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. Journal of Advanced Nursing, 23, 705-713.

Ashton, K.C. (1997). Perceived learning needs of men and women after myocardial infarction. Journal of Cardiovascular Nursing, 12(1), 93-100.

Artinian, N., & Duggan, C. (1995). Sex differences in patient recovery patterns after coronary artery bypass surgery. Heart & Lung, 24(6), 483-494.

Ayanian, J.Z., & Epstein, A.M. (1991). Differences in the use of procedures between women and men hospitalized for coronary heart disease. The New England Journal of Medicine, 325(4), 221-225.

Baker, C., Wuest, J. & Stern, P.N. (1992). Method slurring: The grounded theory/phenomenology example. Journal of Advanced Nursing, 17, 1355-1360.

Beach, E., Maloney, B., Plocica, A., Sherry, S., Weaver, M., Luthringer, L. & Utz, S. (1992). The spouse: A factor in

recovery after acute myocardial infarction. Heart & Lung, 21(1), 30-38.

Becker, R.C., Terrin, M., Ross, R., Knatterud, G.L., Desvigne-Nickens, P., Gore, J.M., & Braunwald, E. (1994). Comparison of clinical outcomes for women and men after acute myocardial infarction. Annals of Internal Medicine, 120(8), 638-645.

Beery, T.A. (1995). Gender bias and the diagnosis and treatment of coronary artery disease. Heart & Lung, 24(6), 427-435.

Benner, P.(1994). Introduction. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring, and ethics in health and illness (pp.xiii-xxvii). Thousand Oaks, CA: SAGE Publications, Inc.

Bennett, S. (1992). Perceived threats of individuals recovering from myocardial infarction. Heart & Lung, 21(4), 322-326.

Bennett, S.J.(1993). Relationships among selected antecedent variables and coping effectiveness in myocardial infarction patients. Research in Nursing & Health, 16, 131-139.

Benson, G., Arthur, H. & Rideout, E. (1997). Women and heart attack: A study of women's experiences. Canadian Journal of Cardiovascular Nursing, 8(3), 16-23.

Berkman L.F. & Breslow, L. (1983). Social networks and mortality risk. In L.F. Berkman & L. Breslow (Eds.), Health and ways of living: The Alameda county study (pp113-160). New York: Oxford University Press.

Berkman, L. F., Leo-Summers, L. & Horwitz, R.I. (1992). Emotional support and survival after myocardial infarction: A prospective, population-based study of the elderly. Annals of Internal Medicine, 117, 1003-1009.

Bickell, N. A., Pieper, K.S., Lee, K. L., Mark, D.B., Glower, D.D., Pryor, D.B. & Califf, R.M. (1992). Referral patterns for coronary artery disease treatment: Gender bias or good clinical judgment? Annals of Internal Medicine, 116, 791-797.

Blair, S.N., Kohl, W.W.III, Paffenberger, R.S. Jr., Clark, D.G., Cooper, K.H. & Gibbons, L.W. (1989). Physical fitness and all cause mortality: A prospective study of healthy men and women. Journal of American Medical Association, 262, 2395-2401.

Boogaard, M.A.K. (1984). Rehabilitation of the female patient after myocardial infarction. Nursing Clinics of North America, 19(3), 433-440.

Boyd, O.C. (1993). Phenomenology: the method. In P.L. Munhall, & C. Oiler Boyd (Eds.), Nursing research: A qualitative perspective, (pp.99-132). New York: National League for Nursing Press.

Bramwell, L.(1986). Wives' experiences in the support role after husbands' first myocardial infarction. Heart & Lung, 15(6), 578-584.

Buja, L.M. & McAllister, H.A. (1995). Anatomic abnormalities. In J.T. Willerson & J.N. Cohn (Eds.), Cardiovascular Medicine, (pp. 324-326). New York: Churchill Livingstone.

Bull, M.J. & Jervis, L.L. (1997). Strategies used by chronically ill older women and their caregiving daughters in managing post hospital care. Journal of Advanced Nursing, 25, 541-547.

Campbell, J.C. & Bunting, S. (1991). Voices and paradigms: Perspectives on critical and feminist theory in nursing. Advances in Nursing Science, 13(3), 1-15.

Canadian Study of Health and Aging Working Group. (1994). Canadian study of health and aging: Study methods and prevalence of dementia. Canadian Medical Association Journal, 150(6), 899-913.

Case, R.B., Moss, A.J., Case, N., McDermott, M. & Eberly, S. (1992). Living alone after myocardial infarction. Journal of the American Medical Association, 267(4), 515-519.

Chafe, W. H. (1972). The debate on woman's place. In W.H. Chafe (Ed.), The American woman: Her changing social, economic, and political roles, 1920-1970, (pp.199-225). New York: Oxford University Press.

Clark, N. M., Janz, N. K., Dodge, J. A. & Garrity, C.R. (1994). Managing heart disease: A study of the experiences of older women. Journal of American Women's Association, 49(6), 202-206.

Colaizzi, P.P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), Existential-phenomenological alternatives for psychology (pp.48-71). New York: Oxford University Press.

Conn, V.S., Taylor, S.G. & Abele, P.B. (1991). Myocardial infarction survivors: Age and gender differences in physical

health, psychosocial state and regimen adherence. Journal of Advanced Nursing, 16,1036-1034.

DeVault, M. L. (1990). Talking and listening from women's standpoint: Feminist strategies for interviewing and analysis. Social Problems, 37(1), 96-116.

DeVault, M.L. (1991). Feeding the Family: The Social Organization of Caring as Gendered Work. Chicago: The University of Chicago Press.

Dhooper, S. (1984). Social networks and support during the crisis of heart attack. Health Social Work, 9, 294-303.

Dishman, M. (1994). Motivating older adults to exercise. Southern Medical Journal, 87(5), s79-s82.

Douglas, P. & Ginsburg, G.S. (1996). The evaluation of chest pain in women. The New England Journal of Medicine, 334(20, 1311-1315.

Dracup, K., Meleis, A., Baker, K. & Edlefsen, P. (1984). Family focused cardiac rehabilitation: A role supplementation program for cardiac patients and spouses. Nursing Clinics of North America, 19(1), 113-124.

Dracup, K., Moser, D.K., Eisenberg, M., Meischke, H., Alonzo, A.A. & Braslow, A. (1995). Causes of delay in seeking treatment in heart attack victims. Social Science Medicine, 40(3), 379-392.

Eaker, E.D., Packard, B. & Thom, T.J. (1989). Epidemiology and risk factors for coronary heart disease in women. Cardiovascular Clinics, 19(3), 129-145.

Flavel, C.M. (1994). Women and coronary artery disease. Progress in Cardiovascular Nursing, 9(4), 18-27.

Fleury, J., Kimbrell, L.C. & Kruszewski, M.(1995). Life after a cardiac event: Women's experience in healing. Heart & Lung, 24(6), 474-482.

Fleury, J. & Cameron-Go, K. (1997). Women's rehabilitation and recovery. Critical Care Clinics of North America, 9(4), 577-587.

Fried, J.P.& Becker, D.M. (1993). Smoking and cardiovascular disease. In P. S. Douglas, (Ed.), Cardiovascular Health and Disease in Women. (pp. 217-30). Philadelphia: W.B. Saunders.

Friedman, M.M. (1993). Stressors and perceived stress in older women with heart disease. Cardiovascular Nursing, 29(4), 25-29.

Gilligan, C. (1982). In a different voice: Psychological theory and women's development. Cambridge,MA: Harvard University Press.

Ginzel A.R. (1996). Women's compliance with cardiac rehabilitation programs. Progress Cardiovascular Nursing, 11(1), 30-35.

Gilliss, C.L., Gortner, S.R., Hauck, W.W., Shinn, J.A., Sparacino, P.A. & Tompkins, C.(1993). A randomized clinical trial of nursing care for recovery from cardiac surgery. Heart & Lung, 22(2), 125-133.

Greenwood, D., Packham, C., Muir, K & Madeley, R.(1995). How do economic status and social support influence survival

after initial recovery from acute myocardial infarction? Social Science Medicine, 40(5), 639-647.

Gulanick, M. (1991). Is phase 2 cardiac rehabilitation necessary for early recovery of patients with cardiac disease? A randomized, controlled study. Heart & Lung, 20(1), 9-15.

Gullickson, C. (1993). My death nearing it's future: A Heideggerian hermeneutical analysis of the lived experience of persons with chronic illness. Journal of Advanced Nursing, 18, 1386-1392.

Gurwitz, J.H., Col, N.F. & Avorn, J. (1992). The exclusion of the elderly and women from clinical trials in acute myocardial infarction. Journal of the American Medical Association, 268, 1417-1422.

Hamilton, G.A., & Seidman, R.N. (1993). A comparison of the recovery period for women and men after an acute myocardial infarction. Heart & Lung, 22(4), 308-315.

Hamric, A.B., Spross, J.A. & Hanson, C.M. (1996). Advanced nursing practice: An integrative approach. Philadelphia: W.B. Saunders Company.

Hawthorne, M.H. (1994). Gender differences in recovery after coronary artery surgery. IMAGE: Journal of Nursing Scholarship, 26(1), 75-80.

Healy, B. (1991). The yentl syndrome. The New England Journal of Medicine, 325(4), 274-275.

Heart and Stroke Facts. Dallas: American Heart Association, 1992.

Heart and Stroke Facts. Ottawa: Heart and Stroke Foundation of Canada, 1997.

Hedin, B.A. & Duffy, M.E. (1991). Researching: Designing research from a feminist perspective. In R.M. Neil & R. Watts, (Eds.), Caring and nursing: Exploration in feminist perspectives (pp.227-235). New York: National League for Nursing.

Heidegger, M. (1992). The concept of time. Oxford: Blackwell Publishers.

Hilbert, G.A. (1993). Family satisfaction and affect of men and their wives after myocardial infarction. Heart & Lung, 22(3), 200-205.

Hochschild, A. (1989). The Second Shift. New York: Avon Publishing Company.

House, J.S. & Kahn, R.L. (1985). Measures and concepts of social support. In S. Cohen and S.L. Syme (Eds.), Social support and health (pp.83-106). Toronto: Academic Press.

Jackson, M.F. (1994). Discharge planning: Issues and challenges for gerontological nursing. A critique of the literature. Journal of Advanced Nursing, 19, 492-502.

Jacobsen, B.S., Lowrey, B.J. & McCauley, K. (1992). Why me? Causal thinking, affect, and expectations in myocardial infarction patients. Journal of Cardiovascular Nursing, 6(2), 57-65.

Jacobson, D.E. (1986). Types and timing of social support. Journal of Health and Social Behavior, 27, 250-264.

Janesick, V.J. (1996). The dance of qualitative research design. In N.K. Denzin and Y. S. Lincoln (Eds.), Handbook of

Qualitative Research(pp. 209-219). Thousand Oaks, CA: SAGE Publications.

Jasper, M.A. (1994). Issues in phenomenology for researchers in nursing. Journal of Advanced Nursing, 19, 309-314.

Johnson, J.L. (1991). Learning to live again: The process of adjustment following a heart attack. In J.M. Morse & J.L.Johnson (Eds.), The illness experience: Dimensions in Suffering(pp13-88). London: SAGE Publications.

Johnson, J.L. & Morse, J.M. (1990). Regaining control: The process of readjustment after a myocardial infarction. Heart & Lung, 19(2), 126-135.

Kahn, S.S., Nessim, S., Gray, R., Czer, L.S., Chaux, A. & Matloff, J. (1990). Increased mortality in coronary artery bypass surgery: Evidence in referral bias. Annals of Internal Medicine, 112, 561-567.

King, K.M. & Gortner, S.R. (1996). Women's short-term recovery from cardiac surgery. Progress in Cardiovascular Nursing,11(2), 5-15.

King, K.M. & Jenson, L. (1994). Preserving the self: Women having cardiac surgery. Heart & Lung, 23(2), 99-105.

Kirby, S. & McKenna, K. (1989). Experience, research, social change: Methods from the margins. Toronto: Garamond Press.

Koch, T. (1994). Establishing rigor in qualitative research: The decision trail. Journal of Advanced Nursing, 19, 976-986.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. Journal of Advanced Nursing, 21, 827-836.

Kvale, S. (1996). Interviews: An introduction to qualitative research interviewing. Thousand Oaks, CA: SAGE Publications.

LaCharity, L.A. (1997). The experiences of postmenopausal women with coronary artery disease. Western Journal of Nursing Research, 19(5), 583-607.

Lazarus, R.S. & Folkman, S. (1984). Stress, appraisal and coping. New York: Springer Publishing Company.

Leonard, V. W. (1994). A Heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring, and ethics in health/ illness (pp. 43-63). Thousand Oaks, CA: SAGE Publications, Inc.

Lerner, D.B. & Kannel, W.B. (1986). Patterns of coronary heart disease morbidity and mortality in the sexes: A 26 year follow-up of the Framingham population. American Heart Journal, 111, 383-390.

Lincoln, Y.S., & Guba, E.G. (1985). Designing a naturalistic inquiry. In Y.S. Lincoln & E.G. Guba (Eds.), Naturalistic Inquiry (pp. 221-249). London: SAGE Publications, Inc.

Luxton, M. (1986). Two hands for the clock: Changing patterns in the gendered division of labour in the home. In M. Luxton & H. Rosenberg (Eds.), Through the kitchen window: The

politics of home and family (pp.9-36). Toronto, CAN: Garamond Press.

MacKenzie, G. (1993). Role patterns and emotional responses of women with ischemic heart disease 4 to 6 weeks after discharge from hospital. Canadian Journal of Cardiovascular Nursing, 4(2), 9-15.

MacPherson, K. (1992). Cardiovascular disease in women and noncontraceptive use of hormones: A feminist analysis. Advances in Nursing Science, 14(4), 34-49.

MacPherson, K.I. (1983). Feminist methods: A new paradigm for nursing research. Advances In Nursing Science, 5(2), 17-24.

Manson, J.E., Colditz, G.A. & Stampfer, M.J. (1991). A prospective study of maturity-onset diabetes mellitus and risk of coronary heart disease and stroke in women. Archives of Internal Medicine, 151, 1141-1147.

Markle-Reid, M.F. (1989). Social support and perception of illness in the early discharge phase for the MI patient. Canadian Journal of Cardiovascular Nursing, 1(2) 9-18.

McLaughlin, T.J., Soumerai, S.B., Williamson, D.J., Gurwitz, J.H., Borbas, C., Guadagnoli, E., McLaughlin, B., Morris, N., Cheng, S.C., Hauptman, P.J., Antman, E., Casey, L., Asinger, R. & Gobel, F. (1996). Adherence to national guidelines for drug treatment of suspected acute myocardial infarction: Evidence for the undertreatment in women and the elderly. Archives of Internal Medicine, 156, 799-805.

Miller, N.H., Warren, D. & Myers, D. (1996). Home-based cardiac rehabilitation and lifestyle modification: The MULTIFIT model. Journal of Cardiovascular Nursing, 11(1), 76-87.

Morey, M.C., Crowley, G.M., Robbins, M.S., Cowper, P.A. & Sullivan, R. J. (1994). The gerofit program: A VA innovation. Southern Medical Journal, 87(5), s83-s87.

Morse, J. M. (1989). Strategies for sampling. In J.M. Morse (Ed.), Qualitative nursing research: A contemporary dialogue (pp.127-145). Newbury Park, CA: SAGE Publications, Ltd.

Morse, J. M. (1994). Designing funded qualitative research. In N.K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (pp. 220-235). Thousand Oaks, CA: SAGE Publications, Inc.

Morse, J.M., & Field, P.A. (1995a). An overview of qualitative methods. In D.S. Foster & G. Dickens (Eds.), Qualitative research methods for health professionals (pp.21-41). Thousand Oaks, CA: SAGE Publications, Inc.

Morse, J.M., & Field, P.A. (1995b). Principles of data collection. In D.S. Foster & G. Dickens (Eds.), Qualitative research methods for health professionals (pp. 89-124). Thousand Oaks, CA: SAGE Publications, Inc.

Moser, D.K. & Dracup, K. (1995). Psychosocial recovery from a cardiac event: The perceived influence of control. Heart & Lung, 24(4), 273-280.

Murphy, J.F., & Hepworth, J.T. (1996). Age and gender differences in health services utilization. Research in Nursing & Health, 19, 323-329.

Nelms, T.P. (1996). Living a caring presence in nursing: a Heideggerian hermeneutical analysis. Journal of Advanced Nursing, 24, 368-374.

Nyamathi, A., Jacoby, A., Constancia, P & Ruvevich, S. (1992). Coping and adjustment of spouses of critically ill patients with cardiac disease. Heart & Lung, 21(2), 160-166.

Oakley, A. (1974). The Sociology of Housework. Bath, England: Martin Robinson.

Olesen, V. (1994). Feminisms and models of qualitative research. In N.K. Denzin & Y. S. Lincoln (Eds.), Handbook of Qualitative Research (pp.158-174). Thousand Oaks, CA: SAGE Publications.

Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5, 49-63.

Opie, A. (1992). Qualitative research, appropriation of the 'other' and empowerment. Feminist Review, 40, 56-64.

Parkes, C.M. (1982). Role of support systems in loss and psychosocial transitions. In H.C. Schulberg & M. Killilea (Eds.,) The modern practice of community mental health (pp. 215-229). San Francisco: Jossey-Bass.

Plager, K.A. (1994). Hermeneutic phenomenology: A methodology for family health and health promotion study in nursing. In P. Benner (Ed.), Interpretive phenomenology: Embodiment, caring, and ethics in health/ illness (pp. 65-83). Thousand Oaks, CA: SAGE Publications, Inc.

Polit D.F., & Hungler, B.P. (1995). Experimental, quasi-experimental, and nonexperimental designs. In M. Belcher & S.P.

Jirsa (Eds.), Nursing research: Principles and methods (pp. 157-186). Philadelphia: J.B. Lippincott Company.

Prentice, A., Bourne, P., Cuthbert Brandt, G., Light, B., Mitchinson, W. & Black, N. (1996). Canadian women: A history. Toronto, Ont: Harcourt Brace & Company, Ltd.

Primomo, J., Yates, B.C. & Woods, N.F. (1990). Social support for women during chronic illness: The relationship among sources and types to adjustment. Nursing Research & Health, 13, 153-161.

Rankin, S.H. (1988). Gender, age, and caregiving as mediators of cardiovascular illness and recovery. Unpublished doctoral dissertation, University of California, San Francisco.

Rankin, S. H. (1992). Psychosocial adjustments of coronary artery disease patients and their spouses: Nursing implications. Nursing Clinics of North America, 27(1), 271-284.

Rich-Edwards, J.W., Manson, J.E., Hennekens, C.H. & Buring, J.E. (1996). The primary prevention of heart disease in women. The New England Journal of Medicine, 332(26), 1758-1766.

Riegel, B.J. & Dracup, K.A. (1992). Does overprotection cause cardiac invalidism after acute myocardial infarction? Heart & Lung, 21(6), 529-535.

Riegel, B. & Gocka, I. (1995). Gender differences in adjustment to acute MI. Heart & Lung, 24(6), 457-466.

Romeo, K.C. (1995). The female heart: Physiological aspects of cardiovascular disease in women. Dimensions of Critical Care Nursing, 14(4), 170-177.

Rosenberg, M.W. & Moore, E.G. (1997). The health status of Canada's elderly population: Current status and future implications. Canadian Medical Association Journal, 157(8), 1025-1032.

Ryff, C.D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personality and Social Psychology, 57(6), 1069-1081.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. Advances in Nursing Science, 16(2), 1-8.

Sandelowski, M. (1994). Notes on transcription. Research in Nursing & Health, 17, 311-314.

Sandelowski, M. (1995). Sample size in qualitative research. Research in Nursing & Health, 18, 179-173.

Schutz, S.E. (1994). Exploring the benefits of a subjective approach in qualitative nursing research. Journal of Advanced Nursing, 20, 412-417.

Sharpe, P.A., Clark, N.M. & Janz, N.K. (1991). Differences in the impact and management of heart disease between older women and men. Women & Health, 17(2), 25-43.

Sorrell, J.M. & Redmond, G.M. (1995). Interviews in Qualitative nursing research: Differing approaches for ethnographic and phenomenological studies. Journal of Advanced Nursing, 21, 1117-1122.

Song, M. & Lee, E.O. (1996). Development of a functional capacity model for the elderly. Research in Nursing & Health, 19, 173-181.

Sparks, K.E., Shaw, D.K., Eddy, D., Hanigosky, P. & Vantrese, J. (1993). Alternatives for cardiac rehabilitation patients unable to return to a hospital- based program. Heart & Lung, 22(4), 298-303.

Statistics Canada, (1994). General Society Survey.

Statistics Canada, (1995). A Portrait of Seniors in Canada. (Catalogue no. 89-519-XPE).

Statistics Canada, (1997). Heart Disease and Stroke in Canada.

Statistics Canada. (1997). Growing old in Canada: Demographic and geographic perspectives. (No. 96-321-MPE.1).

Steingart, R.M., Packer, M., Hamm, P., Coglianese, M., Gersh, B., Geltman, E.M., Sollano, J., Katz, S., Moye, L., Basta, L.L., Lewis, S.J., Gottlieb, S.S., Bernstein, V., McEwan, P., Jacobson, K., Brown, E.J., Kukin, M.L., Kantrowitz, N.E. & Pfeffer, M.A. (1991). Sex differences in the management of coronary artery disease. The New England Journal of Medicine, 325(4), 226-230.

Stewart, M.J. (1989). Social support and instruments created by nurse investigators. Nursing Research, 38(5), 268-275).

Stokes, J. & Lindsay, J. (1996). Major causes of death and hospitalization in Canadian seniors. Chronic Diseases in Canada, 17((2), 63-73.

Tanner, C.A., Benner, P., Chesla, C & Gordon, D.R. (1993). The phenomenology of knowing the patient. IMAGE: Journal of Nursing Scholarship, 25(4), 273-280.

Theis, A.L. & Merritt, S.L. (1994). A learning model to guide research and practice for teaching elder clients. Nursing & Health Care, 15(9), 464-468.

Varvaro, F.F. (1991). Women with coronary heart disease: An application of Roy's Adaptation Model. Cardiovascular Nursing, 27(6), 31-35.

Walters, A.J. (1995a). A Heideggerian hermeneutic study of the practice of critical care nurses. Journal of Advanced Nursing, 21, 492-497.

Walters, A.J. (1995b). The phenomenological movement: Implications for nursing research. Journal of Advanced Nursing, 22, 791-799.

Wellard, S. (1998). Constructions of chronic illness. International Journal of Nursing Studies, 35, 49-55.

Wenger, N.K. (1990). Gender, coronary artery disease, and coronary bypass surgery. Annals of Internal Medicine, 112(8), 557-558.

Wenger, N. (1992). Exclusion of the elderly and women from coronary trials. Is their quality of care compromised? Journal of American Medical Association, 268(11), 1460-1461.

Wenger, N.K. (1994). Guidelines for exercise training of elderly patients with coronary artery disease. Southern Medical Journal, 87(5), s66-s69.

Wenger, N.K., Speroff, L. & Packard, B. (1993).

Cardiovascular health and disease in women. New England Journal of Medicine, 329(4), 247-256.

Webster, N. (1974). Webster's the new twentieth century dictionary of the English language. New York: The World Publishing Company.

Weiss, R.S. (1994). Learning from strangers: The art and method of qualitative interview studies. Toronto: The Free Press.

Wilson-Barnett, J. (1981). Assessment of recovery: with special reference to a study with post-operative cardiac patients. Journal of Advanced Nursing, (6), 435-445.

Wingate, S. (1995). Quality of life for women after a myocardial infarction. Heart & Lung, 24(6), 467-473.

Wingate, S. (1997). Cardiovascular anatomy and physiology in the female. Critical Care Clinics of North America, 9(4), 447-452.

Yates, B.C., Skaggs, B.G. & Parker, J.D. (1994). Theoretical perspectives on the nature of social support in cardiovascular illness. Journal of Cardiovascular Nursing, 9(1), 1-15.

Young, R.F., & Kahana, E. (1993). Gender, recovery from late life heart attack, and medical care. Women & Health, 20(1), 11-31.

Appendix A:

Conceptual Model of Hermeneutic Circle for Data Analysis

Adapted from : Leonard, V.M. (1994). A heideggerian phenomenological perspective on the concept of person. In P. Benner (Ed.), Interpretive phenomenology embodiment, caring, and ethics in health and illness. Thousand Oaks, CA : Sage Publications.

Appendix B: Patient Information Letter and Informed Consent

Women's Perception of Their Recovery Post Myocardial Infarction

Investigator: Evelyn Kerr, RN BScN MScN student
Phone: 613-831-1707

Supervisor: Frances Fothergill-Bourbonnais, RN Ph.D.
Full Professor, Thesis Committee Chair,
University of Ottawa

Phone: 613-562-5800, ext.8422

Introduction:

You are invited to participate in a nursing research study being conducted by a registered nurse who is presently enrolled in the Masters of Nursing Science program at the University of Ottawa. The purpose of this research study is to increase nurses' understanding of how women, 65 years of age and older, perceive their experience of recovery from a myocardial infarction (heart attack) within the two weeks following discharge from hospital. An understanding of these perceptions may help nurses be more aware of home care issues, which in turn may lead to improved discharge planning.

Procedure:

If you agree to participate in this study, an interview will be held at your convenience, with the researcher. This interview will take place in your home or a place that you choose and will last approximately one and one half hours. During this interview, you will be asked about physical and mental difficulties or challenges you may have encountered during the first two weeks while at home following hospital discharge. As well, you will be asked how you managed and whom or what has helped you the most. A follow-up interview may be conducted one month later by the researcher to see if you agree with the interpretation of the previous interview. The interviews will be audio-taped to ensure accuracy of the information collected.

Risks of Participation:

There are no risks for people who participate in this study, however, some people may become uncomfortable or distressed answering some of the questions. If you begin to feel uncomfortable or distressed, you may ask the researcher to stop the interview. Also, if there are specific questions you do not wish to answer, you may ask the researcher to skip that question.

Benefits of Participation:

There may be no direct benefits to you as a participant of this study, but the information you provide may be useful to healthcare professionals in planning for future female patients following the completion of this study. Also, some women may find it helpful to talk about their experiences.

Participation in Research:

Participation in research is completely voluntary. You are free to choose to participate or not to participate in this research study. If you agree to participate in this study, you may refuse to answer any question during the interview, and you are free to withdraw your consent and terminate your participation in this study at any time. This will not affect your present or future care at the Ottawa Heart Institute in any way.

Confidentiality:

The information from the interview tape recordings will be treated in a confidential manner. The data collection forms and tape recordings will be given a code number for subject identification and no names will be used. The final report, containing anonymous quotes, will be available to all at the end of the study. These tapes and the data collection forms will be kept in a locked cabinet accessed only by the researcher. They will be retained for five years after the interview, at which time they will be destroyed. The information may be published in the future, but neither your name nor any identifying factors will not be associated with the research.

Ethical Considerations:

This protocol has been approved by Human Research Ethics Committee of the University of Ottawa Heart Institute. The committee considers the ethical aspects of all research projects using human subjects. If you wish, you may talk to the Chair of the Human Research Ethics Committee through the Secretariat at (613) 761-4885.

.....

Consent to Participate in Research

THIS IS TO CERTIFY THAT I, _____ (print name) have read the above information letter about the research project "*Women's Perception of Their Recovery Post Myocardial Infarction*".

I have been given the opportunity to ask whatever questions I desire, and all such questions have been answered to my satisfaction. If I have any additional questions I may contact Evelyn Kerr at (613) 831-1707.

I understand the risks and benefits which may result from my participation in the research. I hereby give permission to be interviewed, and for these interviews to be tape-recorded. I understand that the information may be published, but my name and any other identifying factors will not be associated with the research.

I agree to participate in this research study.

Participant's Name:	_____
Participant's Signature:	_____
Date:	_____
Witness:	_____
Investigator's Signature:	_____
Date:	_____

Appendix C: Sample Interview Schedule

The following questions are a sample of the potential questions to be asked of participants. Questions may change during the course of the interviews to reflect areas of interest to the participants, the researcher and evolving concepts and themes.

- 1) Please describe for me what it has been like for you since you have come home from the hospital.
- 2) What has been your biggest challenge since coming home from the hospital?
- 3) How have you felt physically since coming home from the hospital?
- 4) How have you felt emotionally since coming home from the hospital?
- 5) How have you been managing with your meals, your housework, grocery shopping?
- 6) Who or what has been your biggest support since coming home?
- 7) Is there anything that you would like to ask me?
- 8) Is there anything else I should have asked you?

Probes may be used throughout the interview (Polit & Hungler, 1995):

Are there any other reasons?

How do you mean?

Could you tell me more about that?

Why do you feel that way?

Would you tell me what you have in mind?

Appendix D - Demographic Information

Age: _____ Type of MI _____

Length of hospital stay: _____

Complications during hospitalization: _____

Other co-morbid factors: _____

Marital Status:

Married: _____

Divorced: _____

Single: _____

Widowed: _____

Other: _____

Living arrangements:

Alone: _____

With spouse or significant other: _____

With family member: _____

Other: _____

Appendix E: Contact Summary Sheet**Participant Code #** _____**Interview Date:** _____**Starting Time:** _____**Ending Time:** _____**Pre-interview goals for interview:**

Location of Interview: _____**People Present:** _____**Description of environment:** _____

Nonverbal Behavior: _____

Content of the Interview (key words, topics, focus, exact words): _____

Researcher's Impressions: (discomfort of participants regarding certain topics, emotional responses)

Analysis:

Technological Problems: (i.e. tape recording):

Appendix F: Letter to Agency

My name is Evelyn Kerr and I am currently enrolled in the Masters of Nursing Science program at the University of Ottawa. From September until December, 1997 I will be on your unit in order to enroll women who have sustained a recent first time MI in a research study I am conducting for my thesis. This qualitative research study will explore elderly women's perception of their recovery post MI, within the first two weeks post-discharge. From the literature, little is known regarding elderly women's psychosocial and physical experiences during their early recovery from an MI. I hope that through my research, interventions may be implemented both in the hospital and in the community to assist these women with their recovery.

I anticipate recruiting approximately 6-8 women within 3 to 4 days of admission who are 65 years of age and older and are English speaking. I will be reviewing the daily census records for suitable participants. My involvement with the clients on the unit is simply that of enrollment to the study. I will subsequently interview those women who agree to participate in this study in their homes post-discharge.

Following the data collection and analysis I will gladly present the findings of this research to any interested staff at the University of Ottawa Heart Institute. In addition, if any person requires further information or has questions regarding the nature of this research study, please feel free to contact me by telephone at 613-831-1707 or e-mail at kerrg@istar.ca.

Sincerely,

Evelyn Kerr, RN BScN, MScN student

Appendix G: The Mosaic of Recovery - The Schemata