Women's Experience with Myocardial Infarction: A Phenomenological Approach

by

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Abstract

The purpose of this study was to examine the nature of women's experience of myocardial infarction (MI) from a subjective perspective in order to explore and describe how women made meaning of this potentially life threatening event. A phenomenological approach was used to guide the data collection and analysis. Data were collected through in-depth semi-structured interviews with a volunteer sample of 10 female co-researchers hospitalized with MI at a local city hospital. The initial interview focused on obtaining a description of co-researcher's experience and was conducted after women were transferred from the critical care unit to the cardiac ward. I conducted validation interviews with co-researchers several weeks post hospital discharge via telephone. The validation interview provided co-researchers with the opportunity to confirm or clarify my understanding of the description of their MI experience, as well as providing any further information that would crystallize my understanding of their story.

Audiotaped interviews were transcribed verbatim and analyzed according to Giorgi's (1975, 1985) method of phenomenological data analysis. Nine common themes emerged from the data including: (a) the experience of illness awareness; (b) the experience of feeling emotionally overwhelmed; (c) the experience of fear and worry; (d) the experience of loss; (e) difficulty asking for help; (f) the experience of needing information; (g) the experience of care and support; (h) making sense of the MI experience; and (i) the experience of planning for the future.
evident in co-researcher accounts, the uniqueness of each woman was captured and reflected in the variations in which the themes were expressed.

The implications of this research suggest the importance of understanding women's experience of MI at a subjective level in order to fully understand the extent and nature of women's issues and concerns within this area.

Thus counselling psychologists should act as both educators and counsellors in order to raise the awareness of other health professionals as to the nature of women's experience of MI, to assist in the teaching of skills that would better enable the implementation of patient-centered care, and to provide women a forum through which they can receive counselling related to issues surrounding MI. Moreover, results of this study provide the basis for future research, and in helping medical professionals implement the provision of cardiac care that is more germane to women.
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CHAPTER ONE

Introduction

Background to the Research

Coronary heart disease (CHD) is currently the leading cause of death among both women and men in Canada (Statistics Canada, 1994) and the United States (Packard, 1992). This is contrary to the conventional belief that heart disease is a serious health concern for only middle-aged men. Myocardial infarction (MI), the major medical emergency of the cardiovascular system and most serious manifestation of CHD, accounts for the greatest number of these deaths. Whereas the incidence of MI is more prevalent in men, statistics confirm the magnitude of this health concern for women. In 1991, 19,496 Canadian women died as a result of CHD. Of these deaths, 9,844 were as a result of acute MI (Statistics Canada, 1994). Quite clearly, MI is a serious health concern for women as mortality rates continue to increase.

Despite the prevalence rates of CHD for women, the preponderance of information regarding the etiology, incidence, management, prognosis, and rehabilitation of MI is based primarily on studies comprised of men (Eaker, Packard, Wenger, Clarkson, & Tyroler, 1986; Murdaugh, 1990; Packard, 1992; Wenger, 1989). Women have either been excluded or are under represented in cardiac research to the point that a gender comparison or separate analysis of women's data is difficult or impossible (Eaker et al., 1986; Isles, Hole, Hawthorne, & Lever, 1992; Rodin & Ickovics, 1990). As a result, many clinical decisions involving women and cardiac health are based on data obtained from men (Eaker et al., 1986; Isles et al., 1992). The little research
that has focused on or included women suggests that gender differences do exist in various clinical features of heart disease such as morbidity and mortality rates, and that distinctions across subgroups of women have also been established (Eaker et al., 1986; Young & Kahana, 1993). For example, Eaker et al. (1986) contends that cardiovascular disease mortality is twice as high amongst black women as in white women, and substantially higher in white women as compared to women of other non-black groups.

Although there is little cardiac research solely devoted to an examination of women and MI, even fewer studies have examined the psychosocial factors related to women's cardiac health or the needs and responses of women in cardiac rehabilitation programmes (Eaker, 1989; Parchert & Creason, 1989). Eaker (1989) contends that when studying women and disease, it is essential to consider factors related to their behavior, environment, and psychological milieu. Although Eaker reviewed research that examined socioeconomic status, social support, and personality variables in relation to women and heart disease, none of these studies examined women's experience of MI in terms of personal meanings. In other words, these studies have neglected to explore the nature of women's experience with cardiac illness from a subjective or patient perspective. Similarly, there has been no documented studies examining the nature of men's experience with MI from a subjective perspective. As a consequence, there is a lack of research that can guide a study of women's experience of MI.

Conrad (1990) describes a branch of social research that
places greater emphasis on studying the subjective experience of individuals with illness. This research emphasizes the person's perceptions, behaviors, and illness experiences rather than the physiological process. Thus, an examination of the meaning that people attribute to their experience and how they make sense of what is happening to them is central to understanding the illness experience.

In addition, Benner and Wrubel (1989) suggest that the meaning of an illness is derived out of a transaction between an individual's cultural heritage and personal history, as well as features of the illness itself.

The purpose of this study is to add an extensive description to the small existing body of literature on women and MI, and provide an explicit portrayal of the experiences lived by these women. I examined the nature of women's experience of MI from a subjective perspective, in order to explore and describe these experiences and to understand how women made sense of MI.

Understanding how women perceive and make sense of their illness experience with MI may provide the basis for further understanding the nature of women's needs within the realm of cardiac care. Moreover, this information is essential in helping health professionals implement the provision of cardiac care and rehabilitation services that are more germane to women. Thus the specific questions addressed in this study were: (a) What are women's experience of MI? (b) How do women make sense of this illness experience?

Definition of Terms

In order to provide a frame of reference for the terms to be
used in this study, the following definitions are provided:

**Coronary Heart Disease (CHD)** - Heart ailments caused by a narrowing of the coronary arteries, and therefore, decreased blood supply to the heart (American Heart Association, 1980).

**Myocardial Infarction (MI)** - A potentially life threatening manifestation of CHD. More specifically, the death of an area of heart muscle resulting from an inadequate oxygen supply to that area that may result in disability or death of the individual, depending on the extent of heart damage (American Heart Association, 1980). (The term heart attack will be used interchangeably with MI, particularly when interviewing co-researchers).

**Angina Pectoris** - Chest discomfort or pain, brief in duration, which is caused by a decrease in blood supply to the heart (American Heart Association, 1980).

**Angiogram** - A diagnostic x-ray procedure that outlines the arteries of the heart and takes pictures of them in order to determine the severity of obstruction to blood flow to the heart. This procedure is instrumental in determining treatment options (American Heart Association, 1980).

**Coronary Bypass Surgery** - A surgical procedure to improve the blood supply to the heart muscle when narrowed coronary arteries reduce the flow of oxygen-containing blood which is vital to the pumping heart. (American Heart Association, 1981).

**Illness Experience** - Reactions to disease or discomfort based on personal, interpersonal, and cultural factors (Kleinman, 1988).

**Meaning of Illness** - The personal and subjective significance related to a person's illness (Lipowski, 1969).
CHAPTER TWO
Review of Related Literature

Introduction

What is the nature of women’s experience with MI, and how do women make sense of this illness experience? This specific issue has not been adequately addressed in the literature that examines women and cardiac health. A review of research related to MI and women, women and recovery from MI, as well as a brief examination of the meaning of the illness experience, provides background information related to the nature of this issue.

Myocardial Infarction

Developing physical illness symptoms and undergoing medical treatment can be a highly stressful experience, especially in the case of a potentially life threatening event. The experience of MI is typically sudden, frequently without forewarning, usually distressing, and almost always life-threatening (Byrne, 1987b).

MI occurs when an obstruction in one of the coronary arteries prevents sufficient oxygen to supply the heart resulting in the death of a portion of the heart muscle. Symptoms may be non-existent, mild, or severe, and may include chest pain (which may radiate to the shoulder, arm, neck or jaw), nausea, cold sweat, and shortness of breath. Although symptoms may be varied, individuals frequently describe their pain as being heavy, crushing, or squeezing, and many report a sense of impending doom or imminent death (American Heart Association, 1980). The extent to which the heart is damaged will directly determine the likelihood of death or the degree of disability after recovery (American Heart Association, 1980).
Although women and men who develop CHD typically present with similar symptoms, regardless of risk factors, demographics, and age (Coglianese, Sollano, & Bilodeau, 1992), women tend to experience chest pain as their chief symptom more frequently than men (Kannel & Abbott, 1987).

In general, physical illness is considered to be an extremely potent stressor as it may extend over a long period of time and lead to permanent changes in the person and potentially changes in their family (Moos, 1979). The stressors associated with MI are diverse and may vary depending on their meaningfulness to the individual. These physical and emotional stressors include the potential threat to one’s life, bodily integrity, functional status, self-concept, values and belief systems, social and occupational functioning, commitments and future plans, and emotional equilibrium (Cohen & Lazarus, 1979; King, 1985; Kleinman, 1988). The experience of the hospital environment can also be highly stressful given the constant reminders of illness and mortality, distressing procedures, and the frequent sense of unfamiliarity, boredom, or loss of autonomy (Cohen & Lazarus, 1979).

In addition to the physical trauma of MI, the experience of MI is considered to be a major life crisis for most individuals, and typically results in various forms of emotional distress. The most common and expected emotional consequences following MI are depression and anxiety (Byrne, 1987b, 1990; Croog, 1983; Hackett & Cassem, 1984; Mayou, 1984; Stern, Pascale, & McLoone, 1976, 1977). Most psychosocial research in this area however, is comprised of studies sampling predominantly men, and have not
adequately identified or explored women's experiences.

Byrne (1990) suggests that various factors may affect an individual's affective and behavioral responses to MI, thereby influencing their immediate medical and long-term recovery. These include past experience with MI either personal or indirect, the amount of information communicated by the physician regarding the nature of the illness, patterns of personality, sociocultural expectations of MI, levels of life stress, and social support.

Women and Myocardial Infarction

Most of the existing literature within the area of women and MI is epidemiological in nature. For example, the Framingham study, the longest ongoing investigation of CHD risk factors, has generated a wealth of data as researchers have collected and evaluated a wide assortment of information related to the characteristics found in persons free of cardiovascular disease compared to those who later developed the disease (Kannel & Gordon, 1973). The Framingham study has been one of few projects that has provided longitudinal data related to women, and is frequently cited in the cardiac literature. Although a full review of this material is beyond the scope of this study, an overview of the limited and relevant material specifically examining women is explored.

In general, CHD differs significantly in women than in men. The Framingham data suggests that MI as the initial manifestation of CHD is less common in women than in men, and occurs almost 20 years later (Kannel, as cited in Packard, 1992). More typically, women present initially with angina pectoris (Eaker et al., 1986; Packard, 1992; Peberdy & Ornato, 1992; Rankin, 1990; Wenger,
The Framingham data also suggests that MI is more likely to be fatal among women, and that mortality rates in the first month and the first year after MI are likely to be higher (Kannel, as cited in Packard, 1992). As well, post-MI morbidity, and rates of re-infarction appear to be higher among women (Eaker et al., 1986; Murdaugh, 1990; Wenger, 1989, 1992). Data from the Framingham study also revealed that except for the elderly, the proportion of unrecognized or silent infarctions were greater in women (Kannel, 1990).

Although the major risk factors for CHD in women are similar to those found in men and include age, high blood pressure, high blood cholesterol, cigarette smoking, diabetes, and high lipoprotein (Eaker et al., 1986; Murdaugh, 1990; Peberdy & Ornato, 1992; Rosenberg et al., 1983), gender differences appear to exist in terms of the expression of these risk factors (Peberdy & Ornato, 1992). For example, Peberdy and Ornato (1992) suggest that the prevalence of hypertension in women with CHD is significantly higher than in men with CHD, while diabetes increases the risk of CHD significantly in women and places effected individuals at the same risk level as age-matched non-diabetic men. Moreover, more women than men have diabetes at the time of their first MI. Although the association between smoking and MI is equally as strong in women and men, the detrimental cardiovascular effects of smoking in women are dose related and believed to occur both before and after menopause. The risk of acute MI however, is believed to be significantly greater in premenopausal women who smoke compared to those who do not smoke (Slone et al., 1978; Rosenberg et al., 1983). With respect to
cholesterol, women have an advantage over men as the fraction of protective high density lipoproteins in young and middle aged women are higher than in age-matched men. Nonetheless, this protective advantage eventually decreases with age at a rate faster in women than in men and reflects the dramatic increase in women's risk of developing MI after menopause (Stampfer et al., 1991).

Other risk factors affecting women include sedentary lifestyle, obesity, previous family history of MI or stroke, high triglycerides, and stress (Dustan, 1990; Eaker et al., 1986; Peberdy & Ornato, 1992). Female specific risk factors for CHD, such as the current use of oral contraceptives, have raised serious concerns, especially in the presence of cigarette smoking. The relationship of menopause to the risk of CHD is not fully conclusive (Parchert & Creason, 1989; Slone et al., 1981; Stampfer et al., 1991). Eaker, Packard, and Thom (1989) suggest that it is difficult to isolate the effects of aging.

Type A or coronary-prone behavior pattern has presented an ongoing controversy in its association with MI (see Bass & Wade, 1982; Byrne, 1987a; Friedman & Rosenman, 1974; Haynes, Feinlib, & Kannel, 1980; Scherwitz, McKelvain, & Laman, 1983; Thoresen & Low, 1990). Much of what we know about the Type A construct remains primarily limited to middle-class adult white men. Type A is characterized by several loosely related attributes including intensive striving for achievement, easily provoked impatience, urgent sense of time, and hostility (Byrne, 1987a). In a literature review examining Type A and women, Thoresen and Low (1990) suggest that a definitive coronary-prone behavior pattern
for women has yet to be identified and confirmed via methodologically sound research. They suggest that Type A is related to some but not all CHD markers, although no evidence currently links Type A to MI in women. Furthermore, Thoresen and Low (1990) suggest that the limited research concerning Type A and women has been plagued by inadequate assessment (also see Haynes & Feinlib, 1980).

According to the Framingham 14-year follow-up data, education level is significantly associated with CHD in women (Eaker et al., 1989). Women with 8 years of education or less, demonstrated almost four times the risk of developing CHD over the 14 year follow-up period as compared to women with 12 years or more of education. When regression analysis was performed controlling for factors such as age, cholesterol, smoking, blood pressure, relative weight, and blood sugar levels, low education remained a significant predictor of CHD.

In general, it is likely that a woman's experience and perception of the world will be influenced by her lifestyle and associated risk factors. For example, the highly educated menopausal career women who works long days, smokes excessively, and has an extensive family history of CHD, may thrive on stress as an ideal context in which to work and live for a moderate number of years. In contrast, the homemaker who maintains a strict diet, exercises, and practices yoga daily, may experience the world as an active and healthy individual with the intention to live life fully and for as long as possible.

Although women's social roles and lifestyles have changed and continue to change over the years, Eaker et al. (1986) suggest
that we do not yet have enough available information to relate these changes to women’s experience of MI.

**Women and Recovery from Myocardial Infarction**

It is inappropriate to assume that women’s experience post-infarction is similar to that of middle-aged men (Conn, Taylor, & Abele, 1991; Johansson, Vedin, & Wilhelmsson, 1983; Johnson & Morse, 1990; Rankin, 1995; Sharp, Clark, & Janz, 1991). Although there has been a plethora of literature examining the aftermath of MI amongst men (see Burgess et al., 1987; Mayou, 1984; Mayou, Foster, & Williamson, 1978; Miller, Wikoff, Garrett, McMahon, & Smith, 1990; Oldridge, 1988), minimal research has examined women’s experience or special needs after infarction or during the process of rehabilitation (Boogard, 1985; Conn, Taylor, & Abele, 1991).

Conventional rehabilitation goals often do not reflect the goals of the MI patient (Godin, Valois, Jobin, & Ross, 1991; Johnson & Morse, 1990). To illustrate, "return to work," has long been the steadfast and pervasive outcome measure of MI adjustment (Byrne, 1987b, 1990; Croog, 1983; Smith, 1992; Stern, Pascale, & Ackerman, 1979) and reinforces the emphasis placed on male experience while potentially camouflaging the needs and experiences of women, especially those who are do not work at paid employment. Sharpe, et al. (1991) suggest that this holds particularly true for elderly women who are less likely than men to have worked outside the home and do not retire in the same formal sense. Not suprisingly, women’s reproductive and caring labour has also traditionally not been viewed as work and has remained for the most part absent in the MI recovery literature.
Sharpe et al. (1991) also suggests that the return to work measure inadequately captures the experience of daily living that is not related to paid employment, or an individual’s perception of well-being.

Rankin (1995) suggests that because women are typically older than men when they suffer MI, this has implications for recovery and rehabilitation from MI. For example, older women are more likely to be plagued with comorbidities such as arthritis, orthopedic impairment, or vascular disease, which may impair their ability to participate in cardiac rehabilitation programs that typically emphasize exercise participation.

Chirikos and Nickel (1984) examined gender differences in labour force withdrawal after acute MI. Study results suggested that a larger proportion of previously working women withdrew from employment after MI, compared with working men. Chirikos and Nickel suggest that this finding may be related to women’s way of responding to the course of the disease and to the lack of work or financial incentives, as opposed to disease severity or concern about future survival. The women in this study were influenced more by their behavioral response to their illness, meaning their withdrawal from the market work force, rather than the severity of their disease. In contrast, men’s return to work was significantly influenced by financial incentives.

Although return to sexual activity has also been a well established indicator of recovery from MI, only a few studies have included women in this area of research (Baggs & Karch, 1987; Papadopoulos, Beaumont, Shelley, & Larrimore, 1983).

One study that did examine the effects of MI on the sexual
activity of women included 130 female cardiac patients (Papadopoulos, Beaumont, Shelley, & Larrimore, 1983). Through interviews women were asked to report on the resumption and frequency of sexual activity, and to describe symptoms during sexual activity after MI. Findings indicated that MI had a negative impact on women's sexuality. More specifically, half of the women that were sexually active prior to MI, expressed fears of resuming sexual activity, while over a quarter of this group failed to resume any sexual activity. Findings also indicated that less than half of these women received some form of sexual counselling or instruction prior to hospital discharge.

In the Papadopoulos et al. (1983) study, only women under the age of 65 were interviewed, which may have influenced the number of women that were sexually active prior to MI. Whether this sample is representative of all women post MI is questionable. Moreover, the study failed to closely examine the women's subjective experiences of sexuality after MI.

In a recent study, Rankin (1995) examined the recovery process of women from MI within the framework of life-span development as compared to that of men. Rankin suggested that normative age-graded factors as well as normative history-graded factors should be considered as influential components effecting women's recovery from MI. More specifically, Rankin argued that the cohort of women most vulnerable to the effects of heart disease and MI, as a result of normative age-graded factors, are older when they have MIs, more likely to experience co-morbidities that influence different aspects of recovery, and less likely than men to have support, particularly spousal support.
as a result of widowhood, during the MI recovery period. Results from Sharpe et al. (1991) study examining the impact and management of heart disease in older women also confirm these findings.

Normative history-graded factors such as attitudes toward health promotion, health restoration, and health maintenance, are also useful to help explain such risk factors as smoking, dietary and exercise patterns, and lack of adequate financial and social resources often characteristic of this older cohort of women. For example, the older cohort of women who are predominantly those who experience heart disease and MI today, likely did not have the benefits of the information currently available to younger women regarding the effects of smoking, poor diet, and lack of exercise.

Rankin (1995) further argued that other sociohistorical factors related to past work and marital roles are also significant factors that influence women's recovery from MI. For example, low socioeconomic status is likely a greater source of stress for more women than it is for men. This is especially true for older women who are more likely to be widowed, retired, or living on a fixed income.

One interesting finding in Rankin's study was that the women were identified to have twice as many social support needs as compared to a group of male cardiology patients. Subsequently, health care providers should not assume that women have similar support needs as male cardiac patients, or that women have the same degree of support and caretaking assistance available to them as do men.
Implications of Rankin's (1995) research relate to increasing health care professionals awareness about the differences between women's and men's experience of cardiac illness, and the importance of considering developmental context as it relates to the chronicity of heart disease and how this affects women's recovery from MI.

In a seminal work, Boogard (1984) compared the rehabilitation of women and men post MI. Using qualitative methodology, the study demonstrated that women's experience of rehabilitation differed significantly from men's in terms of return to physical activity, psychosocial aspects, and family interrelationships. Using semi-structured interviews, 20 cardiac patients (10 women and 10 men) were interviewed between 3 and 6 months after MI. Participants in the study were between 25 and 55 years of age, mostly married, and from diverse social economic backgrounds.

Within 1 week of discharge from the hospital, women reported engaging in higher levels of exertion, including light housework. Most of the women did not perceive household activity to be work, or consider this work to be potentially harmful. Women were more likely to increase their level of housework than to enrol in a walking or rehabilitative program. In contrast, post-discharge activities for men included resting, relaxing, and walking.

Boogard (1984) reported that women in the study also experienced a delay in return to work and sexual activity. These findings are congruent with other research (Baggs & Karch, 1987; Papadopoulos et al., 1983). Although both women and men reported feeling depressed during their rehabilitative period, only women reported feelings of guilt, particularly when family members
performed household tasks for them. As well, these women were more likely to resist receiving help from others.

Boogard (1985) concluded that health professionals need to be sensitized to the potential difficulties of women facing cardiac rehabilitation, and to incorporate the knowledge of women's needs into educational guidelines geared to facilitate optimal rehabilitation in women.

Boogard's (1984, 1985) work was reviewed in detail because it is methodologically conducive to understanding the process of women's recovery from MI, and is one of the few documented studies that has examined psychosocial aspects of women's experience. Although information surrounding women's delay in return to work and previous levels of sexual activity could not be determined, the study provides a useful model for future research.

Using a grounded theory approach, Johnson and Morse (1990) examined adjustment after MI in a group of 7 women and 7 men. All but four participants were interviewed a few months post MI, as the remaining interviews took place between 10 and 45 months after MI. Johnson and Morse suggest that adjustment to MI involves the progression through four major stages, including the initial threatened loss of control, coming to terms with the MI, reestablishing control after MI, and recovery. As the fundamental task in each major stage is regaining a sense of control, the role of the individual's perceptions is critical in the adjustment process. Subthemes, reflecting strategies and responses directed towards regaining control, were also delineated from the four major stages. Although Johnson and
Morse's proposed theory of adjustment appears to be plausible, as they emphasize the subjective experience of the individual in terms of regaining a sense of control, they do not present the possibility of an overlap or integration of stage progression. Instead, they endorse the belief that adjustment to MI is a fairly linear process. As well, it would be of interest and relevance to identify whether gender differences, demographics, or social context influenced the existence of the emergent stages of themes. These issues did not appear to be addressed by the researchers.

Aside from these major findings, Johnson and Morse (1990) reported that the women in the study tended to minimize their illness symptoms and returned to their homemaker roles sooner than was deemed medically safe. This perpetuated the belief that housework was not "real" work. As well, most of these women were protective of their homemaker and mothering roles, and felt uncomfortable receiving support from family members. Moreover, these women were more likely to make lifestyle changes independently, being careful not to interrupt or offset the family routine. These findings are similar to and provide support for Boogard's (1984, 1985) and Dunn's (1985) earlier research findings.

Based on this research, Johnson and Morse (1990) developed a theory of adjustment that emphasized the importance of the role of patient perceptions in the adjustment process. Although their study examined the illness experience of women and men, it provided limited information about the participants (e.g., social and cultural context), and the process of data collection and
analysis. Although the authors limited their sample to persons in rehabilitation programs, their developing theory could have been strengthened by the addition of an alternative group to test the limits of generalizability.

Dunn (1985) used a phenomenological method to examine women’s experience of MI between 2 and 14 weeks following hospital discharge. Through a series of semi-structured interviews, Dunn explored the illness experiences of eight women. The core theme that emerged from the data analysis and captured the essence of the women’s experience with MI was loss. Women reported multiple losses including: the loss of a physically healthy state; the loss of predictability in terms of experiencing a sudden shift from health to illness, and a sense of uncertainty towards the recovery process; the loss of social support from their families (especially their husbands); and a loss of power and control as they experienced changes in their usual social and homemaker roles. Women in the study also reported feelings of guilt in relation to giving over their household roles to their husbands and other family members. As well, Dunn (1985) reported that the women had difficulty putting themselves first when conflict developed between the competing demands of their home and family lives, and their own health status and rehabilitation. Moreover, women in the study did not identify physical rehabilitation, the prescription of choice in the cardiac literature, as a means to gain control over their perceived sense of losses. This study demonstrated the uniqueness of women’s illness experience with MI. Dunn’s findings were similar to Johnson and Morse’s (1990) later research findings and suggest that the women returning home
from hospitalization with MI were concerned about family and relational issues, particularly around the effects of their illness on their family, and in terms of juggling personal and familial needs.

Dunn (1985) explored and described the meaning of women's illness experience of MI after being discharged from hospital. Although the information derived from this study is invaluable, it is equally important to explore and understand the illness experiences of women while hospitalized with MI.

Although there is limited qualitative research in this area, there are numerous quantitative studies examining adjustment to MI via the measurement of multiple constructs including anxiety, depression, coping, functional capacity, self esteem, social support, and social adjustment (see Ben-Sira & Eliezzer, 1990; Keckiesen & Nyamathi, 1990; Stern, Pascale, & Ackerman, 1977; Winefield & Martin, 1981). Although these studies yield quantifiable data, they generally do not examine the social or cultural contexts of the individuals being studied. As women are typically excluded or under-represented from much of the MI recovery literature, this provides limited information to aid understanding of women's subjective experience of MI.

In previous research that has specifically examined women's illness experience of MI (Boogard, 1984, 1985; Dunn, 1985; Johnson & Morse, 1990), data collection took place after participants had returned home following hospital discharge.

According to Byrne (1990), women's perceptions of their illness experience are likely to be much different while hospitalized with life threatening symptoms than reporting
retrospectively at several months post-hospital discharge. Byrne further suggests that anxiety levels of hospitalized patients fluctuate over time depending on the perceived seriousness of the challenge faced at different points in their illness process. For example, a patient’s anxiety level will likely be high soon after symptom onset when the threat to life is the greatest, and again prior to hospital discharge when constant medical attention must be relinquished.

Capturing women’s initial experiences of MI, before being exposed to the responsibilities of their home life, and exploring how women make sense of these experiences, is the focus of the current research. Consequently, it is necessary to document women’s experiences while co-researchers are still hospitalized with MI.

Meaning of Illness

Central to understanding how women make sense of their potentially life threatening experience with MI, is the perception of meaning attached to all aspects of their illness events. Taylor (1983) suggests that when individuals experience a personally threatening event or setback, the process of adjustment involves cognitively adaptive efforts involving three fundamental themes. These fundamental themes include a search for meaning within the experience, an attempt at mastery over the threatening event, and an effort to restore a sense of self esteem despite the experience of a personal setback. More specifically, the search for meaning is an attempt to explain why the event occurred, and to understand the personal impact and significance of the threatening event. Taylor further suggests
that this process of cognitive adjustment may enable individuals to "return to or exceed their previous level of psychological functioning." Although Taylor's (1983) adaptation theory appears plausible in terms of a model for cognitive adjustment to threatening events, the stages fail to fully illuminate aspects of the whole person and subsequently limits the extent to which we can thoroughly understand and capture the nature of women's responses to MI. For example, the impact of an individual's cognitions is dependent on that person's life story. It is within this entire context, that we would more fully comprehend women's response to MI.

Lipowski (1969) suggests that illness meaning is derived from the personal and subjective significance of all information related to an individual's illness. Meaning is the core of a person's psychological response to illness, and will strongly influence their emotional and behavioral responses. Multiple factors effect the construction of meaning and each component of the illness experience including personality, life history and experience, intrapsychic aspects, social context and relationships, and the disease process itself. Lipowski suggests that to understand an individual's illness experience, it is necessary to understand their subjective interpretation of the experience and the personal meaning associated with illness related events.

Kleinman (1988) suggests that the illness experience has several meanings. For example, cultural values and social relations tend to shape how individuals perceive and monitor their bodies, label and categorize bodily symptoms, and interpret
symptoms and complaints within the context of their lives. Kleinman endorses the use of qualitative methods via the construction of a illness narrative or life story, as a means for individuals to give shape and meaning to her or his illness experience. An individual’s life story contains personal metaphors and rhetoric that enable others to create knowledge about the individual’s personal and cultural models for making meaning of the illness experience, as well as providing a method for communicating those meanings. Furthermore, Kleinman (1988) emphasizes the importance of "empathic witnessing," or the commitment of helping a sick person facilitate their telling of their illness story which enables them to make and give value to their illness experience.

Benner and Wrubel (1989) draw on a phenomenological approach to working with illness and health, and suggest that an individual’s meaning of illness is derived out of an interaction between personal and cultural background meanings, and features of the illness situation.

It becomes evident that the ways in which an individual construes her or his experience of illness is closely related to the perceived meaningfulness or personal significance of the experience. As well, an individual’s personal values, beliefs, and cultural relations influence the meaning attached to various aspects of the illness experience. In terms of understanding women’s experience with MI, women need to tell their own life story or illness narrative via qualitative methods such as phenomenology, in order to fully explore and communicate the richness of their illness experience.
Related Research

Although little research has been done in the area of women's adjustment to MI, Compas (cited in Compas & Orosan, 1993), in a similar undertaking, has explored the meaning of the diagnosis and treatment of cancer for patients and their families. The central concern in this research is to understand what aspects of the individual's values, goals, and commitments are at stake in a given stressful encounter, in order to understand the individual's meaning of that encounter. Compas attempts to situate the patient's experiences within the framework of Lazarus and Folkman's (1984) stress and coping model.

According to Lazarus and Folkman's (1984) phenomenological cognitive-transactional theory of stress and coping, individuals and their environments reciprocally affect each other in a dynamic and constantly changing relationship. Moreover, psychological stress is defined as "a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19).

Lazarus and Folkman (1984) discuss "perceptions of meaning or significance" in terms of personal stakes, or what is at stake for the person in a stressful encounter. Significant to Compas' work is the idea of personal stakes. Stakes involve those aspects of the person and their relationship with the environment that have been threatened, harmed, or challenged in a stressful encounter. Understanding a person's appraisals of meaning (or stakes) provides relevant information for understanding why a
particular situation is appraised as stressful by an individual. Clearly, this is useful in examining individual differences in response to similar circumstances.

Compas and Orosan (1993) have designed a preliminary 10-category framework consisting of various appraisals based on the meanings of stressful events. These include such categories as affiliation, achievement-power, personal growth, personal health, and pleasure seeking. Each patient was asked to describe aspects of their illness or treatment that was perceived to be most stressful to them. Compas and Orosan suggest that the threat to personal health is not always the most stressful aspect of one’s illness. Patients felt that having other areas of their lives threatened by illness was often more stressful.

Although Compas’s research has focused on cancer patients, the notion of personal stakes is discussed by Lazarus and Folkman (1984) with respect to any stressful encounter. In terms of women’s illness experience with MI, the stress and coping model and the notion of personal stakes may be useful to consider when contemplating co-researcher themes during data analysis. It is crucial however, that the descriptions and experiences of the co-researchers inform the phenomenological data analysis as opposed to creating constructs to inform the co-researcher’s experience.

**Summary**

Despite the dramatic presentation of MI, and the extent and degree to which MI impacts on women, there is a scarcity of literature and reflects the lack of knowledge surrounding this life threatening event.

Although research suggests that women present and manifest MI
symptomology and risk factors differently than do men, the majority of cardiac studies have either excluded or under represented women in their study samples. As well, much of the current literature is based on narrow constructs, that are not conducive to an examination of women's illness experience from a subjective perspective. Subsequently, a major limitation to much of the available research is that women are not being asked about the nature of their experiences.

Boogard (1984, 1985) and Dunn's (1985) work has further illuminated the uniqueness of women's illness experience, and emphasized the need for further qualitative research in the area of women and MI. Qualitative methodology provides a means for exploring and describing the richness of women's experience. Finally, research on the meaning of illness emphasizes the importance of exploring the meanings that women attribute to all aspects of their illness experience. It is evident that a woman's personal and cultural history influences what she deems as being meaningful.

Current research focuses on collecting data post-hospital discharge. In order to broaden our scope of knowledge within this area, it is necessary to examine the experiences of women who are still hospitalized. In terms of an illness time line, hospitalization represents the beginning of the treatment process for MI and marks a significant stage in an individual's illness experience.

The current study aims to expand our scope of knowledge within the area of women and MI, by using phenomenological methods to explore and describe the meaning that hospitalized
women attribute to their illness experience of MI.
CHAPTER THREE

Methodology

Research Design

The primary focus of this study is to explore how women make sense of their illness experience of MI. A phenomenological approach was used to guide the data collection and analysis. This method was selected as the most appropriate means of describing and understanding the meaning of women's illness experience, from their own frame of reference and view of social reality (MacMillan & Schumacher, 1989).

The phenomenological method attempts to contact "phenomenon as people experience it" (Colaizzi, 1978, p.57), and is concerned with understanding human behavior in greater depth than is possible with other methods of investigation that seek to control or predict behavior (Knaack, 1984). Giorgi (1975) suggests that rigor and discipline can be applied without necessarily transforming data into quantitative expressions.

Giorgi (1975, p.83) defines phenomenology as "the study of the structure, and the variations of structure, of the consciousness to which any thing, event, or person appears." Giorgi further suggests that phenomenology illuminates not only the phenomena which appears, but also the manner in which the phenomena appears.

Personal Assumptions

A fundamental principle of phenomenology is the researcher's participation in the formulation of the research question, the determination of what constitutes the data, and decisions around data collection and analysis (Osbourne, 1990). Subsequently, the
researcher's frame of reference becomes an explicit part of the research report.

The primary task of the researcher is to reveal the meaning of the co-researcher's experience, therefore it is necessary for the researcher to make personal biases or predispositions as explicit as possible (Giorgi, 1975). Through a process of "rigorous self-reflection" known as bracketing (Osbourne, 1990), the researcher attempts to articulate and temporarily suspend personal biases and predispositions, that may otherwise distort or interfere with the expression of the co-researcher's experience. Bracketing enables those reading the research report to consider the researcher's perspective through which the co-researcher's descriptions and meanings are understood (Giorgi, 1975; Osbourne, 1990).

Based on my own life experience, including an extensive background working as a cardiology technologist in several hospitals and rehabilitative settings, I have identified several general and personal assumptions that are of relevance to this study. The assumptions that guided this study included:

(a) Women will be able to describe their experiences of MI while hospitalized.
(b) Phenomenological methods will provide a means to understand women's illness experience of MI.
(c) Women interviewed post MI will be well enough to participate in follow-up interviews.
(d) Health care professionals are concerned about better understanding women's illness experience with MI.

My personal assumptions guiding this study include:
(a) People are their own best experts. 
(b) The experience of being hospitalized with MI is an extremely stressful experience for most people. 
(c) There is diversity among individuals in terms of their understanding of the seriousness of their illness. 
(d) People have an urgent need to tell their story regarding the events surrounding their MI and hospitalization, and appreciate the opportunity to be able to talk about their experiences. 
(e) The hospital environment does not adequately provide patients with the opportunity to explore or voice their emotional concerns regarding their illness experience. 
(f) Patients are likely to describe their concerns more in terms of themes such as loss of control or uncertainty, than in terms of personal meanings. 
(g) Individuals that have experienced MI need to attribute a particular cause or causes to their illness. When medical professionals are unable to provide adequate information, patients are more likely to create lay theories in order to make sense of their experience. 

The Interview

Phenomenological research differs from the traditional scientific model in the view of the subject of research as a co-researcher or participant (Osbourne, 1990). This distinction emphasizes the co-operative and voluntary nature of the qualitative research approach (Osbourne, 1990), and contrasts the scientific model, where the experimenter and subject relationship is characterized by an imbalance of power (von Eckartsberg, 1971). In phenomenology, the researcher engages in a cooperative
dialogue with the co-researcher in order to explore and clarify the meaning of her or his experience. To facilitate the dialogal relationship, it is essential that the researcher establish a trusting relationship and rapport with the co-researcher (Osbourne, 1990). This was achieved by creating an atmosphere of concern and respect for the co-researcher, communicating an interest in understanding the co-researcher’s experience, and by encouraging the co-researcher to describe and express this experience (Osbourne, 1990; von Eckartsberg, 1971).

As a graduate student in counselling psychology, I have gained extensive interviewing and counselling experience, based on the Egan (1990) model of therapeutic skills. As well, I have thoroughly examined the work of phenomenological researchers including Giorgio (1975, 1985) and Colaizzi (1978).

**Ethical Considerations**

Approval for this study was granted from the University of British Columbia ethics committee, St. Paul’s Hospital research and ethics committee, and the director of Cardiology at St. Paul’s hospital in Vancouver.

Prior to participation, potential co-researchers received a patient information letter briefly outlining the nature of the project and requirements of participation (Appendix D). Written consent was subsequently obtained from each woman who agreed to participate in the study (Appendix C).

Co-researcher’s rights were protected throughout the research. Confidentiality and anonymity of co-researchers was assured and respected at all times throughout the study. Pseudonyms were used to assure co-researcher anonymity, and any
identifying information was omitted from transcripts and the final report. In addition, lists of co-researchers, their pseudonyms, and their consent forms were kept separate from the audiotapes and transcripts and were accessible only to myself and my immediate research advisor at the university. Co-researchers were assured that the audiotapes, used in the interviews, would be erased after completion of the research.

As well, the following considerations were emphasized to co-researchers prior to participation in the research interview. Co-researchers could choose to: (a) withdraw from the study at any time without concern that this would jeopardize current or future health care, (b) refuse to answer any interview questions, (c) and ask to stop the audio-tape at any point during the interview.

Selection of Co-researchers

Co-researchers were recruited by the following process. For purposes of confidentiality, potential co-researchers were initially contacted by a nurse, while in CCU, and provided with a patient information letter (see Appendix D) briefly outlining the nature of the research project and requirements of participation. Nurses then asked these women for permission to forward their names to the researcher. I later contacted these women once they were transferred onto the cardiac ward in order to determine their study eligibility and to further describe the project. One co-researcher was not admitted to the CCU but transferred directly to the cardiac ward from a small rural hospital. The head nurse of the cardiac ward agreed to distribute the patient information letter to this women and any other eligible patients that had not been fully briefed about the research in the CCU.
The study comprised of 10 volunteer women, between the ages of 40 and 75, that were diagnosed and hospitalized with MI in a city hospital located in Vancouver's greater mainland. Recent hospital statistics indicated that 147 women had been admitted over the year with MI (R. Herrick, personal communication, October 29, 1992). It took approximately 5 months, between June and October, to recruit 10 co-researchers for the study.

Co-researcher's met the following criteria for study inclusion: (a) were diagnosed with MI, (b) were alert and oriented to time, person, and place, (c) were able to speak and read English, (d) provided informed consent for participation in the study, (e) were willing to discuss their MI experience.

Five of the co-researchers resided in Vancouver where they were hospitalized, whereas the remaining five women resided rurally and were transferred from their local hospital to the city hospital.

Five of the women were married or living common law with their partners, three were widows, one was divorced, and one woman identified herself as being single. Eight of the 10 co-researchers had children, 1 of whom was living at home.

All of the women interviewed had recently been diagnosed with MI. Five of the co-researchers had never experienced a cardiac event, while two of the co-researcher reported having previous MIs. Two other women described experiencing ongoing angina, and one woman had experienced a previous cardiac event requiring treatment. Moreover, three of the co-researchers required coronary bypass surgery as a result of their current MI, and two of the women had already undergone previous bypass surgery. None
of the co-researchers terminated their participation in the study.

Data Collection

The data were "descriptions of experience" (Osbourne, 1990), and were collected through a series of in-depth semi-structured interviews and validation interviews. In addition, my field notes supplemented the interview data. The purpose of the interview was "to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena" (Kvale, 1983, p. 174).

Co-researchers were interviewed in hospital, soon after being transferred from the CCU to the cardiac ward. Typically, co-researchers were transferred onto the cardiac ward a few days after MI. This time frame varied between the women, and was dependant on MI severity, symptom stabilization and medical complications, as well as the availability of hospital beds (SPH CCU nurse, personal communication, January 30, 1994).

Pilot Interviews

Two pilot interviews were conducted prior to data collection in order to verify the suitability of the study questions and interview format. This provided me with the opportunity to adjust study questions or devise additional questions as needed, to determine whether potential co-researchers clearly understood the wording and instructions of the interview script, and to estimate the length of time required for the interview. Moreover, the pilot interviews allowed me to become more familiar with the script, the interview process, and with my role as researcher.

The pilot interviews included meetings with a 40-year-old CCU
nurse several months post MI, and an 85-year-old hospitalized woman 1 week post MI. Although the interviews were audiotaped, they were not transcribed or included in data analysis.

The first pilot interview was reviewed by two members of the thesis committee. No recommendations for improving the interview process were made at that time. After the completion of the second interview, only nominal changes were made to the original interview script and study questions.

Data Collection Interviews

The study involved one preliminary meeting, and two interviews with co-researchers. During the preliminary meeting, I met with potential co-researchers and introduced the research, I provided a statement of purpose and a consent form, and I answered any questions that the women had. The first interview included the principal semi-structured data collection interview, whereas the second interview involved a telephone validation interview. All data collection and validation interviews were audiotaped.

Preliminary meetings took place with co-researchers once they were transferred from the CCU to the cardiac ward. During these meetings, I introduced myself as a graduate student in the Counselling Psychology Department at the University of British Columbia, and as a cardiology technologist currently working at the hospital. I also explained the rationale for the study, requirements of study participation, confidentiality and anonymity issues, and answered any questions about study participation. At this time, I usually left the women with the consent form (see Appendix C) and arranged a time to meet for the
first interview. Research interviews were always scheduled to accommodate both the co-researcher and the hospital staff. The preliminary meeting also served as an important opportunity for initial rapport building with co-researchers.

The first interview was conducted after receiving consent to participate in the study. To ensure confidentiality, interviews were conducted either in a private room beside the nursing station or in the co-researcher's hospital room.

Co-researchers were interviewed using an in-depth semi-structured interview format. Although the interview length varied, the average length of the interviews was approximately 1 hour and 15 minutes. All co-researchers felt well enough to complete the interview in a single session. The actual time spent with co-researchers was often much longer due to conversation before and after the interview.

Initially, I acquainted co-researchers with the nature and approximate duration of the interview. As well, I advised each woman to inform me if she felt ill, and that she could take a break if necessary. As well, co-researchers were advised that they could refrain from answering questions that they felt uncomfortable with, and could also ask to have the audio-tape turned off at any time.

The first interview was guided by the research question, "how do you make sense of your MI experience?" Co-researchers were encouraged to describe their experiences in the form of a story, with a beginning, a middle, and an end (see Appendix A).

White and Epston (1990) suggest that stories provide a means to express ourselves and make sense of our lives. Furthermore,
the experiences of past, present, and what is predicted to occur in the future, must be connected in a lineal sequence in order to develop the storied account. As all stories have a beginning, a middle, and an ending, this structure provides a frame through which an individual can organize and make sense of their experience (White & Epston, 1990).

This storied approach provided co-researchers with a means to frame their experiences of MI within the context of the interview. Co-researchers were encouraged to describe their story in as much detail as possible, with a focus on any thoughts, feelings, and behaviors that surrounded their experience. Open-ended questions aimed at facilitating the description of the co-researcher’s illness experience were used (see Appendix A). When necessary, prompts were used to help co-researchers further articulate, elaborate, or clarify their responses to questions.

Background information was also collected from each co-researcher at the end of the interview, and included brief demographic questions related to age, education, income, employment status, ethnicity, marital status, number of children, and previous history of illness (see Appendix B).

Before ending the interview session, co-researchers were given the opportunity to ask any questions or discuss their experience of the interview. I briefly explained the forthcoming process of transcription and data analysis. As well, I made arrangements to contact them following hospital discharge for a second validation interview.

Detailed field notes were recorded immediately following each interview in order to document co-researcher demeanour and
behavior (verbal and non-verbal), the emotional climate of the interview, and any notable distractions or disruptions that took place. As well, I recorded my subjective impressions of how I felt the interview proceeded, including my role as researcher, impressions or hunches about interview content, personal biases that arose, as well as any other personal reactions or "gut feelings" that would be helpful in documenting the experience. Brief field notes were also recorded for all of the validation interviews.

In general, it appeared that the co-researchers enjoyed being interviewed and welcomed the opportunity to talk about their experiences. Several co-researchers described feeling somewhat relieved to talk about the course of events surrounding their MI experience, while other women acknowledged feeling more clear about understanding their feelings surrounding certain aspects of their illness and hospitalization. Other women, who initially claimed to have little to discuss, expressed their surprise at having spoken extensively during the course of the interview.

The second validation interview, was conducted with co-researchers via telephone approximately 4 to 6 weeks post hospital discharge. The purpose of the validation interview, was to present my understanding of the co-researchers' descriptions of experience, and notable issues as revealed during the data collection interview. Co-researchers were encouraged to clarify, further develop and validate the descriptions and to ensure that all prominent aspects of their experience were included.

Prior to each validation interview, the interviews were reviewed via audiotape and then transcribed. The transcripts were
then reviewed in detail in order to gain a clearer sense of the women's descriptions, issues, and potential emerging themes.

Hycner (1985) acknowledges the value of the validation interview, and suggests that it provides co-researchers with the opportunity to confirm whether the researcher has accurately and fully captured her experience, to clarify any vague or incomplete material, and to provide further information that may crystallize the researcher's understanding of their experience. Validation interviews also serve to fully involve the co-researcher in the ongoing research process.

Hycner (1985) also suggests that the potential consequence of retrospective report is confabulation. Although usually done unconsciously, a co-researcher may fill in gaps of memory, or respond in a manner believed to please the researcher.

As a result of the validation interviews, co-researchers reported feeling as though I had accurately captured the essence of their MI experiences. Furthermore, none of the women felt the need to provide further clarification or information. Several co-researchers reiterated almost verbatim many of the issues they had discussed during the initial interview, whereas other women identified current concerns since returning home. Women also reported being at different places along the continuum of recovery. Four of the women reported being readmitted to hospital for further anginal symptoms or diagnostic testing.

Common to most of the validation interviews was the sense of appreciation for having had the opportunity to contribute to research concerning women's health. As well, most of the women voiced their appreciation for the follow-up telephone contact.
All of the co-researchers agreed to be contacted, if necessary, if further validation or clarification of the data were needed.

**Researcher's Impressions of the Interviews**

The process of conducting phenomenological interviews represented a challenging but rewarding learning experience.

My background as a cardiology technologist provided me with a fundamental understanding of cardiac illness and treatment, and of hospital procedures and routine. Having this knowledge and familiarity of the illness environment was particularly useful during the interviews. As a result, I felt as though I was better able to understand their hospital experience and felt that this enabled me to better hear women's stories. In addition, there were times where I was able to identify the name of a forgotten drug or procedure, or perhaps ask a co-researcher just the right question to facilitate a moment of insight into their own understanding of their MI experience. I felt that this presence strengthened the sense of trust and rapport that developed between me and the women I interviewed.

During the initial interviews, I found myself feeling concerned that although some women discussed their experiences as being deeply emotional, other women focused more on a cognitive or symptomatic level. It took only a couple of interviews before I felt more comfortable with these differences and acknowledged that inherent to this method are commonalities as well as differences as women described the meaning of their experiences. Moreover, I had to examine this initial reaction and recognize that my underlying bias implied that the contribution of a woman who explores existential concerns is more valuable than the
contributions of a co-researcher who does not. Once I was aware of this bias, I felt more able to set it aside.

Adopting the role of the researcher was one of the most challenging aspects of the interviewing process. At times, the boundaries between interviewer and counsellor felt unclear, and I had difficulty making the switch between roles. For example, when one of the women became extremely tearful while recounting an emotional experience, it felt inappropriate and uncomfortable to remain in the "neutral" researcher role. After a few data collection interviews, I became increasingly aware of the importance of finding a balance between the roles of researcher and counsellor. Oakley (1981) suggests that the pretence of neutrality on the part of the research interviewer is counterproductive to receiving the quality and depth of the information given by co-researchers.

In most cases, the goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical and when the interviewer is prepared to invest his or her own personal identity in the relationship. (p. 42)

For some of the interviews, I felt more directive than in other interviews where co-researchers felt more comfortable in the role of storyteller. Over the course of interviews, I became much more aware of a sense of rhythm that was either present or absent between me as researcher and co-researchers in the interview process.

I was also struck with the extent to which most women wanted to talk about their experiences. The depth to which most women shared their stories further reinforced the fact that there is little opportunity to address introspective concerns during the
course of medical treatment. One pilot interviewee described being intrigued by the notion of framing her experience of MI in terms of telling a story.

...the story part is intriguing...creating a story out of it rather than just giving the facts maam...which is often what you get in the hospital...the kind of responses that they just want in hospital are just facts...as opposed to feelings thoughts or whatever and as opposed to a story...how things came about more than just the symptoms.

Data Analysis

Data analysis occurred concurrently with data collection. Following each interview, audio-tapes were reviewed in order to get an initial sense of the co-researcher's experience and to become more familiar with the content of the interview. I then transcribed the tapes verbatim (including all verbal pauses). Transcripts were reviewed again and analyzed according to a qualitative method of analysis.

Giorgi's (1975, 1985) phenomenological data analysis method provided the means to identify and extract women's themes. This process included the following essential steps (Giorgi, 1975, pp. 74-75).

(a) The researcher reads through the entire text (verbatim transcription) in order to get a general sense of the whole description.

(b) The researcher reads through the same description more thoroughly and as many times as necessary, in order to delineate each time a transition in meaning is perceived with respect to the phenomena being studied. A series of meaning units or constituents are obtained through this process. More simply, the entire text cannot be analyzed simultaneously, and therefore must
be broken down into manageable units.

(c) Once meaning units have been delineated, any redundancies are eliminated. The researcher then clarifies and elaborates on the meaning of these constituents, by relating them to each other and to the sense of the whole description.

(d) The researcher reflects on the given meaning units that are still expressed in the language of the co-researcher. Meaning units are then transformed from the language of the co-researcher into psychological language, and examined for what they reveal about the phenomena in question, given the individual's situation. It is during this stage that the presence of the researcher is most evident.

(e) The researcher synthesizes all of the insights derived from the transformed meaning units into a consistent description of the structure of the co-researcher's experience.

Although Giorgi's (1975, 1985) steps for phenomenological data analysis were followed, there were numerous other common sense steps that I constructed that helped to supplement Giorgi's somewhat vague guidelines.

Following transcription, each transcript was reviewed several times before delineating meaning units. Meaning units were then highlighted and numbered. Numbering the meaning units allowed me to easily return to the text when necessary. Meaning units were then paraphrased, maintaining the integrity of the co-researchers language. This allowed me to more fully understand the nature of the woman's experience.

The paraphrased meaning units were then translated into psychological language, and underwent an ongoing iterative
process of revision until I felt clearer and consistent about the language I was using to describe their experiences. In other words, it was clearly important that the same language was being used to describe the same or similar experiences or events.

Initially, I followed this strategy for the first three transcripts to become familiarized with the process. The next three transcripts were analyzed following the same strategy, and then integrated with the previously analyzed transcripts. Once again, this entailed an ongoing iterative process of comparison and revision. At this point, I had almost created a guiding framework to analyse the remaining transcripts.

Once I had completed the psychological translations, they were catalogued and their frequency of occurrence was determined. At the same time, the corresponding meaning unit numbers were recorded. I created a list for each transcript outlining the translations and locations of corresponding text. Checking the frequency of these preliminary themes served to confirm my own sense about its relative importance. For some of the women, more than 50 preliminary themes emerged from this analysis.

An ongoing process of collapsing these preliminary themes into smaller categories resulted in data that were significantly more manageable. These preliminary themes were then further collapsed into thematic groupings from which nine common themes emerged.

Before translating meaning units into psychological language, I returned to my own subjective understanding of the co-researcher accounts and recorded what each women identified, either overtly or covertly, as being an important issue or
concern. I repeated this verification process, once the paraphrased meaning units were translated into psychological language, again recording important issues or concerns. Interestingly, both of these records closely resembled the final nine common themes that emerged from completed data analysis.

This thorough yet tremendously time consuming task resulted in the identification of commonalities that were evident across co-researcher accounts. Some of themes may appear to be more significant to some women than to others. As well, there was considerable variability in how co-researchers experienced these themes.

Summary

Qualitative methodology, namely phenomenology, was used to guide this study. Co-researchers were selected on the basis of recent MI diagnosis, informed consent, competency, ability, and willingness to describe their MI experience. Ten volunteer female co-researchers were interviewed twice over a period of 5 months. As well, two pilot interviews were conducted prior to data collection. Data comprised of transcribed audio-tapes and field notes taken from co-researcher interviews. Data analysis was conducted according to the phenomenological methods as outlined by Giorgi (1975, 1985). Completion of data analysis resulted in the description of co-researcher accounts and the identification of nine common themes.
CHAPTER FOUR

Presentation of the Findings

Introduction

This chapter presents the co-researchers accounts of their experience with MI as well as the common themes that emerged from the interviews using phenomenological analysis.

In order to gain a better understanding of the women that participated in this research, as well as to provide the basis and context for further analysis, I present a brief background for each co-researcher in the following section. Pseudonyms have been used to assure co-researcher anonymity. Excerpts, quoted verbatim, have been recorded in a way that most accurately reflects the co-researcher's actual conversation. For a concise summary of co-researcher's background information see Appendix E.

Background of Co-researchers

Lydia

Lydia is a 73-year-old retired nurse. She currently lives alone and has remained unmarried without children. Lydia came from an upper-middle-class family of medical professionals. She was previously hospitalized in the early 1980s with breast cancer and pulmonary fibrosis. As well, Lydia reported having one previous episode of angina several years ago.

Lydia was interviewed just prior to being discharged from hospital. She was interested and willing to participate in the study, yet felt that she was "not going to be very helpful." Lydia was pleasant to talk to and presented her opinions in an articulate manner. She appeared to be strongly independent and clear about her needs. At one point, she challenged my own
thoughts around how I would respond to having an MI.

Lydia’s account began with a recollection of having unusual chest pains that her doctor did not believe to be cardiac related. A few weeks later, she returned home from an appointment and experienced a chest pain that she quickly assessed to be cardiac in origin. Concerned about her vehicle, Lydia drove her car home before calling for the ambulance. In retrospect, she realized that her decision to drive home was "not very bright."

Lydia quickly arrived at the hospital where she was treated in emergency and admitted to the CCU. While in emergency, Lydia’s "chief reaction was interest to see what they do now days." She had worked in the hospital’s emergency department 30 years ago as a head nurse, and was familiar with the routine. Lydia felt that this familiarity provided her with the ability to better understand and anticipate the events surrounding her MI.

Lydia also reported being "very impressed" with the care that she received while hospitalized. She emphasized the importance of having rapport with one’s doctors in terms of feeling secure, and described feeling highly confident with both her general practitioner and cardiologist whom she had previously consulted as a patient and worked alongside while nursing..."she instills all sorts of faith and confidence in me."

Lydia made several references to her lack of fear or apprehension surrounding the process of getting to the hospital or to the notion of potentially not surviving, "the thought of maybe not surviving just didn’t bother me." She attributed this to her strong Catholic faith and to her background in nursing. She also revealed having two sisters living with Alzheimer's and
felt strongly that dying was preferable to experiencing the progressive degeneration inherent to the disease.

Lydia recounted her experiences in a rational and matter of fact manner, and rarely discussed her MI in terms of emotional affect. She did however, frequently question her own reaction of not feeling more concerned about the course of events.

When asked about the meaning of her MI experience, Lydia responded by discussing the information she would obtain from the results of her angiogram that was scheduled for the following week. This suggested that having concrete information was associated with the meaning of her experience.

While hospitalized, Lydia felt "absolutely overwhelmed by the concern" demonstrated by her large social network and described her friends as being particularly important to her.

Although Lydia exuded a strong aura of independence, her friends and family overrode her decision to remain alone after being discharged from the hospital. She did not identify any apprehensions about returning home and insisted that having an MI represented "just another day in my life."

Kiko

Kiko is a 65-year-old retired Japanese woman. For several years, she had worked in the fruit and vegetable wholesale business. She has 2 sons, 2 step daughters, and 3 grandchildren. Kiko is widowed and is currently living with her oldest son. She has no previous cardiac history, but was hospitalized 10 years ago with gallstones.

Kiko was eager to participate in the study. She appeared contemplative in terms of describing her experience and feelings,
and occasionally became tearful while talking about her family. Kiko's words suggested that she was an independent and spirited woman with an appetite for travel and adventure. She demonstrated an active sense of humour throughout the interview.

Kiko began her story by recalling a "cramping feeling" one night on the way home from visiting relatives. She attributed this to heartburn as it disappeared later that evening. A couple of days later, Kiko experienced a sense of feeling immobilized and dizzy while taking a bath. Several hours later, her son called for an ambulance when Kiko's symptoms became more intense and she was unable to get dressed. She was taken to a local hospital where she was diagnosed with MI.

Kiko described herself as feeling "immobilized by the pain." After several doses of morphine, her chest pain resided and she was admitted to the CCU. Kiko found it "really surprising until you yourself [are there]" to see how the "doctors and nurses work together." She recalled that the emergency staff "thought I can't speak English so they brought my son in there." After realizing that they were both English speaking, he was asked to wait outside.

Although Kiko felt as though she understood what the doctors and nurses were talking about while she was hospitalized, she expressed great concern for older Asian patients that could not speak English. She inquired as to whether the hospital provided interpreter services and felt that patients that did not have a sense of what was happening to them were disadvantaged. Kiko also expressed the belief that as a patient "you really have to trust them." She felt that "when the nurses and doctors are talking
it's good I find out everything."

During the interview, Kiko discussed several experiences of other people's illnesses including her husband's death; a girlfriend's stroke; her sister's heart attack; and her mother's experience with angina. She appeared to be deeply moved by all of these experiences.

Kiko also talked extensively about her concerns regarding the perceived effects of her illness on her two sons, and described feeling more worried about her family in terms of what they might go through if she did not survive her illness. She recounted the events surrounding her husband's death and how she felt this caused her sons a lot of grief. Kiko's comments suggested that she did not want to upset her sons in the same way or burden them with having to take care of her.

Although Kiko was looking forward to going home, she expressed some apprehension about what her recovery was going to look like. She felt determined that she would get better and looked forward to being able to have contact with her friends, pursue volunteer work, and make plans to travel. Although she expressed a desire to go home directly, she agreed to stay with her sister's family for a few days in order to appease her sons.

Kiko discussed several personal realizations when asked about the significance of having a heart attack. She felt that she had "learnt a lesson" by thinking there was "no way" she would have a MI, and felt that it would be wise to draft a will. Feeling less invulnerable, Kiko felt as though she had been given a second chance and that it was her turn to help others. She particularly felt that it is important to teach young people the value of
life. As well, Kiko discussed the prospect of more volunteer work as well as a desire to do more travelling.

Kaye

Kaye is a 75-year-old woman with a history of coronary artery disease. She had her first heart attack 8 years ago and underwent coronary bypass surgery over 16 years ago. Over the past several years she has been plagued with increasing back pain, shortness of breath, and has been diagnosed with hypertension. Kaye is currently self-employed as the manager of an income property in which she owns and also lives. Her previous employment history includes retail management, and property rental and management. A widow of many years, she has one son, and a young grandson. Her daughter-in-law works as a nurse at the local hospital in which she was hospitalized.

Kaye was interviewed shortly before hospital discharge and seemed to appreciate the opportunity to voice some of her concerns. She was strongly opinionated and talked unrelentingly about her experiences. Kaye appeared to be fiercely independent and described her plans for the future with an air of feisty determination. She frequently used humour when responding to emotional content as well as to demonstrate her sense of optimism. On several occasions during the interview, she appeared visibly restricted by her shortness of breath.

Kaye began her story by describing an intense radiating back pain that she experienced one evening while at home. Assuming this was a flare up of her chronic back pain, she put her hot water bottle on her back in hopes to ease the pain. "Naturally it wouldn't dawn on me that it was my heart." As Kaye prepared to
get ready for bed she became very ill. She described her pain as "severe" and felt that "[she] could have climbed the walls."

Shortly thereafter, she was taken to the emergency department of the local hospital by her son who had coincidentally dropped by. Kaye made several references to feeling concerned about not knowing what had happened to her in the emergency department due to the fact that she had lost her memory for the first several days of hospitalization, "I don't what they did...and I don't suppose that I'll ever know...it bugs me, I'd like to know." At one point, Kaye questioned even having a MI, "they're talking about heart attack and I didn't have no heart attack." She frequently expressed feeling dissatisfied and angry with the lack of information she had received and felt as though she had to "fight" with her doctor in order to find out the status of her condition. Kaye was adamant that patients should be able to frankly discuss their health with their doctors. Subsequently, she talked about switching to a doctor who she felt would take better care of her.

When asked about the meaning of her MI experience, Kaye talked extensively about her concerns of taking care of her financial affairs. More specifically, the pressure that surrounds selling her income property and settling into a more suitable accommodation. "I've got to get out of there and settled...and then if I die, I die...I have to feel prepared...I've got to get rid of the place I've got and the worry of all the work." She expressed feeling overwhelmed by the enormity of this task.

Kaye also discussed her frustration and embarrassment around her deteriorating physical condition. Although she considers
herself to be "more agile than a lot of older people," she acknowledged that her shortness of breath and back pain had increasingly restricted her mobility in the past few years and had interrupted the process of finding a new home.

When asked about returning home, Kaye remarked "I can’t wait to get home...I can’t wait to get in the door." She talked about the pleasures and familiarity of her home, and the support of her neighbours and her son.

Roslynn

Roslynn is a 47-year-old professional engineer. She is currently employed and has worked extensively within the field of engineering in positions such as shoreman engineer and geologist, university lecturer, and engineering management consultant. Roslynn recently relocated from overseas and is presently living with her aging mother. She is a divorcee of many years, and has 1 son, 1 daughter, and 4 grandchildren. In terms of cardiac history, Roslynn had two MIs in 1988, but has experienced few cardiac symptoms during the last several years. She has been diagnosed with high cholesterol, and had a kidney stone removed in 1993.

Roslynn gladly agreed to participate in the study. She articulately discussed her experiences and philosophies with an air of honesty and self reflection. As well, she appeared to be strongly independent and decisive about her needs and plans for the future. I was struck by my sense of familiarity and ease with her during the interview, and by the profound sense that we had met before.

Roslynn began her story with a detailed account and
description of the events surrounding her first MI in 1988. While at work, she became increasing symptomatic with angina. "I didn’t know what was happening to me...I didn’t know it was a heart attack...I didn’t know it was angina...all I knew was...it hurt like hell." The receptionist called for an ambulance and Roslynn was taken to the hospital and ultimately diagnosed with MI. A couple of days later she experienced her second MI while still in hospital.

Following her first MI, Roslynn became determined to take control over her health. Subsequently, she made lifestyle changes in terms of diet, exercise, controlling her cholesterol, as well as an overall mindfulness towards health and wellness.

Roslynn discussed her recovery from her first MIs in terms of rehabilitation, return to work, making sense of the experience, and the subsequent emotional and cognitive process following the illness. For example, she talked extensively about the impact of memory loss post MI, and described her fear and frustration of forgetting information and student’s names while teaching at the university. Roslynn also recounted, "the scary part was wondering how is my body going to cope with the emotions." She described her process and experience with such clarity using terms such as "acceptance factor," "regret syndrome," and "denial factor." It was as though Roslynn had constructed a theory of psychological recovery from MI based on her own experience and personal research.

Furthermore, she theorized extensively about the differences between women and men in terms of attributions, self reliance, and self control and how these factors related to MI. On numerous
occasions, she reiterated the importance of women regaining a sense of control of their bodies and their lives. She also explored the relationship between mind control and MI, and suggested that "the cleansing of the system starts with a cleansing of your mind...correct all of your problems...cure those problems and then you can cure your heart attack...and then you can cure your heart."

Roslynn’s current MI occurred approximately 5 months after relocating from overseas. After experiencing a few episodes of angina over the course of several days, Roslynn was examined by her doctor who gave her a clean bill of health. Two nights later, she experienced angina before going to sleep, and later again that night. Her symptoms continued into the morning, when she realized that she was having a heart attack. In a calculated and strategic manner, she called 911 and prepared herself for transport to the hospital. In the mean time, Roslynn’s mother developed an arrhythmia as a result of witnessing the attack and was taken to the same hospital in a second ambulance.

When the ambulance arrived, Roslynn told the attendants "I’ve got this bad angina [knowing] it was a heart attack," and was quickly taken to the local hospital. "I finally get there...I’m all smiles...it had passed...it was done." While in emergency, Roslynn waited several hours before seeing a cardiologist. "I knew I was in good hands and anything I needed was there...I wasn’t worried but somebody else could of raised a helluva fuss because it was not my first heart attack and I knew what I had."

Roslynn had her fourth MI later that night in the CCU. Subsequent angiography revealed further occlusions and her
doctors recommended immediate bypass surgery. In response to these recommendations, Roslynn negotiated for time with her doctors and maintained that she would have the surgery when she felt that it was the right thing to do. "I've got to straighten my life first." She also suggested that "nobody has given me the chance to treat myself yet, and...I want the chance to treat myself naturally before the knife is going to cut me open."

In terms of making sense of her current MI, Roslynn suggested that "the first thing I did wrong was indulging in some food that I shouldn't have." She suggested that the second contributing factor was the stress associated with her perceived loss of freedom resulting from the responsibility of caretaking her aging mother.

Roslynn made very little mention of her experience of hospitalization or of the quality of care that she received while hospitalized.

With respect to returning home, Roslynn was looking forward to having her daughter visit and spend time with her and her mother. Her comments suggested that returning home represented a point of transition in terms of making changes with respect to her caretaking responsibilities for her mother. She described her plan to arrange for an attendant to take over the majority of these responsibilities. "That's the only way I'll regain my freedom...when my mother transfers her reliance onto somebody else...only at that time can I move into my control...in order to cure myself."

Roslynn also discussed her vision to create a healing center for people like herself who are living with heart disease. She
envisioned integrating a more intuitive or introspective component into the center including practices such as meditation. She suggested that a central focus of the center would be to encourage people to regain a sense of personal control. Roslynn acknowledged that the center would also serve as a vehicle through which she could move away from her current career that "she couldn't actively do any more." Finally, Roslynn made reference to her experience of this last heart attack "like pieces of a puzzle that come and fall into place." "Everything is falling into place and like this heart attack business...I don't believe it just happens, it's got a medical cause but my philosophy is that it may happen because I need to do this centre...maybe this is what I'm here for."

**Penny**

Penny is 40 years old and the youngest of the study's co-researchers. She has no previous cardiac history or recognized risk factors, and reported having no previous illnesses. She was once hospitalized with vertigo several years ago. Penny is married without children and currently works in the social housing department of a large mortgage and housing firm.

Penny was eager to participate in the study and appeared to appreciate the opportunity to share her experience of MI. She was soft spoken and pleasant to talk to, and became increasingly animated as the interview progressed. Penny provided a detailed and articulate account of her experiences, feelings, and reactions to events.

Penny recounted being on vacation with her husband and teenage nephew when she started to experience intermittent chest
pain which she attributed to indigestion. After a few nights, Penny’s symptoms worsened as her chest pain intensified and she became increasingly ill. After deciding "that this wasn’t anything normal," her husband called for an ambulance. "I knew that there was something seriously enough wrong that I had to go to the hospital...but I still had no idea that it was a heart attack." Penny made a conscious effort to pace herself and relax, knowing that the ambulance would take about 2 hours to arrive from the closest town.

Within minutes of arriving, the ambulance attendants transported Penny to the local hospital where she underwent several routine tests and was diagnosed with MI. She recalled her disbelief at having a MI. Penny was quickly transferred to the CCU where she mostly slept for the first few days.

Penny described feeling worried about the severity of her condition only after she was told she required a temporary pacemaker. She quickly felt relieved after staff provided a thorough explanation of the procedure and dispelled her notions of major surgery.

Penny noted several occasions where she was surprised by the fact that her experience in the CCU "didn’t seem that bad... everything seemed to go in and come out very quickly...I was surprised at how painless everything was...nothing really hurt." At the same time, she expressed a sense of relief at getting rid of the tubes and lines, and regaining her mobility, "it made me feel much better to know I didn’t have to rely on all these things...my body was able to do all these things again by itself which was a real relief."
Although Penny "tried not to think about what had happened a lot of the time," she admitted feeling a sense of uneasiness at night before going to sleep. She attributed this to feeling fearful that something might happen to her while sleeping, "I guess after a few night of waking up every morning I kinda realized that I was going to be...hoping to be okay."

Penny remained in the local hospital for about a week before being transferred to the city center for further invasive testing. She felt "happy" to be transferred, and believed the angiogram would provide more information about the status of her heart. She made a point of asking her cardiologist for a picture of her angiogram and "felt better" when she could see it for herself. She later described the angiogram as being "a milestone" in terms of her hospital experience. "I [felt] much more relaxed...much more comfortable about my heart."

Penny described the care that she received both at the rural and city hospital as being "excellent," and felt that the nurses had really taken the time to make her experience as "comfortable" as possible.

When asked about the meaning of her MI experience, Penny suggested that her MI was a "freak" event because of her age and lack of risk factors. She did however, express some concern about making sure that she did not have another one.

Penny expressed her desire to return home after spending 2 weeks in the hospital. Her comments suggested that she would maintain a sensible approach to recovery, and did not expect to return to the same level of responsibility or activity until she was given clearance by her doctor. Although Penny reassured her
husband that she would follow doctor’s orders, she was concerned that he was going to overextend himself once she returned home. Consequently, she felt more "worried" about her husband than herself.

Hilda

Hilda is a 64-year-old retired woman who is currently married and living with her husband who also has a history of MI. She has 9 adult children and 17 grandchildren. Hilda reported having had occasional employment as a cook and baker in local restaurants, as well as maintaining entrepreneurial interests with her husband. Previous illnesses included appendicitis as a child. She also reported having one previous episode of angina and angiography several years ago, and is currently on medication for high blood pressure.

Hilda was interviewed shortly before hospital discharge. She described feeling enthusiastic to potentially be able to help other heart patients. Hilda communicated her thoughts and feelings in a direct and thoughtful manner. She provided vivid descriptions of her experience of hospitalization and appeared comfortable discussing the emotional impact of these events. I was struck with the ease at which the interview transpired, and Hilda's ability to eloquently summarize what several other co-researchers had discussed.

Hilda's account began hours after returning home from a celebration of her 45th wedding anniversary. She awoke to "severe" chest pressure that radiated into her neck. As her symptoms worsened, Hilda's husband took Hilda to the local hospital, "he was more concerned than I was...I knew something
was going on but I never considered a heart attack...I didn't think that my condition was serious enough."

After a series of tests, Hilda was diagnosed with angina and admitted for observation. Over the next 6 days, Hilda continued to experience intermittent pain. In addition, she had two more angina attacks, including a severe event that occurred the night before she was to be discharged. Subsequently, Hilda was transferred to the city hospital. By then she had developed pneumonia and was found to be highly allergic to the blood thinner she had been given for the past several days. She continued to experience angina symptoms and underwent angiography a few days later. Test results confirmed a blocked artery and angioplasty was performed.

The next day, Hilda experienced "another kind of pain I never had before" and promptly went into cardiac arrest. Although she was successfully resuscitated, Hilda described feeling more fearful anticipating emotional discomfort than towards the pain or discomfort associated with treatment.

Hilda talked extensively about her experience in the CCU in terms of losing her "dignity," "privacy," "independence" and just the "regular" way of doing things. As well, Hilda suggested how difficult it was to endure setbacks in the process of getting well, "everyday it's different...you feel good 2 or 3 days and then suddenly something comes in and knocks you down and you try to get up."

When asked about the meaning of her MI experience, Hilda talked about reevaluating what is important to her. She also mentioned having a greater awareness and appreciation for all the
things that are easily taken for granted such as mobility, independence, or watching a granddaughter’s first step. "It is a terrible thing when you lose the smallest privileges...nobody knows until it happens...what we take for granted."

Hilda also described feeling much closer to her family and her husband, and realized the importance of simply spending quality time with them. In terms of her husband, she felt that their "situation had changed" in that he had undergone the same "awful stress and strain" that Hilda had experienced when he had been hospitalized with MI.

Despite her unfavourable experience in the CCU, Hilda described receiving "excellent" care from the nurses, "they would have done anything to make your life a little more easier."

Although she talked mostly about nursing care, she described an incident where a doctor had gone out of his way to be kind. Hilda felt that any extra efforts made by health care professionals made a big difference to a patient’s well-being.

In contrast, Hilda described an incident with her cardiologist that "just about threw [her]." He felt "iffy" about recommending bypass surgery because of her highly allergic reaction to blood thinners, and therefore suggested that she should "ride it out for a while and live with a little bad plumbing" and see what happens. Hilda felt unclear as to the potential ramifications of her doctor’s advice, and felt that she needed more information in order to better understand her options and limitations.

Hilda talked extensively about her experience of being transferred from the constant care of the CCU to the independence
of the cardiac ward once her condition had stabilized. She described feeling somewhere between "abandoned" and "neglected" as a result of this transition. Although Hilda appreciated regaining the privacy she had lost while in the CCU, she felt anxious about how independent she was expected to be and described wanting more guidance from the nurses.

At times, Hilda found herself feeling concerned about "silly things" such as whether her heart monitor was working at the nursing station, or whether her nurses knew she was there at all. Once again, she attributed these concerns to the changes in care and attention from the CCU to the ward.

Hilda described feeling anxious about returning home both in terms of regaining the comfort and familiarity of her home, "to be able to go out my back door and smell fresh air and look at the garden I planted...and to be able to just look out at the mountains," but also in terms of questioning her ability to "cope" with the uncertainty of her health.

Hilda received substantial support from her husband and family throughout her hospitalization. Although she felt somewhat "guilty" about the extent of her family's efforts, she confessed that she would have felt sad had they not made the effort. Hilda emphasized that she had always been an independent type of person and "hate[s] to put anybody out."

In terms of planning for the future, Hilda recognized that it would be beneficial to try and slow down a bit and adopt a more "laid back" attitude. Moreover, she felt that her sense of urgency in terms of getting things accomplished will no longer be important to her.
Anne is a 63-year-old woman hospitalized with her fourth MI. She is married with 2 adult children and 1 grand child. Anne is a homemaker, and has been heavily involved in the Eastern Star, a Masonic affiliation for the past 28 years. She has an extensive cardiac history that began around the age of 40 with her first MI, and included bypass surgery after her third MI. In terms of previous illness, Anne was diagnosed with high cholesterol several years ago, has had a benign breast tumour removed, and had several surgeries as a teenager related to a neck cyst. She also recalled that her mother had an extensive cardiac history, and died after her 13th MI.

Anne agreed to participate in the study despite initial concerns that she had little to contribute. As she eased into the interview, Anne became more animated and seemed to appreciate the opportunity to share and reflect on her experiences. While she appeared as a gentle and sensitive woman, she also exuded an aura of strength, determination, and independence. She recounted her experiences in a thoughtful and detailed manner, and shifted eloquently between vividly describing experiences and exploring emotional concerns.

Anne's story began with a detailed account of the events surrounding her first MI which occurred over 20 years ago. While camping with her family, Anne became increasingly symptomatic with pain and nausea. After seeking help from a nearby rural hospital, she was told that she was fine and was released. A couple of days later, Anne returned to the hospital with severe pain and was diagnosed with MI, "it never entered my mind I was
having a heart attack...I was mad it was on holidays...I was mad that I was sick...I didn’t waste time worrying about me." She felt more concerned about her "poor" husband than herself, and felt badly about interrupting the family’s plans. Anne was hospitalized for a week before being sent home and readmitted to her own local hospital.

It was then that Anne made the connection between her own health and her mother’s extensive history of cardiac illness, "that’s the way I’m going to die...I didn’t think I was going to die then...but when I do die...it will be a heart attack that I die from." She acknowledged feeling regretful for not asking her mother more about her heart condition.

Four years later, Anne experienced her second MI. She recalled feeling agitated several days before the attack. Anne’s cardiac symptoms began while at home with her husband, and increased in severity after being admitted to hospital. She was transferred to the intensive care unit of a larger hospital where she was kept for observation and was later sent to the city hospital for subsequent angiography. She recalled being told that her test results were positive, and feeling shocked when her doctor suggested that she was "inoperable" as "there was really nothing they could do" except prescribe medication. She was hospitalized for about a month.

Anne described feeling "very frustrated" as a result of her memory loss which lasted over a year after her second MI. At times, she felt "really mad" at her family when they would get angry at her forgetfulness.

Several years later, Anne had her third MI while at home. She
was lucky to catch her husband’s attention before he left for work, "he happened to look up because I know he couldn’t have heard me the window was closed...but I guess I looked white as a sheet." Shortly thereafter, Anne collapsed in the bathroom, "that was the only time that I know of that I came out and said I don’t think I was going to make it this time." She was quickly transported to hospital and admitted with MI.

Although Anne remembered very little of her third MI, she described it as being the most severe. During her 2 month hospitalization, she underwent coronary bypass surgery, and was at one point, on a ventilator for over 16 days. Prior to surgery, Anne recalled being too weak to get herself off the bed or walk even a few steps, "that was a terrible shock...I couldn’t believe I couldn’t do it."

During her recovery, Anne’s sister told her that the family had been called in because she was not expected to live through the day, "I never thought I was going to die...it just never entered my mind." Anne recalled telling someone after recovering from surgery, "...well you know it really isn’t so bad to go and die because you’re unconscious and you don’t know a damn thing anyway...so it doesn’t really bother you at all."

Anne’s current MI occurred 8 years after her previous attack. She recalled feeling irritable a few days before the event and wondered if she was going to have another attack. In retrospect, she recalled having a vague sense that something was wrong, "for about a month and a half, I had a funny feeling that I might have a heart attack but there’s not a thing I could put my finger on...I didn’t even know what I didn’t feel right about."
Anne had experienced MI symptoms after a strenuous morning of working in her garden. Being alone, she immediately called her neighbour for help and was quickly taken to hospital. Once in emergency, Anne reassured the attending doctor that her pain was a heart attack and not indigestion. She became very ill and was transferred to the CCU. Unlike previous MIs, "I didn't think about [my husband]...I didn't think about the kids...I just wanted the pain to stop." As a result, she remembered feeling "selfish."

Anne was transferred to the city hospital's CCU where she underwent further angiography. Although she dreaded undergoing the procedure, she felt more apprehensive about obtaining the results.

In general, Anne described feeling more intuitively aware of her body and illness symptoms since her first MI. For example, at one point, she informed the CCU nurses that she was in heart failure. Although she described the current heart attack as being one of the most painful ones, she felt that it had been "easy" compared to the others, "I've just sort of perked up and I'm pretty good...I'm not an invalid at all."

On several occasions, Anne described feeling embarrassed at the lack of privacy and the experience of feeling exposed while hospitalized, particularly while in the CCU which she noted is mostly occupied by men. She felt more fearful of being put in an embarrassing position than of experiencing another heart attack.

Anne also talked about the difficulty of being transferred from the CCU to the cardiac ward, "in a way you feel let down because inside you're really in a cocoon...you are in a cocoon
and you’re protected and all of the sudden you’re out into the next room...abandoned." Anne also talked about the feelings of vulnerability she experienced and about having felt "very weepy" after her MIs, "I hate myself when I do it...I just hate it...I don’t want to lose that kind of control...[I want] people to think I’m in control whether I am or not.

With respect to treatment and care, Anne described being treated "just super most of the times." She did however, recall a some incidents where she had felt humiliated by a few nurses and doctors. In general, Anne described herself as being "a pretty good patient because [she does not] complain very much."

When asked about the significance of this MI, Anne talked about how "furious" she had felt because of being forced to give up certain activities that she really enjoys. She also talked about the importance of changing her lifestyle as well as having "some regrets" about not preventing some of her illness, "...why did I smoke...I know part of it is hereditary, I know that for sure....80% is probably the smoke...it took me two heart attacks to quit smoking." Although she knew she would never really know why she had this MI, she attributed it to the "stress" of being overworked.

In terms of going home, Anne emphatically expressed her desire to "get out of here and get strong and start doing my thing again." She talked about having a lot to do including the responsibilities related to her work. She acknowledged feeling worried at the prospect of not getting her work done and felt that she did not have "the little button that can shut that stress off."
Anne also expressed her concerns about being alone once she returned home, and recalled a frightening experience after her third MI where she had felt stranded in her kitchen without anyone being at home. Despite her concerns, she acknowledged feeling much less weak after this MI than in the past.

Although Anne described having familial and social support throughout her illness, she also talked about previous experiences of feeling "smothered" by her family after returning home from the hospital. She described times where there was little she could do without her family being afraid that she would have another attack, and firmly believed that her illness was probably harder on family members than on herself. While she wanted to "reassure" them that she was going to be all right, she also needed to be the one who decided whether or not she needed their help, "I want to be in control...I didn't realize...but that did bother me when I got home last time...that I just could not be myself."

In terms of the future, Anne acknowledged that there are many things that she wants to do in her life but wonders how long she will live with her heart condition. She also talked about the importance of spending time with her family, as well as her desire to travel.

Reflecting back on her experience of having four MIs, Anne recognized that "every one [was] different...they are not the same and that probably was one of my biggest surprises." She also suggested that when you experience MI symptoms, part of your mind says "I can't be having another one" and the other part of your mind says "sure you are having another one."
Noreen

Noreen is a 58-year-old woman that underwent coronary bypass surgery while hospitalized with MI. Prior to her MI, she was working part-time as a cook and waitress in a local cafe, providing child care for one of her daughters. Noreen has 7 adult children, and currently lives with a married daughter in a small rural town. She described a vague history of cardiac arrhythmia for which she had taken medication for 10 to 15 years. Other than birthing her children, Noreen had only been hospitalized for appendicitis as a young child. She is currently a smoker.

When I first met Noreen, she appeared somewhat disoriented as a result of her medication. A few days later, she was lucid and agreed to participate in the study. Noreen described her experiences in a straightforward manner, and was willing to share her feelings surrounding the dramatic course of illness events. Moreover, she appeared to maintain a common sense and self nurturing approach to coping with her illness and expected recovery.

Noreen began her story by recalling how "scared" she had been, "I didn't know what was happening...the whole experience was kinda dumped in my lap." For 2 months prior to her MI, she had experienced increasingly severe anginal symptoms. Noreen admitted that she did not want to acknowledge these symptoms as being serious, "I didn't want to think that I was heading for a heart attack so I didn't bother."

She recalled being out with her daughter when she experienced chest and arm pain that became worsen over the evening. She was taken to the local diagnostic center and was given nitroglycerin
which subsequently relieved her chest pain and shortness of
breathe. Noreen was told to go home and return the next day to
have her blood pressure checked. The next night, she had a
"really bad attack" and returned to the diagnostic center where
she was given more nitroglycerin and other medication. Again, she
was sent home and asked to return to have her blood pressure
monitored the following day. Noreen returned to the diagnostic
center four or five times over the next week to have her blood
pressure monitored.

A week later, Noreen was told by her doctor that her blood
pressure had stabilized. She was given more medication and asked
to return for further blood tests. Shortly after arriving home,
she experienced "excruciating" chest pain and became extremely
ill. Subsequently, she was sent by ambulance to the closest rural
hospital. From there, Noreen was transferred to a larger rural
hospital where she was told that she had experienced a massive
coronary attack.

Noreen described her initial reaction as being "just blank
mostly...that first initial shock was just kind of blank." She
became "perturbed" at her doctor and felt that she should have
been hospitalized earlier, "it may of given me the leap I
needed." Noreen also recalled feeling "scared" that she would
never see her kids again.

Shortly thereafter, Noreen was flown by air ambulance to the
city hospital for further treatment, despite her fear of flying.
She was accompanied by her youngest daughter which helped to
relieve some of her anxiety.

Central to Noreen's experience of hospitalization was her
adverse reaction to the various medications she was prescribed. She talked extensively about her stay in the CCU and described her experience of hallucinations as being "scary" and "horrifying." Noreen provided detailed and vivid accounts of several hallucinations, in which the theme of death was frequently depicted.

She recounted several instances where she felt overwhelmed by her experiences while in the CCU. For example, Noreen recalled telling the nurses "I'm all by myself...don't leave me," while at the same time feeling "panicked" and screaming "get out of here." She felt badly about her often "sarcastic" and "rough" behavior towards the nurses and wondered why they "hadn't just given me a shot...something to put me under...something to kind of shut me up." In retrospect, she knew that they were trying to do everything they could for her. Noreen described herself as being a normally pretty calm and cool individual, "the heart attack I'd go through a hundred times again before I'd ever go through one of those drug things...it was just horrendous...horrible...the worst experience I ever had in my life." Subsequently, Noreen was sent for angiography and coronary bypass surgery. During the interview, she made very little reference to having undergone surgery.

In terms of treatment and care, Noreen talked about having a different appreciation for the medical profession. She described the nursing care she had received as being "fantastic" and felt they "deserved a medal...I don't think I'll ever look at a nurse or anything like that again and take them for granted." She also described the doctors as being "good people" who "know what
they’re doing."

Noreen talked about having "a lot of people supporting her" throughout her illness, including her children who had been "100% great." Her children often visited and stayed with her, "I was better as long as somebody stayed right there and hung right onto me." Noreen described feeling very concerned about her children and wondered what was going to happen to them once she was "gone." She further described them as being just about everything that she has and wanted to leave each of them a special message for when she is no longer around.

When asked about the significance of having had a heart attack, Noreen suggested that it has made her stop and contemplate the direction of her life particularly since she is without a partner. She also acknowledged the importance taking better care of her health in the future. In terms of making changes, Noreen understood that she needed to quite smoking and caffeine, and make some "common sense" alterations to her diet. She acknowledged that her biggest challenge would be to stay away from the cigarettes particularly "when I get home and on my own and back with my friends and playing bingo...and things like that."

In terms of going home, Noreen talked about focusing on "just getting better" and wanted to "mostly just go to bed and recuperate." She wanted to spend time with family members during her recovery and had offers to visit both her daughter and sister who live out of town. More immediately, Noreen described how different it was going to be for her to stay at her daughter’s home without doing all the things that she was used to doing
prior to her MI and surgery. She felt that this transition was "going to take some getting used to" in terms of having to "sit back and not do anything."

In general, Noreen appeared optimistic towards the future and suggested that "it will work out alright I hope...I don't know...I guess we'll just have to wait and see." She also demonstrated a realistic approach to recovery in terms of taking care of herself and understanding the need to make some changes in her life. For example, she did not expect to return to either child care or cafe work, and did not feel "too concerned" about future employment, "I don't know what I'll get...but I'll get something somewhere along the line."

Noreen felt that if there was one piece of advice that she could give to other women it would be to have regular medical check-ups, particularly if there was any suspicion of heart trouble.

Brynn

Brynn is a 51-year-old woman without a previous history of cardiac disease. She is currently living with her second husband and has three adult children none of whom are living at home. Although currently unemployed, Brynn has a bachelors degree in nursing and has worked in nursing for many years. In terms of previous illness, Brynn had her gall bladder removed and has received treatment for dysplasia. She is currently taking medication for depression.

Brynn was enthusiastic about participating in the study. She was outspoken and willing to share her thoughts and feelings related to her MI experience. Throughout the interview, Brynn
expressed an lively sense of humour, which seemed to balance her introspectiveness brought on by her sudden illness. She frequently drew upon her nursing knowledge in terms of making sense of her experiences.

Brynn began her story by describing the symptoms that she initially attributed to indigestion. Despite treatment with prescribed medication and antacids, her symptoms intensified. The next morning, Brynn’s pain suddenly became worse and she became "very frightened." She felt torn between having a sense of "disbelief that this was happening to me," and having the expertise of a nurse and the knowledge that her symptoms were cardiac related. After contacting her doctor for a second time, she was taken by her partner to the city hospital located only a few minutes away. Shortly thereafter, she was diagnosed with MI and transferred to the CCU.

Brynn talked extensively about her experience in the emergency department. She described feeling worried about small things even before she was admitted, "you don’t lose your mind...you just go into a panic thinking about all these other things that are crowding into your mind." Brynn felt worried about finding accessible parking, and about how her partner was feeling. She felt as though she had to be "strong" for him until they reached the emergency and where she assumed she would be in good hands. As well, she was concerned that he was not allowed to be with her in the treatment area and was disappointed that the staff did not treat him in a reassuring manner.

Brynn was struck with "the different levels of professionals asking questions...asking the same questions over and over" while
in emergency. She felt aggravated by this process, particularly when she was trying to cope with her increasing pain. At one point, someone had asked her to participate in a research study, "I was frightened and it was making me angry." She also felt "frightened" by one particular intern who she felt had behaved aggressively towards her and who was not working collaboratively with the other staff. Brynn emphasized the importance of feeling safe and secure as a patient and felt that this is largely influenced by the medical staff one encounters while hospitalized.

After being hospitalized, Brynn was sent for an angioplasty which confirmed that she had suffered a massive anterior MI. Although she recalled very little of her first 3 days in the CCU, she described having gone through "the crazies" and was told by staff that her aggressive behavior was likely caused by a lack of oxygen.

Brynn received lots of support from her family as they came from across the country to visit her, "I didn't know they cared all that much... it pulled me through." Other than her emergency experience, she talked very little about the quality of care that she had received from other health care providers. She did briefly comment on the CCU staff, "it's great...you scratch your back and they run into see what you are doing."

Brynn attributed her MI to the current stressors in her life including financial worries and the difficulties that both her and her partner have had trying to find employment. She also discussed the dramatic death of one of her best friends, and concerns related to her partner's health.
Brynn described feeling "very introspective" during her time in hospital. She talked freely about her spiritual beliefs as well as her thoughts about having survived a potentially life threatening event. She reflected on her life and her accomplishments revolving around raising her children, surviving a divorce, building an emotionally successful second marriage, and returning to school. "I've been proactive about a certain number of things, but I haven't looked after my own health very well."

Brynn felt that having an MI provided her with an opportunity to recognize that for a long time she has taken care of others and now must learn how to take care of herself. Moreover, she felt "grateful" that God has given her another chance to "live a better life". Brynn also felt that she was undergoing a transformational or objective period and needed to analyze and reevaluate her values.

She described feeling "emotionally labile" throughout her hospitalization and found that she had difficulty concentrating. At other times, Brynn felt suddenly teary and remorseful about past events. She talked openly about death, "I'm not afraid of dying...if I die it's Gods will...actually there are some great people I'm looking forward to seeing."

When asked about the significance of having a MI, Brynn suggested that her experience has brought her closer to her children and husband. She described having a greater sense of appreciation for her relationships with her children and how these have evolved into friendships. She hoped that she would serve as a "good role model" for them, and that her children
would learn from her experiences.

In general, Brynn appeared hopeful about the future. Although she anticipated having to make adjustments, she was looking forward to returning home. She felt that the hardest task for her would be to quit smoking, and she expressed some "fear" around this task. In terms of making other changes, Brynn described wanting to stop doing the "mini mouse," a term she describes for being afraid to stand up for herself and feeling taken advantage of by others.

In retrospect, Brynn suggested that every household should prepare themselves for emergency situations by learning cardiopulmonary resuscitation (CPR), and by posting emergency numbers in accessible places. As well, she emphasized the importance of getting a yearly medical check-up.

Gina

Gina is a 44-year-old woman with an extensive family history of heart disease. She is married and has two adult children. She is currently employed as a clerk in a beer and wine outlet, and is involved with building a family dude ranch. In terms of previous illness, Gina had a tonsillectomy as a child, a hysterectomy in her twenties, and sciatica. Gina was also diagnosed with slow esophageal reflex after an episode of severe stomach pain.

Gina was interviewed a few days before undergoing coronary bypass surgery. She was pleasant and easy to talk to, and had an animated sense of humour. She appeared to be outspoken and discussed her experiences in a candid manner. Gina also appeared to appreciate the opportunity to share her more existential
questions and concerns.

Gina's account began with a recollection of stomach pain during heavy housework. Since this pain was almost identical to an episode of pain she experienced a year ago, she assumed it was related to an alleged stomach ailment. Subsequently, Gina stopped working and the pain subsided. After resuming work, the pain returned and again she stopped working. By the time Gina had asked her husband for help with the house cleaning, she had overexerted herself and was having severe pain. When her symptoms worsened, she realized she was having a MI and was taken to the local rural hospital by her husband.

Once in emergency, the nursing staff initiated treatment for stomach trouble. After more thorough testing, she was diagnosed with MI and transferred to the intensive care unit. Gina recalled feeling disappointed that she had had to wait to see a doctor in emergency.

She described feeling not "particularly alarmed" that she had suffered a heart attack, given her extensive family history of heart disease and her "ignorant lifestyle." "I knew it was a matter of time before I had a MI of my own...I knew it was coming...I just didn't know when." At this time, it occurred to her that her previously diagnosed stomach trouble was angina.

Gina was hospitalized for 5 days and then released with the instructions "to take it easy" and to return in a few days for a stress test. In retrospect, Gina assumed that taking it easy meant not to work or lift anything, but admitted that these instructions had not been clarified.

Later that day, Gina ran a series of errands and then visited
with friends and family. After being startled while napping, her anginal pain returned and she was taken to the local hospital for treatment. She was admitted to a different hospital and told that she had "fairly significant" heart damage. Moreover, her doctor felt she had been previously released too early and recommended that she be sent to the city hospital for angiography.

Gina felt that neither herself or her husband had wanted to admit the severity of her condition, but "we both had to sit up and take note" after her second hospitalization. She described feeling "reassured" at the thought of being transferred to the city hospital and assumed that she would receive better care.

Gina reported being "totally impressed" with the quality of care she received in the city hospital, particularly while in the CCU. She felt awed by the nurses ability to provide sincere and "consistent compassion." She also felt that the care she received after being transferred to the ward was "good" and reported feeling "secure", despite the fact that the staff was busier and could not spend the same amount of time with patients.

Although Gina was not too surprised that she had had a MI, she felt "really alarmed" at the results of her angiogram which indicated that she had seven blockages and required coronary bypass surgery. More specifically, she was astonished at the extent of her disease because of her age, even though she knew she had been "gambling" with smoking and being overweight.

Gina talked extensively about her concerns related to bypass surgery. Although the surgeon suggested that "she would be good for another 40 years" provided she watch her diet, quit smoking, and exercised, she still expressed her misgivings. She recalled
having a hysterectomy at age 23, along with at least 10 other women she had gone to school with, and felt that the surgery was unnecessarily radical. Moreover, the surgery prevented her from having more than 2 children.

Gina's felt concerned that she was once again being misguided by the medical profession. She questioned the factors that were relevant in deciding treatment and wondered whether she had other options such as angioplasty. Moreover, she felt unclear about the repercussions of having bypass surgery and felt that she had not received satisfactory information from her doctors. Although Gina described herself as being very outspoken, she acknowledged having difficulty approaching her doctors to discuss these concerns, and admitted feeling quite "helpless."

Gina suggested that her biggest fear surrounding the surgery itself was the "lack of control" and "feelings of helplessness" that she associated to waking up in the recovery room. She recalled several unpleasant experiences related to other surgeries.

At one point during her hospitalization, Gina had considered calling a cab and checking herself out. "I really didn't want to do this." She acknowledged her reasons for staying included "keeping it together for the family," and because she would probably otherwise die.

When asked about the meaning of her MI experience, Gina responded by suggesting that she needed to "clean up her lifestyle," and attributed her illness to the "stress level" in her life. She contemplated existential questions such as her purpose in life and felt as though it was time that she she make
some important decisions about the direction of her life. She expressed her thoughts around leaving an abusive marriage and felt that pursuing a different lifestyle would do more for her psyche and her health than would quitting smoking or losing weight. Gina also reported having several visions and dejavues while hospitalized. She also discussed previous spiritual experiences that encouraged her to examine issues around death.

In retrospect, Gina felt "disappointed" that her doctor did not "go a little deeper" in terms of investigating her suspected stomach problems especially considering her family history of heart disease. Moreover, she felt that her symptoms could have served as a warning had she been properly diagnosed.

Gina did not express concerns about returning home, as she emphasized her "backup" in terms of strong familial and social support. For example, her family had made plans to rearrange their work schedules in order to spend time with her at home.

Gina’s final words about her MI experience were related to the importance of "listening to your body."

Description of Themes

Nine themes were found to be significant and common to most of the co-researcher’s experience of MI. Although each theme was operationalized and has its own distinguishable features, they did not occur in isolation to other emergent themes. Subsequently, identified themes frequently overlapped and interacted with each other in a manner that reflects the complex nature of the co-researcher’s experience. For example, the themes of care and support overlap with the experience of needing information in the capacity that acquiring satisfactory
information from health care providers is closely related to one’s assessment or perception of the quality of care they have received.

It is important to recognize that each co-researcher offered a unique perspective and description of MI experience, based on their own individuality and particular circumstances. Although these common themes were evident in co-researchers accounts, the uniqueness of each woman is captured and reflected in the variations in which the themes were expressed. Specific excerpts from the interviews have been chosen to best capture and reveal the essence of the co-researchers MI experience. The order in which the themes are presented does not reflect the relative importance or frequency of the co-researcher’s experience.

The nine common themes that emerged from the co-researchers accounts include the following:

1. The experience of illness awareness.
2. The experience of feeling emotionally overwhelmed.
3. The experience of fear and worry.
4. The experience of loss.
5. Having difficulty asking for or receiving help from others.
6. The experience of needing information.
7. The experience of care and support.
8. Making sense of the MI experience.
9. The experience of planning for the future.

In the following descriptions, pseudonyms have been included to allow the reader to better follow the accounts of each women’s experience. In some cases, excerpts of text will follow the respective order in which women’s names were recorded.
The Experience of Illness Awareness

The first emerging theme concerns women's experience of illness awareness. For all of the co-researchers, the experience of illness awareness marked the beginning of their accounts describing their MI experience. Most of the women provided a vividly detailed and often extensive description of how and where they experienced the initial symptoms of MI. Although the nature and severity of these reported symptoms varied across co-researchers, all of the descriptions included the identification of one or more symptoms associated with MI including chest, back, neck or arm pain, nausea, shortness of breath, sweating, dizziness, and extreme fatigue, "I had severe pressure...right up into my neck...it was almost smothering me like somebody had put the bed on top of my chest," "the pain was severe and in my back and across the top of my shoulders...I could have climbed the walls I was in so much pain," "I was sweating buckets," "I just got really sick and I couldn't stop throwing up."

Co-researchers differed in the time they took to make sense of their initial symptoms. While some women made sense of their symptoms almost immediately, others took up to several days before seeking assistance. For example, 7 of the 10 co-researchers acknowledged that at some point during their experience of illness awareness, they had questioned whether their identified symptoms were related to indigestion. For some of the women this was a fleeting thought, while for others the assumption of having indigestion postponed the act of seeking help.

Co-researchers responded to their awareness of symptoms in
several ways. Some of the women identified symptoms without having a sense of what was happening to them. Kiko dismissed a series of symptoms that emerged over the course of a few days, including an immobilizing sense of fatigue and "funny feeling" that she attributed to heartburn. It was only several days after the initial onset of symptoms when she was unable to move and "really got a hot sweat and all of the sudden started tingling" before her son called for an ambulance.

Penny described her experience of what she thought was indigestion that had occurred intermittently over a couple of days. "I didn’t really think I was having a heart attack... because of my age, and the fact that I don’t smoke, not overweight...I didn’t have all the risk factors." She described her symptoms as gradually intensifying, "I started to get worried because the time between feeling good seemed less and less so we decided that this wasn’t anything normal." At this point, she asked her husband to call for the ambulance.

Other co-researchers appeared to block out their experience of illness awareness. Noreen described her symptoms as becoming progressively worse in the 2 months prior to her MI.

I’d feel really rotten one day or I might get up in the morning and have rotten chest pains...but they’d go...maybe last for an hour or I’d lay around and take it easy and they’d go away. So I would forget about them...push them out of my head kind of deal and...I just didn’t want to think that I guess...that I was heading for a heart attack so I didn’t bother...oh I’m fine...indigestion you know...cause it is a lot like indigestion.

An important aspect of the experience of illness awareness was described by five of the women as an intuitive sense that they knew their symptoms were related to MI. All of these women
responded fairly quickly to their symptoms in terms of help seeking behaviors.

Lydia and Brynn had been nurses and were familiar with the indicators of MI. They quickly appraised their symptoms and systematically sought help. Brynn described feeling "very frightened" as her chest pain intensified, "I thought it had to be heart because I have a number of family members that had heart attacks and I know a fair bit about the signs and symptoms...being a nurse."

Roslynn and Anne, both with a history of previous MI, intuitively felt their symptoms were related to MI. Before describing their current experience of illness awareness, both provided a lengthy account of their heart history beginning with their first MIs. An enormous amount of detail was evident in these accounts despite the fact that their first cardiac events had occurred 6 and almost 23 years ago, respectively. Likely, these stories had been told to various health care providers over the years, and served to provide a starting point and context for their current MI.

Several days before Anne’s MI, she recalled noticing a shift in her mood, "funny...2 or 3 days before I was sort of crabby...and I remember thinking to myself...oh god...I hope I’m not going to have another heart attack...I’m getting really bitchy." Anne did have an attack, several days later, after a strenuous morning working in the garden. After being transported to the hospital, she assured the emergency doctor that her symptoms were not indigestion.

Roslynn described experiencing a few mild episodes of angina
over the course of the night, "here comes another angina attack and it starts hurting...and I thought this is not angina...this is heart attack." Both Anne and Roslynn responded to their symptoms in what appeared to be a series of "calculated steps" in preparation to being transported to the hospital.

Gina had an extensive family history of heart disease and reported not feeling surprised that she had an attack.

I knew what was going on...and I wasn't particularly alarmed...because I was waiting for it basically...I knew that I didn't particularly have stomach problems and given the history in our family, I knew it was just a matter of time before I had a heart attack of my own.

Although the experience of illness awareness marks the beginning of women's accounts of the MI experience, the process of appraising and making sense of the severity of bodily signs and symptoms continues throughout the course of hospitalization.

The Experience of Feeling Emotionally Overwhelmed

The second major theme emerging from the research was the experience of feeling emotionally overwhelmed. In this context, the sense of feeling overwhelmed denotes an intense emotional reaction to some part of the MI experience. Women used words like "shock," "horrendous," "powerless," "embarrassing," and "cared for" to describe the intensity of their reactions to various aspects of MI symptomology, diagnosis, and the hospitalization and treatment process. For some of the women, feeling overwhelmed at the intensity of their emotional reactions was more distressing than for other women who were able to manage the experience.

All co-researchers described feeling emotionally overwhelmed at some point prior to or during their hospitalization
experience. For several women, feelings of shock and disbelief comprised their reactions to the diagnosis of MI. Penny recalled thinking, "I just can’t believe it...I can’t believe it’s a heart attack...I just never thought that I would be the one to have a heart attack." Despite her expertise as a nurse, Brynn described feeling overwhelmed at the idea of having a MI, "I just couldn’t believe that it was happening to me...you know...there is a sort of disbelief there...like that grief thing...no not me...and this little voice says...yes it is you."

Four of the co-researchers described their experience in the emergency department as being overwhelming. Although Brynn initially felt that because she had arrived in emergency she was "in good hands" her sense of assurance changed as the staff began treatment.

The thing that I remember the most is different levels of professionals asking questions...and they all had to come and do their own assessment...when did the pain start, how old are you, have your ever had this before...it was very aggravating...I just felt like lashing out at them...I was frightened and it was making me angry... and I usually don’t get frightened or angry for anything.

Kiko recalled having to be physically restrained by the emergency room staff, "I guess they’ve been giving me needles and everything and I think that something must have clicked or something...I just got so bad that they had to hold me down."

Several co-researchers described the experience of feeling exposed and vulnerable while in the CCU. Anne and Hilda discussed their sense of feeling overwhelmed specifically in terms of the "embarrassment" they experienced while in the CCU.

So finally I get upstairs and back into intensive care with all these men around me and I found that very embarrassing...I found that really embarrassing...because they were
really constantly on you to have a bowel movement and the curtain stopped there...and it was horrible...I just hated it.

When you are laying in bed and you’re sick and you’ve got both arms in these things and you got things stuck down into your neck into your chest right into your heart...you can’t turn over in bed...you’ve got a catheter in...you have absolutely no control over your bowels...you do but it’s so embarrassing to have somebody else do what you take for granted every day...to have a shower, to be able to go to the bathroom in privacy...cause everything is taken right away from you...and then you’re sore and you hurt...aching and paining and you’re just laying there...you just want to jump out a window...I mean thank god it doesn’t last...it passes...it’s awful you know.

Other co-researchers described feeling overwhelmed after receiving test results from their doctors. Although Gina was not surprised by her diagnosis of MI, she described reacting adversely to being told the results of her angiogram, "that’s another whole story, then. I was really alarmed that it was so bad because I had seven blockages...and that really surprised me you know that it was so bad." Several days before Anne’s angiogram, the cardiologist had roughly sketched her a picture of her heart, outlining what he thought could be wrong. Although Anne was reassured that her condition did not reflect the worst scenario, her tests results proved otherwise.

I remember it was Sunday when they came to talk to me about the angiogram...at that point I was told that I was inoperable...there was really nothing they could do...I would have to go on drugs and they wanted me on an experimental drug...I think the feeling was total disbelief...I never said a word...and neither did my husband...you don’t think of intelligent questions because you just don’t think.

Several women described feeling overwhelmed in response to other aspects of the treatment process including reacting adversely to medication, and misinformation related to medical procedures. Noreen’s experience of recovering from MI and bypass
surgery seemed mild in comparison to the severe effects of the drug reaction she endured for almost her entire hospitalization.

I got so disoriented...that was the horrible part of it...the hallucinations and all the rest of it...I wasn’t who I thought I was and other people weren’t...they would change like right there in that chair talking to you...and you’d change into somebody else...it was scary...horrifying...you think you’re losing your mind or I did...I thought I was right out of it...they had to tie me to the bed one night to keep me in there.

Penny had remained calm throughout her hospitalization until she was told that she required a temporary pacemaker implant. Initially, she reacted strongly to her preconceived notions and lack of information about the procedure.

That was the first time that I really got worried that it was really serious even though I knew that I had a heart attack. I felt I was ok...that I wasn’t in any danger...but when I heard about doing a pacemaker and then they said something about my heart blocking and I didn’t know what they meant...and then they told me what they do and took me down and it was just so simple to do...but I didn’t know...I had major surgery in my mind and then a 15 minute procedure was done and that was it...what a relief.

Although co-researchers mostly described feeling overwhelmed to situations or experiences of adversity, two co-researchers expressed feeling overwhelmed in response to the experience of receiving extensive care from others. Lydia who expressed having "little apprehension or fear" surrounding the actual MI or her experience of hospitalization, described her sense of feeling overwhelmed by the extensive care she received from her friends and family.

You don’t realize until a time like this how many and how dear the friends you have are...I have been absolutely overwhelmed by the concern and the everything...the cards...and the calls...you don’t quite realize till a time like this how much your friends mean to you.

Penny described how deeply moved she was by the care she had
received from the nurses while in the CCU.

[while sobbing] I was just thinking about all the nurses...just taking the time...like to talk to explain what they were doing...everyone of them was just so good...even when you didn’t ring the bell or want anything they would still be in there saying are you ok...do you need anything...always making sure that you were comfortable as you could be under the circumstances...and it made a big difference...it was really nice.

The Experience of Fear and Worry

The emotional responses of fear or worry were common amongst most of the co-researchers as they spoke about different aspects of their MI experience. Although a few of the women described sometimes feeling other adverse emotions including powerlessness, helplessness, or frustration, fear and worry were the principal emotions reported.

Lazarus (1994) makes the distinction between fear and worry in the following manner. Fear suggests an acute high intensity but brief state of alarm in response to sudden danger or injury, and disappears when danger has passed. In contrast, worry is synonymous with anxiety and refers to a low or moderate state of distress in response to more vague or uncertain threats. Co-researchers accounts suggested the experience of worry emerged in the form of a present and more future focus. For example, while some women felt anxious about receiving test results, other women worried about what their lives would look like when they returned home from the hospital.

Co-researchers experienced fear and worry in response to various incidents or anticipated circumstances related to the MI experience. Moreover, it is evident that the theme fear and worry overlapped with other major themes including loss and the
experience of needing information. More specifically, it was often the anticipated loss of physical or emotional integrity, or the lack of information related to one's actual or anticipated experience of illness, hospitalization, or treatment that resulted in the experience of fear and worry.

Several women talked about their fear of losing consciousness or physical control as part of their illness symptomology. Roslynn suggested that "the pain didn't scare me and I don't think at any stage it scared me...what scared me the most was losing consciousness...losing control...as long as I was conscious I knew I could do something about it."

Penny described feeling afraid of falling asleep for the first few days while in the CCU.

I don't know whether I thought I might die in my sleep or I might have an attack in my sleep or pain while I was sleeping and not know it...but I knew when I was asleep I wouldn't have any control over what happened I guess...during the day I felt that if I had any pain I could let them know...whereas when I was sleeping I might not...it might sort of creep up on me...I might not wake up until it was really bad or I don't know...so I think I would think about that for a bit before I went to sleep...after the first little bit nothing ever happened so I didn't worry.

Anne described being more fearful of fainting in the hospital hall on her way to the x-ray department than of having another MI.

I was sent downstairs for x-rays by myself...I hated it...for one thing I got lost...and for another thing I was so weak I didn't want to faint in the hall way and everybody look at [me]...and you sort of panic a little bit...it wasn't that I was afraid that I was having a heart attack...I didn't know where I was going...and I was just sort of hanging on to the wall.

Other co-researchers talked about feeling anxious about undergoing treatment procedures. For example, Gina described her
biggest fear about having bypass surgery was related to being in the recovery room and re-gaining consciousness.

The biggest part of the operation that I'm afraid of is the part where you are in the recovery room and you got the damn pipe down your throat...and the lack of control down there and being dizzy...I hate the dizzy feeling...I hate the thought of having the pipe down my throat and the feeling of helplessness is driving me crazy...and the fact that I can't move...that really turns me off.

Anne felt worried about undergoing the upcoming angiogram, as well as receiving the information from her test results.

So now I have to wait until Friday and have this angiogram again...that I'm dreading...I don't like the angiogram because I don't like when they shoot the dye in you...it's a horrible feeling but it's the results we're more worried about.

A few co-researchers described feeling more uncomfortable with aspects of the hospitalization process that threatened their sense of personal integrity and dignity. Hilda felt more fearful of being put in a position against her will than from the pain associated with treatment.

I would just be afraid whenever they came in what they were going to do to me or...not that I was afraid of the pain or the needle or nothing like that...that wasn't bad...the things that you go through...you know...the position that you're put in against your will that you've got no control over...I mean I'm not a control freak or nothing like that...just an average person.

Other co-researchers talked about feeling worried about the effect that their illness had on their futures. Although Penny reported not feeling traumatized by her MI, she wondered how it was going to effect the rest of her life, "then you start to think what's going to happen after this...what effect it is going to have on your life and those kinds of things...I was just worried you know."

Kaye felt worried about her ability to organize her business
affairs now that she was ill. For the past couple of years, she had been looking for more appropriate housing. Her words suggested that she felt more concerned about securing a new home than about regaining her health.

I’ve got to get rid of my house, but I’ve got to get enough out of it so that I can find me a senior citizen’s suite somewhere where I’ll have a roof over my head...this is all pressure...this creates pressure, stress, and worry...and that’s what’s on my shoulders right now...it’s a lot...that’s the first thing that hit me right between the eyes...the worry of everything...what’s going to happen now.

Other co-researchers described feeling worried about their significant others, and the impact that their illness had on them. Three of the five co-researchers who had spouses, described feeling more concerned about their husbands than themselves in response to their illness. Penny was worried about how her husband was coping with her illness and recognized that he also needed support.

It was scary...I was worried about him...I felt that I was in excellent hands and I wasn’t worried about me...I was just worried about him...I know he had family and friends and everything to talk to but he just wanted to sit in the room and stare at me for three days...I wish that maybe there could have been somebody to help him...that’s so unusual because usually it’s the woman...I sort of felt sorry for him that he didn’t know how to handle it or what he should be doing.

Penny also described feeling concerned about how her husband was going to manage once she returned home from the hospital.

I’m worried that he’s going to be trying to do everything and he’s got to work...so it’s him I think I’ll worry about more than me...and to try and get him not to treat me like I’ll fall apart...I’m worried that he’s worried about me so much that it’s going to affect him and his work and stuff like that.

Several women mentioned feeling afraid that family members were not allowed to be present while they received medical
treatment. Kiko felt scared when the hospital staff asked her son to leave the emergency treatment area.

...they were all holding me down and that’s when they noticed my son came in...they pushed him right out and that really made me more scared...to see what they were doing...fear on the one hand...and yet I felt I had my oldest son here and then two days before I said to my youngest son....if I go I feel that at least I see him.

Brynn recalled feeling more concerned for her spouse after arriving at the emergency department.

I remember them keeping my husband out of the section and he was a very big concern of mine because he was attending to his own father’s bedside when his father died of a coronary...so this the second time that someone closely dear to him...you know when you’re that close to someone.

One co-researcher reported feeling scared for her children after being told that she had suffered a massive heart attack.

...I felt scared for my kids...that I’d never see my kids again...they’re about all I have anyways...my kids are my whole being like you know...well I don’t have anything else to really worry too much about...but sure I thought a lot about them the last few days while all this was happening.

The Experience of Loss

All of the co-researchers vividly described experiences of loss relating to some aspect of their MI experience. Loss in this context suggests a diminishment of or existence without something that has personal meaning attached to it. Loss directly relates to the unpredictable nature of the MI experience itself which inherently suggests the transition from a place of wellness to a place of illness, or potentially death.

Co-researcher accounts suggested that women experienced different kinds of loss at various times during the MI experience. For some of the women loss was experienced as being more dramatic and distressful than for others.
Many co-researchers described their experience of loss in terms of an impairment to their physical integrity. They described feelings of extreme fatigue, loss of strength, and loss of mobility as a result of MI symptomology or treatment. Anne recalled the day when her doctor discussed her diagnosis of MI.

...by then I was so incredibly tired...I mean I cannot describe how incredibly tired you are...that I think I was past reacting to anything...I wasn’t asleep but I was too tired to talk...does that make sense...even my hands were tired.

Kaye had asked her son to contact her physician because she was physically unable to make the phone call.

...I’d sit in the chair for a few minutes at the phone and then I’d have to stand up and then I couldn’t stand any longer so I’d sit down...it was a most embarrassing moment and it made me very angry...I’m used to finishing what I start to do and I couldn’t finish my conversation.

Although Penny understood that her husband felt much safer when she was being closely monitored, she described feeling frustrated at having lost her mobility.

...he felt a lot safer when I was hooked up to everything but of course he had no idea how awkward and frustrating...trying to sleep at night and things all over your arms and wires...like they didn’t let me walk...they didn’t have me walking around.

A number of co-researchers reported some memory loss during their MI experience. Memory loss was often associated with cardiac arrest or loss of consciousness, a reaction to medication, or to feeling overwhelmed with the events leading to hospitalization. Penny tried to recall the sequence of tests and procedures that occurred prior to being admitted to the CCU.

I think it seemed that it was an hour at the most that I was there and then they took me up to CCU...I think they took me for an x-ray too...I couldn’t remember...should have written ...I keep saying that...ever since it’s happened I should of wrote everything down like what happened because I sort of
forgotten...so I don’t really know what happened.

Anne and Roslynn described the prolonged memory loss that they had incurred as a result of previous MIs. Both women’s accounts suggested that they anticipated this to be an inevitable part of the MI experience. As a university professor at the time of her first attack, Roslynn felt enormously distressed by her experience of memory loss.

...I knew the depression was coming and the intensity of which depends on the intensity of the heart attack and the part of the mind that is affected...and the part of the mind that is affected is usually the memory lost and that is the most frustrating thing that could ever happen...especially to a teacher and that for me was the most scary part of it all because you know your material...you know how to teach...you know the kids but there’s always that question that you fear that you have forgotten the answer and I’d rather fear a heart attack than fearing the questions that I can’t answer because I forgot the answer...and it’s not really fear...really it’s frustration...and that happens and it is inevitable it will happen again...it is very embarrassing...for me it was about 6 months before I recovered some of the memory.

In addition to the physical loss that women reported, other co-researcher accounts revealed experiences more closely related to the loss of personal and emotional integrity. For example, women described experiences of loss of privacy, dignity, and independence in response to the process of hospitalization and the intrusions made by teams of health care professionals. Lydia described the lack of privacy that she experienced as a result of the constant attention and monitoring that occurred while in the CCU. Once on the cardiac ward, Lydia requested that she be transferred into a private room.

Initially when you come for the first 2 or 3 days there’s such constant monitoring that you don’t have much time to accept things...you’re being constantly monitored...you keep wishing maybe they’d go away so you could sleep...you know all night and all day...over and over...which I can certainly
understand and I’m grateful for...but doesn’t give you much
time to yourself.

Hilda’s brief memory of her experience of cardiac arrest
revolved around the feelings associated with a loss of dignity.

I just turned grey and light headed and completely missing
right out of my life...that’s the last thing I remember
...they were calling my name and shaking me...and then...the
worst part came...it’s not just the pain...it’s losing the
dignity, losing your independence, losing your...like I’ve
been the type of woman that...I have 9 children...and I’ve
always had control of everything.

Several women reported having a greater sense of privacy and
independence once they were transferred from the CCU to the
cardiac ward. Although Hilda talked about the adjustment of
having to be more independent on the cardiac ward, she
appreciated regaining her sense of privacy.

...I can have my privacy here which I lost when I was in the
other ward...that bothered me so much...you know embarrassing
when things that had to be done for you...you never had to
have done before...here I don’t have to do that...and at the
same time if I need something I let them know...but not all
the time calling...but it’s like if I want to get out and
brush my teeth in the middle of the afternoon I can do it
...it’s preparing myself I guess for when I go home so I can
do what I do normally at home.

Other co-researchers talked about loss in terms of no longer
being able to take things for granted. Anne talked about feeling
angry that she will have to give up important things in her life
as a result of having another MI.

...and there were other times when I was really furious
...things like what I used to take for granted and I cannot
take for granted any more...to know that I have to give up
some things that I don’t want to give up like dancing because
it bothers me when I do it...

Hilda talked about the loss of being able to take things for
granted in more simplistic terms such as just carrying out
ordinary personal hygiene while in the hospital.
...but it's the wee little things until they are taken away that you don't realize that you miss...like trying to brush your teeth...standing in a shower...or just going to the bathroom that you take for granted everyday...you're trying to cooperate with the nurses and do everything you are supposed to do...I mean most people do...but there are still the little wee things that all of the sudden become so important...that it upsets you for some reason or another...you go three weeks and your hair is not washed...and they're trying to save your life and all you're thinking about is getting your hair washed and getting your body powdered but if you are used to having everything washed and cleaned and when it doesn't happen...it's a change from your regular...with me it's the simple things that you took for granted that have become extremely important to me.

Having Difficulty Asking for or Receiving Help From Others

Most of the co-researcher accounts described experiences of either having difficulty with asking for help or receiving help from others. All the co-researchers portrayed themselves as being strongly independent and self sufficient women and to be in a position of dependence or the focus of attention was largely unfamiliar and uncomfortable. Women's accounts suggested that they had varying levels of uncomfortableness in response to either asking for or receiving help from others. Difficulty asking for help is defined as feeling uncomfortable with approaching either care or support providers for assistance or information while hospitalized. In contrast, difficulty receiving help relates to feeling uncomfortable with receiving attention or assistance from either care or support providers while hospitalized.

A few co-researchers' accounts suggested that they had difficulty outwardly asking for help from family members. Although Kiko felt physically unable to telephone for help when she became symptomatic, she did not appear to understand her family's concern that she had not tried to contact them.
They all told me why didn’t you call...why didn’t you call me...but I mean even if I did get to the phone and call my sister-in-law...what can they do cause they can’t get in the house...they can’t do it...I know with my sister I got her key cause if anything happens I’ve got to get in the house.

Several of the women reported having difficulty in terms of asking health care providers for either information or assistance at some point during their MI experience.

For example, a few co-researchers mentioned having difficulty viewing their symptoms as being serious enough to require assistance. Although Hilda felt her illness symptoms were not serious enough to seek medical attention, her husband was concerned and drove her to the hospital.

I thought it’s probably indigestion or something...it will pass...and always felt embarrassed or foolish to go to the hospital cause I thought well maybe I’m going in there and it’s nothing serious...I’m just going in there and they have enough people that are sick enough that they don’t need me in there...I didn’t think my condition was serious enough.

Other co-researchers talked about having difficulty asking their doctors for information related to their illness. Gina felt uneasy about discussing her apprehensions of bypass surgery with her surgeon. Her account alludes to the power imbalance that frequently exists between doctors and their patients.

Well you know how it is when you get those doctors coming in your room...you got three other patients and guests and other people and cleaners...you want to talk personal like that and it’s a little difficult...I shouldn’t say they seem to be in a rush all the time...but they’re preoccupied and they want to keep moving...I don’t know...and then to actually say that to them to their face...would be somewhat critical...Oh God...do I want to criticize a guy who is going to be holding my heart in his hand?...I don’t know...normally I’m not like that...normally I’m very outspoken most of the time and quite often I regret having been so outspoken...I’m feeling at this time that I better keep my mouth shut and do what I’m told.

Co-researchers also described feeling uncomfortable with knowing when it was appropriate to ask for help from the nursing
staff. Several women talked about feeling unclear as to what they were expected to do on their own after being transferred from the CCU to the cardiac ward. Hilda recalled getting upset about a particular incident before she was informed by the nurses that they just assumed she would ring if she needed help.

I'm the type of person that I don't like to bother people...I don't like to be a burden on anybody and like I said I'm a fairly independent person and I don't want to be on those things ringing every five minutes...I need this and I need that...you know be a pest...I don't like to be that type of person...so there's things that I think...well I could do that myself without bothering them...but like they say if you need us all you have to do is call.

Women that had difficulty receiving help from others frequently described situations where family members had made arrangements based on their interpretation of the patient's needs. Lydia talked about the arrangements that her sisters and friend had made to come stay with her after she was discharged from hospital. Although she initially tried to convince them that she did not need their help, she eventually acquiesced.

I don't think I need anybody much but they say I shouldn't lift or carry groceries or anything...so I suppose in my mind it's just as well that someone is around...to vacuum and all that...and I keep saying to my friends you know you don't need to come stay with me for these two days...I'll be fine...now everyone won't listen to me so somebody will be with me.

Anne's husband suggested that he get somebody in to do the ironing after she returned home from the hospital. Although she was agreeable to his offer, Anne was not prepared to relinquish all of her household responsibilities during her recovery, "I said ya...do that because I can't sit down and iron for whatever reason...that will be nice for a while...but not the washing and that because with automatic machines I can do all that."
Kaye described feeling very uncomfortable with receiving help from others who saw her having difficulty walking.

Gee I can’t walk a block...if there’s lots of cars out there parked on the street...I lean up against every third car...so I won’t go for a walk cause I don’t want people seeing me leaning on a car...because I’m funny that way...I don’t want them stopping and ‘can I help’ when otherwise I’m not in difficulty except that I can’t walk...it’s embarrassing to have people stop...can I help you...very embarrassing.

Hilda discussed feeling "guilty" about at the collective efforts that her children had made in terms visiting her while hospitalized.

I feel guilty about them coming but if they don’t come...I wouldn’t tell them...but in my mind I’d feel a little sad...I’m that type of person...I hate to put anybody out...like the nurses or anybody...I hate to put anybody out if it’s not really necessary...I’d hate to be a burden to anybody...I’ve always been so independent and I don’t know why I would feel guilty but you do...you think it’s making it harder on them.

Another co-researcher anticipated having difficulty with giving up her former role of performing child care and house chores while living with her daughter. Noreen expressed her concern about being in a position of not being able to contribute.

It will be a little different because I know [my daughter] is not going to want me to do anything...that’s going to be the biggest thing right there...she’s going to quit her job for a while...I think it’s going to be a real role reversal for a while...it’s going to take some getting used to...to have to sit back and not do anything.

The Experience of Needing Information

All of the co-researchers in this study identified needing information as being crucial to their experience of MI. Acquiring concrete information has important implications in terms of understanding the nature of MI, and all aspects of etiology, symptomology, diagnosis, treatment, and prognosis. Morse and
Johnston (1991) suggest that a lack of understanding about what is occurring to one’s body undermines an individual’s sense of power and control. They suggest that in order to regain a sense of control after having had a heart attack, the person must be able to make sense of their MI. Moreover, actively seeking information from health care providers appears to represent a means of exerting behavioral control over an otherwise unfamiliar and often frightening experience, as well as enabling one to make sense of their MI experience.

In this context, the experience of needing information suggests the need to obtain concrete and relevant knowledge in order to further understand the personal relevance of the MI experience. Co-researcher accounts suggested that the need for information was translated into different experiences for the women.

The experience of needing information clearly overlaps with other emerging themes such as the theme of care and support, and making sense of the MI. The quality of co-researchers’ perceived care will, in part, be related to how satisfied they are with the calibre of information they received from their doctors. This inevitably alludes to the issue of physicians acting as gatekeepers to control the amount of medical information that women have access to. Co-researcher’s experience of not receiving satisfactory information appeared to be related to having poor rapport with one’s doctor.

As well, needing information overlaps with the theme making sense, in that the clarity and depth to which one understands their MI experience will influence how one makes sense of their
MI experience in terms of implications for the present and the future. The ability of the co-researcher to make sense of her experience will likely influence her ability to adjust to MI.

All of the women in the study mentioned the importance of seeking concrete information from medical professionals, namely their doctors. It appeared that part of the process of asking for information from medical professional not only decreased the distance in the doctor-patient relationship, but it allowed women to experience a sense of inclusion in their own treatment process. Co-researcher accounts suggested that some of the women were more assertive than others in terms of information seeking. Penny asked her doctor directly for pictures of her angiogram results.

I asked if I could have pictures...I wanted proof that all those arteries were clear...I wanted to be able to see what had happened and what the damage was and where it was...I felt better when I had that...when he said ya no problem we’ll give you a picture...I felt better when I could actually see for myself...that was probably the best feeling to do that.

After her first MI, Roslynn made the commitment to regain control of her health and to learn as much as possible about heart disease.

Because I was so ignorant and realized that I was ignorant and this ignorance brought on this heart attack I decided that was it...I was going to learn everything there was to learn about heart conditions and heart diseases...in order for me to never lose control of the symptoms and if it did happen again I knew exactly what happened and exactly what to do.

For some co-researchers, acquiring information about the status of their conditions allowed them to more clearly formulate the significance of the illness event. Lydia did not have a clear understanding of the significance of her MI until she received
the results from her upcoming angiogram.

I'm not sure what it means [to have had a heart attack] ... until I have an angiogram which will be sometime next week... I don't know exactly what's going to be involved... it may involve angioplasty... probably not if I pass."

Hilda felt so surprised at hearing her diagnosis and doctor's recommendations that she was unable to ask the questions she needed to in order to fully clarify what he had said to her.

I thought I was all cleared up and he told me that this morning... he just about threw me... it kind of changes your life too... I think well do you live with... or are you going to... it kind of threw me for a minute so I didn't really get a chance to talk to him but tomorrow I will ask him more about it... but I mean what does this mean... does this mean that I go on the rest of my life and I'm going to have pain all the time or am I going to be limited to doing such and such a thing or do I have to stay on special diet or this sort of thing.

Other women talked about their doctors having told them information or medical terminology that they did not clearly understand. For example, Penny suggested "I was just worried you know... everybody said it was a massive heart attack... I don't even really know what that means."

Both Lydia and Brynn felt that they benefitted from their nursing experience in terms of having a greater awareness of both cardiac illness and the hospital routine. For Lydia, her previous work as an emergency room nurse allowed her to have a greater sense of familiarity with hospital procedures and treatment.

I think having worked in an emergency probably has helped at a time like this because you know what's going to happen and what's going on and you're certainly more aware than you would be if you hadn't... even being a nurse I think makes a big difference I think probably because people don't get alarmed and uptight.

Half of the co-researchers in the study had been transferred from small rural hospitals to the larger city hospital where they
received more elaborate cardiac care. Several of these women, including Penny and Gina welcomed the opportunity to be transferred to the city and felt that they would receive more information about their heart. "I felt that I would get more information...that I would know more after coming here and have a better idea of where I was at...that was important I wanted to know exactly what was going on," "in a sense I felt reassured that I was probably going to get better medical care."

Co-researcher accounts suggested that when women had difficulty acquiring information from their doctors they sometimes experienced considerable distress. Kaye felt angry about the lack of information from her doctors and was uncertain that she actually had suffered a MI. Because Kaye's daughter-in-law worked in the same hospital that she was admitted to, she used her nursing expertise and familiarity with the doctors to learn more about Kaye's condition, "I've got a curious daughter-in-law...she got a hold of [my doctor] and sat down with him and looked at my x-rays of me." Gina's felt concerned that she did not have enough information to make an informed choice about having bypass surgery, "am I being railroaded into mainstream medicine...let's do it this way and get it over with...do I have to go through this...I wish I knew...I wish you could tell me." Moreover, she did not fully understand why she was scheduled for bypass surgery when other heart patients were undergoing less invasive treatment.

...there was a lady that was brought in last night...she had another doctor who recommended putting this thing in her arteries by her heart...metal device...it holds it open...she wanted the bypass but I thought Jesus Christ, you can have my bypass...I'll take your stent any day...I mean she's not all
cut up...so what the hell's going on here...like there's some women getting one treatment and another...is it the luck of the draw...what the hell is going on here that's what I'd like to know...they haven't explained that to me...not to my satisfaction.

Common amongst co-researcher accounts was the experience of receiving misinformation from their doctors. At least half of the women recounted being told by doctors that their presenting symptoms were not cardiac related or indicative of the preliminary signs of MI. Anne suffered her first MI while on vacation with her family. The emergency doctor at the small rural hospital suggested that "you're on holidays [Anne]...you've overeaten...well that's what it is...you've over eaten...yes I'm sure it's just the rich food being on holidays."

Roslynn recalled experiencing angina several days before her MI. Assuming it was her medication, she was seen by her doctor who subsequently gave her a clean bill of health.

He looked at me...had blood pressure taken and he said you sound just fine...he said your cholesterol is down...you're just fine...is everything ok at work...I said ya...I'll tell you in 3 years you can reverse the process...I am almost sure that we can clear out that artery for you no problem...so I was all elated about that...no I was cured that was it...I just don’t like the idea...frustrating...because on Tuesday I was doing so well...on Friday I’ve got a heart attack...hey what’s happening here and why?

Gina reported being diagnosed 1 year earlier with stomach problems and put on medication. After experiencing the identical pain with her MI, she was convinced that her stomach pain was misdiagnosed angina.

When I stop and think about it all my stomach problems that began last year...which we have since discovered are heart related...I’m disappointed that my doctor didn’t pick that up because we have a good rapport...he’s a young fellow and we relate very well...I shouldn’t have had a heart attack...but I didn’t know it was a warning...they were telling me it was
stomach...it could have been a warning had I known...I would of quite smoking then and there...I knew I was taking a risk doing what I was doing and that I am a high risk factor...I would have quit...I know I would have because I had done it before...I enjoy smokes but I'm not stupid.

The Experience of Care and Support

The seventh major theme concerns the experience of care and support that all of the co-researchers described in their accounts. In this context, care refers to the perceived quality of medical treatment, attentiveness, and concern that co-researchers received from health care providers while hospitalized with MI. Support refers more to the social support that the women received from family members and friends.

Care

When describing the experience of care they received from health care providers, most of the co-researchers made a point of distinguishing between the care they had received from the nurses and that which they received from their doctors.

Women used words such as "excellent," "awesome," and "wonderful" to describe the care that they received from nurses. Aspects of care that co-researchers identified as being meaningful included: personal and deliberate attention, immediacy, sincerity and compassion, thoughtfulness and respect, taking the time to provide information, and nurturance.

Gina talked about her experience in the city hospital’s CCU.

I was totally impressed with CCU...big time...they’re really good people...those doors, they swished wide open and they pushed us in and there was immediately two nurses coming towards us greeting us...by name and telling us they’re glad to see you, glad you made it here and everything is ok and whatnot...just awesome.
Gina described more specifically her perceptions of the differences between the care she received in the city versus the rural hospital.

Here you have a consistent compassion so to speak...they are consistent with their concern...whereas in [the rural hospital]...if they’re looking at you...ok...they’re paying attention to you right now...but the minute their back is turned they’re gone...they appear more sincere here...I’m sure they must be trained to do that because they can’t all be that nice...you know really...they must go through some special training...unless they’re hand picked by somebody...that’s what I feel anyway...they are awesome.

Hilda also talked extensively about the outstanding nursing care she received.

All those nurses...they were excellent...they went over and beyond their call of what they needed to do...they would just do anything to make you comfortable and they seemed to feel so sorry for you or something...that you were getting all those needles and going for this test...they would have done anything to make your life a little more easier...sometimes I think they know more than the doctors.

Several co-researchers described the transition in care as they were transferred from the CCU to the cardiac ward. Women used words like "abandoned" and "upset" to describe the experience of transition from receiving almost constant care to the expectation of functioning much more independently. A few of the women’s accounts suggested that some of the reported anxiety around this transition stemmed from being unclear as to what they were expected to be able to do. Hilda described at length her experience of transition from the CCU to the cardiac ward.

...everybody says oh you’ll really like it upstairs...and you do and you don’t...you’re so used to being cared for...really really tended to like all the time...and then all of the sudden there’s kind of nobody...that makes you think well they are way down the hall...you sit and you think of silly things like...I hope the monitor is working down there...or do they know you’re here because you never see everybody all day...you’re so used to having the nurses there all the time in and out you kind of you feel not abandoned...not neglected
...it's kinda somewhere in between...I think the first day I was to the point that I was a little upset.

In a larger sense, Hilda compared the experience of transition from the care of the CCU to the cardiac ward to the experience of transition from health to illness.

It's a change... it's a big change... it's relying on something and then all of the sudden it's gone... it's like almost reversing itself... like when you first get your heart attack and then you start to depend... you're so independent at first... then you depend... you have to depend on someone for everything and then all of the sudden... starting back the other way and it's change... you're changing all the time and your trying to adjust to your situation... you have to learn to have a lot of patience with yourself, with the nurses, with everybody... and they have to do the same thing.

When co-researchers discussed the quality of care that they had received from doctors, they often spoke in terms of having a sense of "rapport." This sense of rapport was closely linked with the degree to which the doctor provided satisfactory treatment and information and the manner in which this information was provided. It was clear from the women's accounts that medical care received from doctors held the potential for having notable implications upon the women's experience of MI. For example, acquiring satisfactory information from one's doctor plays a fundamental role in perceptions of the overall quality of care received from health care providers. Clearly, the theme of care is closely interwoven with the experience of needing information.

Co-researchers in the study described having mixed rapport with their doctors. A few of the women reported experiencing extremely satisfactory care from their doctors.

Lydia described the ideal rapport that she maintains with both her cardiologist and her general practitioner.

I have great admiration and confidence in [my cardiologist]
...she really is a lovely person and I have always been full of admiration for her...she instills all sorts of faith and confidence in me...my GP is a very caring man too...highly intelligent...I've always had confidence in him.

Penny's cardiologist had been highly recommended from several respected sources.

...he's the best...and all my family as soon as they heard that I had him...there was just a big sigh of relief...that as far as they were concerned I had the best and I feel that way and I think it's important...so I'm happy about that and I'm prepared to do whatever he says.

Noreen also praised her cardiologist and surgeon.

...they're good people those doctors and surgeons...they know what they're doing too...but they're all so good...they're all so human...they never get really inhumane or business like or you know...they're always so nice about everything they do.

A few co-researchers described feeling "frustrated" and "angry" towards their doctors. These feelings occurred in response to the perceived inattentiveness, lack of concern, or lack of information on the part of the doctor.

Kaye expressed her anger and frustration in not knowing what had happened to her beginning with her arrival in the emergency department, and towards her cardiologist for "not sitting down with [her]" and providing her with concrete information.

...as far as I'm concerned...I feel that we should be able to sit down with our doctor when we can get an appointment with him and go over everything thoroughly...so we know...and tell us the truth whether we are going to be able to do anything about getting it where...to the point...where you can at least walk around the block.

Kaye further described a particularly distressing incident that occurred with her cardiologist.

...he says...if this happens again what do you want me to do...I looked at him and said what are you talking about...you mean to tell me that you are just going to let me die...see what I mean...so if you want anything from the doctor or you've had anything...you've got to fight like a
devil to follow it up and shouldn't have to...that should come absolutely automatically.

Kaye's anger and dissatisfaction with her doctor motivated her to look into finding another physician with whom she felt that her needs would be more readily met.

Anne discussed how angry she had been with her own doctor at his lack of attentiveness after sending her to the intensive care from his office.

...and the doctor didn't show up forever and ever and ever ...I did have a heart specialist and he was super I think ...but my own doctor didn't show up and three days later when he did show up he came panting in and goes there you are...I thought you went home...and I was mad...I was just furious ...you twit...I thought how can a doctor put you in the hospital from his office...dump you into intensive care...I never wanted to go in the first place...and then lose me... that's what made me furious...it has nothing to do with my heart...nothing.

Anne described feeling angry with another doctor who "dumped" on her just prior to undergoing bypass surgery. She talked about seeing him when she woke in the recovery room.

...of course when that doctor said I was middle aged and that my prognosis was really lousy and on and on and look what brought you here I mean you were on death's door for a month ...and when he looked over...if I'd the strength I think I would have stuck out my tongue at him (laughs)...I was so mad...well I'll show you.

Noreen described feeling "perturbed" with the doctor that she had gone to seen everyday for almost a week in the small diagnostic center in her rural town. She wondered why he had not taken more immediate action in terms of treating her symptoms as MI.

...I thought what the heck is going on here...I got kind of a little perturbed at the doctor there because I figured they should of had me over here a week anyway...may of given me the leap I needed you know and then I thought...it's nobody's fault but your own...you did it you know.
Brynn described feeling very angry towards an intern that worked on her after she arrived in the emergency department.

...I could tell he was in a bit of a panic...didn’t want to appear as though he didn’t know how to handle himself...people were waiting and standing back out of respect to him...I was just horrified...just wanted him away from me...felt he was aggressive and he took away from the rights of others...mine were some of those rights...but some of the rights of other people that had their duty to do...and he didn’t realize how these things all have to go collaboratively...he wasn’t a good player...and I knew it was from inexperience...I think his behavior had an impact of my fear and sense that I was safe...my needs of feeling safe and secure having come to the hospital...so I think that’s really a key thing...who you encounter has a big impact...because I know that stress and pain will add more and more to chronic tissue.

Support

Social support was evident in all of the co-researchers accounts. Despite the fact that most of the women used words like "wonderful" and "very good" to describe their experience of support, social support was more profoundly experienced for some than for others. All of the women conveyed a genuine sense of appreciation for the support they had received from friends and family as a positive experience. Moreover, receiving support from others was almost always depicted as being a positive experience. Undoubtedly for many of the women, the presence of family and friends represented the only element of familiarity they experienced while hospitalized.

Women received support at different times throughout their MI experience. For most of the women, family had accompanied them to the hospital during the onset of illness awareness. Kiko recounted how her son had come home much earlier than expected. She wondered how she would have gotten assistance otherwise, "I was just fortunate that my son came back...he kept saying why
didn't you call me earlier...no way [I] could get to a phone...it's not as easy as you say."

After Hilda woke up in the middle of the night with severe chest and neck pressure, it was her husband that took charge of the situation, "he took me in because he was more concerned than I was...although I knew something was going on."

After being diagnosed with MI in her small rural hospital, Noreen was to be taken on an emergency flight to the city center for further treatment. Knowing that her mother had a "real fright of flying" Noreen’s daughter accompanied her during the flight, "I didn’t have to come alone...she held my hand."

For one woman, whose spouse was at work, a neighbour quickly responded when she called for help. Anne had telephoned her neighbour to come over when she realized she was having her fourth MI, "she was down almost before I hung up...I was really really lucky...my neighbour got me to the hospital even faster than an ambulance could."

Almost all of the co-researchers described the importance of their social support in terms of "just being there" while in the hospital.

Noreen talked specifically about having her oldest son stay with her while she was in the CCU.

...that week he spent a big part of his time there with me... he just sat at the edge of my bed and held my hand and I was okay as long as I could feel him...the minute he let go of me and I lost contact with him...I went right into a panic.

Brynn recalled waking up at one point to having almost her entire family, which is scattered across the country, in her hospital room.
I wake up and my children are there...my sister is there...my niece is there...I had a lot of support...it was kind of like a real gift because...I didn’t know they all cared that much...it pulled me through because I’m adopted originally and if there’s anything that will motivate me is anything to do with my kids.

Penny described what her days looked like while she was in the CCU.

...during the day I had tapes to listen to and there was always things going on...I had tons of visitors and they were surprised they let me have so many visitors but they did...I had lots of visitors and I felt good.

One co-researcher felt that her MI experience had brought her much closer to her spouse who also had a history of MI. Hilda suggested that because men typically have heart attacks and are taken care of by their wives, they rarely know what it feels like to experience the emotional strain of being a caregiver.

With us the situation is reversed...he had to take on the role that I took...I’m the one that’s laying in there with all the tubes and needles and the hurt...and when they called him in the middle of the night and told him that I had had a cardiac arrest and they had saved my life...he’s the one that got all shook up, couldn’t eat, and went through everything that I went through...turning white and scared all the time...you get to the point that you just want to cry...which sometimes you almost need to relieve it...now we’ve been on both sides of the coin and because we have it’s brought us a lot closer together...I understand both sides of what he went through, and he understands too.

Three of the five co-researchers who had spouses, described feeling more concerned about their husbands than themselves at different times during their MI experience. Penny described her husband as wanting to spend as much time as he could with her while she was hospitalized.

It was scary...cause I was worried about him...I felt that I was in excellent hands and I wasn’t worried about me...I was just worried about him...I know he had family and friends and everything to talk to but he just wanted to sit in the room and stare at me for three days...I wish that maybe there could have been somebody to help him...that’s so unusual
because usually it’s the woman...I sort of felt sorry for him that he didn’t know how to handle it...what he should be doing.

Similarly, other co-researchers felt that the experience of MI was often much harder on the family than on oneself, "I do realize now that although you get the pain maybe it’s harder on the family than it is on you," "I really thought about...what the kids would go through more than you...you think more of your family of what you’re leaving behind...what they have to go through after you...if anything happens to you."

Most of the co-researchers described the on-going support that they were going to receive from family and friends once they were discharged from hospital. Arrangements were frequently made independent of what the women had requested. Gina talked about her family making themselves more accessible in order to take care of her during her recovery from bypass surgery.

I got a lot of friends and my kids are top notch...my husband too...the older one is going to change her working hours around to accommodate me so she can be with me in the day time...my husband’s self employed so he can give me all of the time I want there.

One of Roslynn’s biggest concerns about returning home after being hospitalized was taking care of her aging mother. Her daughter made arrangements to visit, which helped to alleviate these concerns.

...my daughter is coming over and she’s going to be helpful in the practical sense of making sure the house in order and spending time with her and she would spend time with my mother leaving me free to do whatever I need to do.

For a few of the co-researchers, the expectations or arrangements that family or friends had made for them after leaving the hospital did not really coincide with what they
wanted for themselves. Kiko described how she agreed to stay with her step-daughter after leaving the hospital in order to please her sons.

I want to go directly home but then my son says no...that means that my other son from [overseas] would come home... just to satisfy him we have to say we are going over to his sisters for a few days and she’s got teenagers running around the house and there is always somebody there...so that way [I] reassure my youngest son cause he does a lot of travelling...with [him] worrying about [me] I don’t think he’ll get his work done...so I tell him I’ll go to his sisters...but I think I’d rather be home.

Although Lydia felt that she did not need anyone to stay with her after being discharged from the hospital, her family and friends were insistent.

...my sisters thought I should have somebody take care of me for a while, so my sister is coming up from Colorado and she’ll be with me for two or three weeks...she won’t be here until Sunday...so a very good friend is coming home with me today and there will be someone with me until she gets here on Sunday...I don’t think I need anybody much but they say I shouldn’t lift groceries or anything...so I suppose in my mind it’s just as well that someone is around to vacuum and all that (laughs)...I keep saying to my friends you know you don’t need to come stay with me for these two days...I’ll be fine...now everyone won’t listen to me...so somebody will be with me.

Anne appreciated the support that she had received from her family during her experience of having four MIs, yet she also discussed the importance of not letting "the family smother you" once you return home from the hospital.

...smother you so that you are afraid to move because they’re watching...if you could somehow reassure your family that just because you turn fast or you burped or you bumped your elbow and went "ow" or something that they don’t think that you are going to have another heart attack or something...you almost feel smothered and if you could just reassure the family... just let me be a human...I’ll be ok and if I’m not I’ll tell you...because you do feel totally smothered at one point.

Another valued means of support for four of the co-
researchers was their strong religious or spiritual belief systems. This "faith" provided these women with a framework for making sense of their experience, including a perspective on ideas around death. Lydia made several references to her faith.

I’m a Catholic with a strong faith and the thought I might not survive this episode didn’t really bother me...I have a very strong faith as I was saying and so I think maybe heaven’s just a place...a lot better place than this world ...so I have very little apprehension or fear of death or whatever.

Brynn also talked about her spiritual beliefs.

...I think in the last week has been that sense of appreciation and I don’t mind admitting that I’ve been saying my prayers...it’s almost thanks...I’ve always had a very close relationship with God...I have no fear of dying...if I die it’s Gods will...I looked after enough emergencies myself to know that you can have all the highly technical skills and personnel but if it’s their time it’s their time.

Although care and support were described as separate entities, the co-researcher’s experience of receiving care and support was described more as a whole experience. In other words, women did not necessarily compartmentalize the experience of care and support although they were able to identify elements of each.

Nonetheless, receiving quality medical treatment by concerned medical professionals, as well as having a strong social support appeared to be crucial in terms of facilitating the co-researcher’s sense of security and comfort while hospitalized with a life threatening illness such as MI. Subsequently, some of the women experienced care and support more profoundly than others. Moreover, co-researchers that did receive both a strong sense of care and support appeared to be less distressed than others by the entirety of their MI experience.
Making Sense of the MI Experience

The eighth emerging theme is making sense of the MI experience. Co-researchers attempted to understand their MI experience after they had undergone their initial reactions to the event. In this context, making sense of the MI experience suggests an individual’s efforts at understanding the personal significance or perceived meaningfulness of the illness event. Co-researcher accounts indicated that there were commonalities inherent to the making sense process. Not only did women attempt to identify the reasons for having the MI, but many reported undergoing a more existential experience of a personal review or personal awakening.

The women drew upon information obtained from various sources in order to help them make sense of their MI experience including medical professionals, previous history of illness, life history and experience, as well as personal values and beliefs.

Most of the women attempted to identify reasons that explained why they had a MI. Identifying possible causes of their MI allowed women to perceive their condition as being treatable and provided them with more of a sense of inclusion in their own illness process.

Roslynn discussed the importance for a heart patient to find the reason for having the attack in order "to keep control over that reason." She attributed her current MI to improper diet and the stress of living with a "demanding" elderly parent.

So where did I go wrong...first thing I did wrong it was indulge in some food that I shouldn’t have indulged...no alcohol...no smoking...nothing of the sort...but food was one of the contributing factors...the second contributing factor is the stress that I sustained from the lack of freedom
knowing that I could not go home without either facing a battle of wits with somebody that I dearly love but I just can't stand controlling me that way...and knowing that there was no place for me to go...there was no home any more.

For some of the women, there appeared to be an underlying sense of personal responsibility for having suffered a MI. This self blame posture suggests that MI could potentially have been avoided if certain measures had been taken. Some of the women appeared to be regretful for not having made earlier changes. Despite her extensive family history of heart disease, Gina identified lifestyle and stress as being the main reasons why she suffered a MI at a younger age than her other brothers and sisters.

I was gambling was what I was doing...the smoke and the weight...and I lost...in a nutshell...I need to clean up my ignorant lifestyle...way too much stress...way more heart ache than one person should have to go through in the first twenty years of marriage I guess...and then clean up my lifestyle a little bit...get the weight off and quit smoking.

Anne discussed feeling somewhat regretful about not having made changes earlier in her life.

...change in my lifestyle...and some regrets because some of it I could have prevented...not smoking...it took me two heart attacks to quit smoking...but some I don’t really have regrets because of the hereditary part of it I have no control over that at all...why I have high cholesterol well even the doctor’s don’t know...but I do have it.

A few women were unable to identify reasons why they had had a MI. Despite her efforts, Kaye could not figure out "what she did" that would explain why she had a MI.

My niece that’s a nurse...she phoned me...and her mother said for God’s sake what did you do...I didn’t do anything that’s the trouble...[my niece] says auntie what did you do...I said I don’t know...it hasn’t hit me yet what I did...because I said I wasn’t scrubbing walls or I’d have blamed it on that ...and I wasn’t cutting the lawn...I wasn’t washing the floor...I wasn’t bending over doing the bath tub out...I said I’ve just had this pain for a long time and it just kept
building up...got worse and worse.

Penny was unable to identify any behavior that could possibly be linked to the occurrence of her MI. Subsequently, she felt her MI was a freak incident that happened for no particular reason.

...I don't know what it means to have had a heart attack...I know I've had one...I know that it's unusual for someone like me to have had one...I just think it's some kind of freak thing that happened...I wasn't doing anything that I shouldn't of been doing...it was just something that happened...I don't feel that I've done anything wrong and I don't think I would have done anything differently if I had known this was going to be the outcome...no that's not true...I guess I would have if there was something I could have done differently but I don't think that there's anything that I could have done to prevent it.

Lydia was more intrigued by her lack of emotional response to having a MI than by searching for reasons to explain her illness.

I don't know why I am really not very perturbed about this...it really doesn't concern me that much I don't know why...even I am surprised that I didn't feel a little more something that I did...I really didn't...I was very calm and collected...I think people vary a lot in their emotions...it was just another day in my life.

Other co-researchers felt that they had been granted a second chance at living after surviving their MI. Brynn attributed her MI to a "bunch of stressors" in her life. She felt as though she had been given a warning about her health as well as an opportunity to learn how to better take care of herself.

...there are things in my life that...if I could go back...I could have done better...or just not done them...I'm at that stage in my life now where I'm going to have to learn whole new coping skills...I think this was kind of a dramatic flag waving if you will from on high...I'm telling you you've got to do a better job...a lot of it is grateful that I've been given another chance to live a better life you know what I mean...I guess I wasn't doing it right so...I do believe in God and I think he gave me another chance to tune up.

Kiko felt that having been given a second chance, she needed to help others realize the value of life.
...once you have it [MI] you realize how much life means to you...be good to everybody...you had a chance you’ve got back in you life again so it’s now it would be my turn to help somebody else...make the younger ones realize what they’re life is like...worth it...I’ve got three grandchildren I think they really take their life too easy...life is really to cherish.

In a similar vein, other co-researchers described what appeared to be a personal awakening and found themselves to be in a position of making pivotal life decisions. For some of these women, a sense of personal awakening and impending change appeared to be as important as coping with their illness. Gina suggested that she was at a crossroads in her life in terms of making a decision to leave her marriage. She recognized that either decision was going to have an impact on her health.

...why am I here and what is my purpose in life and what is my job...I wish I knew...I’m coming to a great big branch in my life...now am I going to the right or am I going to go to the left...and I don’t know what I am going to do...am I going to stay in my lifestyle but learn how to deal with my inner conflict or will I just dump it all and go off on my own...I have an idea of what I’d like to do for myself and whether I’ll actually do it or not is another thing...I would like to have a whole totally different life...I think that would do more for me and my psyche and my health than anything...more so than smoking or eating or the genetics that supposedly cause this.

Roslynn pointed out the synchronicity of becoming involved in this research project and her own personal vision of establishing a centre for heart patients like herself.

...like this heart attack business...I don’t believe it just happens...it’s got medical cause but my philosophy is that it may happen because I need to do this centre...I need to have met you for some reason...maybe this sounds absolutely crazy and off the earth...I don’t know and I don’t care what you think but when you came and talked me...my mind snapped back to what I had said to my doctor and I thought hey...maybe this is what I’m here for...maybe this is the time I have to decide...it’s like pieces of puzzle that come and fall into place.

Hilda felt that she had changed her whole attitude as a result of
having survived a cardiac arrest.

...I think it makes me aware of more things in a way different than before...simple...very very simple way that most people take for granted...it's everything you do in life...it's brought me a lot closer to my family and my husband...you seem to change your whole attitude...well I actually died...they had to bring me back with the paddles and everything...yaa I actually died...that was it...it was all over...but the fact that I came back I just figured I'm back here for a reason you know...maybe to teach somebody else this.

Brynn described her MI as a time for reevaluation, "a whole transforming or having a look at myself...almost like an objective period where it's high time that I analyse my values."

As well, she suggested that her MI had brought her much closer to her family, "it's brought me closer and I think an appreciation ...now our relationship is evolving more into a friendship."

Noreen also talked about her MI as being a time for personal reflection.

...makes you stop and think more than anything I think...you have a lot of time in here to think about your life and where it's going especially if you're basically by yourself...like I know I've got my family and I know I have my kids and that but if you're a couple...there's that couple there too...when you're one person it kind of makes you stop and wonder and contemplate things a bit...but I don't have any misgivings or anything much.

For most of the co-researchers, the experience of a potentially life threatening event such as MI appeared to represent an ongoing process of sense making and adjustment. Co-researchers frequently appeared to be making sense of other aspects of their MI experience including hospital routines and treatment procedures, relationships with medical professionals and family members, life events, issues of mortality, and their own emotional responses.

For example, part of the process of sense making for several
co-researchers involved comparing MI to other illnesses. It was as though these women had constructed a continuum of illness severity and ranked MI as being less severe than other illnesses.

Lydia suggested that having Alzheimers was more serious than suffering an MI. She wondered if this belief was a contributing factor to the fact that she was not upset by her MI.

I have two sisters with Alzheimers and maybe this has affected the way I feel...because I can't think of anything worse and I would very much rather end it all now than have to go through something like that...I think that makes a difference for me.

Kaye talked about the high costs of medicare and the expense of having a chronic illness such as cancer, "my girl friends have been nursing women with cancer...and of course that drags out and out and out...I just pray to God I don't get anything like that...it's a long haul."

Although a couple of co-researchers appraised their overall experience with MI as being threatening, other women did not. The perception of feeling threatened is related to several factors including the degree to which a woman's identity has been compromised as a result of her illness. Kiko described feeling fortunate compared to other patients and was determined that she was going to recover.

...I'll get better...you can't be beating it too long...you can't be beating in and saying you can't do this and you can't do that so I still determined...I don't know...when I look at the other people I think that I'm fortunate.

Although Penny did not feel traumatized by her MI and maintained a positive outlook, she did express curiosity about her future.
there's not much you can do about it just sort of go on...and try to see that it doesn't happen again.

On the other hand, Kaye's account suggested she appraised her overall experience with MI as being threatening, "I don't think it's anything wonderful...I don't think it's a wonderful experience at all...I think it's a terrible thing to be told that you've had a heart attack."

The Experience of Planning for the Future

The ninth major theme emerging from the research was the experience of planning for the future. In this context, planning for the future suggests the process whereby co-researchers contemplate the direction they would like their lives to follow in terms of doing specific things, adopting specific attitudes, or making life changes or adjustments. Inherent to this description is the idea of choice and intentionality. The way in which co-researchers made sense of their MI experience influenced their attitudes about the future. In general, most of the women in the study demonstrated a positive attitude towards both the future and a realistic attitude towards recovering from MI. These women contemplated both short-term and long-term plans, however, some women were more active than others in terms of planning for the future.

Co-researchers that provided causal explanations about their illness, also tended to plan strategies to improve their health. Roslynn talked about the measures that she needed to take in terms of rectifying her health. These included reducing her stress at home and finding an alternate arrangement of care with her mother, as well as undergoing her own healing regime to
challenge the need to have bypass surgery.

I will have a volunteer coming now twice a week to take care of her cause I’ve got to regain my liberty in order to cure myself...that’s the only way I’ll regain my freedom is when my mother transfers her reliance onto somebody else...only at that time can I move into my control...I know I can treat myself...I know I can go for walks...I can go onto medication...nobody has given me the chance to treat myself...I want the chance to treat myself naturally before the knife is going to cut me open.

Noreen anticipated making some specific changes in terms of quitting smoking and altering her diet.

I know I’ll be a lot more careful with my body in the future...whether it will do me any good or not I have no idea but it’s for sure worth a try...like smoking who needs it...the day I had my heart attack was the last day I had a cigarette...and I’ve always been pretty active...I’ve never had much of a weight problem...and I’ve always ate fairly healthy too...so I don’t know what’s going to happen but I know I’m going to have to use common sense and cut down on salt, sugar, and fat byproducts...I’ve already cut a lot of bad habits out of my diet.

Other co-researchers talked about taking steps related to improving their sense of personal well being. Kaye needed to have a sense of preparation for the future and emphasized how important it was for her to return to the process of selling her house and finding more suitable accommodation. Perhaps taking care of her house affairs was what she needed to do to reduce her stress level and indirectly benefit her health.

...so I will do as much as I possibly can...have two or three yard sales...I have to feel prepared...I’ve got to get rid of the place I’ve got and the worry of all the work...and I want to go into a brand new place...I’ve got to have enough clear when I sell the house I’m in...money wise so I’ve got a place to live while I’m still alive...a roof over my head in other words...I’ve got to get out there and settled...and then if I die...I die.

Brynn talked about making changes in terms of personal growth.

...I won’t do the mini mouse...mini mouse...she’s afraid of standing up for herself...maybe I was not as repressed but I know more about myself now...one way that I would change
would be that I’ve let people frighten me whereas they don’t now...it that strict upbringing you know.

Kiko felt that she needed to draft a will after having been faced with the unpredictability of MI. As well, she described her plans to continue travelling despite her health, "I still would like to go and travel...I’ve been going every year...so I would still like to go instead of staying at home."

Other co-researchers discussed their uncertainty towards the future. Although Anne was eager to resume living her life fully, she also expressed some uncertainty about becoming ill while travelling.

I hope to just go home and get cracking and do what I have to do and drive the car and "I wonder how long can I go for...there’s so many things I want to do and that’s one thing I think about...I want to go down to the States...there’s all sorts of things happening down there that we’ve been invited to and I’m afraid to do because I don’t want anything to happen to me while I’m down there.

Hilda expressed concerns about how she was going to "cope" with the uncertainty of her health.

I’d rather go home with a clean bill of health instead of having to take part of my problem home with me now...if I don’t have [the bypass] then I’m going to be taking the problem home with me and how I’m supposed to cope with that or whatever I have no idea.

Noreen felt worried as to what would happen to her children if she did not survive her illness.

...what’s going to happen to them...maybe leave a message for them after they’re gone which is one thing that I want to do when I get out of here...compose a letter to each one of them...just some little thing that’s there when I’m not there any more...that they might be able to get something from.

Penny felt some uncertainty around what she was going to be able to do once she returned home.

...not knowing how much I’m going to be able to do...[my
husband] is worried about having to go back to work and I'm going how I'm going to cope with things when he's not there...those things don't really worry me...I'll do whatever I can and whatever can't get done and that kind of thing...I'm not going try...feel I have to vacuum once a week or do any of those things...I told [my husband] that I'm going to do whatever the doctor thinks that I'm up to doing and wait and see.

Some of the women with families felt that they wanted to set examples for their children. Brynn wanted to be a model to her children in terms of how to better take care of themselves.

...the contribution...you know that I think I've set for my children...I mean personally I feel that I can talk to them or teach them...I've talked to them about look at the fact that I smoke and I'm overweight...use it as an example...maybe of what not to do...don't let things get too far along before you take action.

Several co-researchers talked about the importance of being able to see progress in terms of their recovery from MI. Penny felt that she could be patient with the process of recovery if she could reach small milestones along the way.

...I can live with not knowing exactly what day I'm going to be able to do this...as long as I know that there's going to be gradual steps along the way...sort of like milestones that you know...at some point you can do this and at some point you can do this...something to aim for and to know when you get to each one...I don't want it to take a long time but I guess there's not much you can do...follow the doctor's orders I guess...try to do the best.

Summary

Co-researchers described their experience of MI as being more than an illness event characterized by hospitalization. Nine common themes emerged from women's accounts of their MI experiences. The presence of these themes suggests that it is the interaction and expression of these themes that constitute the co-researcher's MI experience. Important here is the notion of examining the entirety of a women's experience of MI.
as opposed to a description of the disease.

Although it is clear that there are commonalities across co-researcher accounts, there was much variability in terms of how these themes were expressed. Moreover, the significance that co-researcher's attached to the themes or aspects of the themes also varied.
CHAPTER FIVE
Discussion of the Findings

Introduction

The purpose of this study was to explore the nature of women's experience of MI. In-depth semi-structured interviews were conducted with 10 female co-researchers, between the ages of 40 and 75, that were hospitalized and diagnosed with MI. More specifically, this study explored women's experience of MI during the acute phase of hospitalization and recovery. Although the study was pioneering in some aspects, some of the findings were nonetheless consistent with previous research.

Phenomenological data analysis of the transcribed interviews led to the identification of nine common themes. These nine common themes included the following experiences: illness awareness, feeling emotionally overwhelmed, fear and worry, loss, difficulty asking for or receiving help from others, needing information, care and support, making sense of the MI experience, and planning for the future.

Despite the uniqueness and variability that characterized women's experience of MI, all nine themes were evident in almost all of the co-researcher's accounts. Although each theme had its own discernable features, several of the themes interacted with each other, thereby reflecting the complex nature of the MI experience.

Integrating Current and Previous Research

Previous Qualitative Research

The present research identified several themes that were consistent with previous research. For example, a number of
themes were similar to findings in Dunn's (1985) study that examined women's perceptions of their illness experience with MI post-hospital discharge. Dunn found that loss provided an overriding framework that characterized women's experiences. The current study also identified loss as a common theme, although loss did not reflect the co-researchers' dominant experience. During the acute phase of recovery, the time frame examined in this study, themes such as illness awareness, feeling emotionally overwhelmed, fear and worry, the need for information, and making sense of the MI experience, were found to be of equal significance. In Dunn's study, these themes were subsumed under different aspects of the loss framework. This would make sense in terms of the time which elapsed between the MI event and research interviews in Dunn's study as co-researchers had more of an opportunity to fully experience recovery and assimilate to the effects of MI as the sense of loss appeared to evolve with time.

Similarly, although both anxiety and depression occur with significant frequency after MI (Mayou et al., 1978), it is only when an individual has had sufficient time to comprehend the reality of the potential threat to life and the potential for future incapacity that the depression is likely to present with clinical prominence (Degre-Country & Grevisse, 1982).

Although Dunn made reference to the theme of support, and receiving help, these themes were construed in a much different manner than the current study. In Dunn's study, women reported experiencing a lack of anticipated support from their families, particularly from their husbands, after
returning home from the hospital. Previous research in this area supports this finding (Boogard, 1984, 1985).

In contrast, most women in the current study reported receiving a great deal of support from family and friends. The acute and life threatening nature of the MI experience is more prominent during early hospitalization (Byrne, 1990). Subsequently, there is a great need for support during this illness phase as the heart patient is often extremely physically and emotionally vulnerable. The five co-researchers with spouses described them as being very supportive prior to and during hospitalization. Either these women experienced a different quality of support than reported in previous research or perhaps, more realistically, the nature of support women require and receive changes once they return home after hospital discharge and move through the process of recovery.

Eaker (1989) suggests that women lacking social support were found to have higher mortality rates post MI compared to women who reported having large social networks. This is particularly relevant for older women, where living alone because of spousal death is normative.

Current study findings also revealed that many of the co-researchers had difficulty asking for or receiving help from medical professionals, family, and/or friends. Moreover, during the hospitalization process, several women's reports suggested they felt stripped of their roles as nurturers and caretakers, and often felt uncomfortable with being in the position of receiving care and attention from others. Dunn also identified women's difficulty asking for or receiving
help in the context of returning home to their families and to household responsibilities. Boogard (1984, 1985) found similar results in her study examining women's and men's experience of rehabilitation post MI.

Jensen and Allen (1994) conducted a meta-analysis of three methods of qualitative research examining health, disease, wellness, and illness, including studies from grounded theory, phenomenology, and ethnography. The synthesis of grounded theory research, which included one study examining MI (Johnson & Morse, 1990), identified a series of phases relating to the process of living with health-disease. These phases suggest that people's experience of illness moves along a trajectory beginning with a lack of understanding of the illness, and ending as the individual comes to terms with their new life. More specifically, Jensen and Allen identified the phases of this process to include comprehending, managing, belonging, normalizing, and valuing. This synthesis or developed theory provides a means to make sense of the present research in terms of arranging various experiences and themes into some form of sequence based on the co-researcher's experience.

The unfolding process of the MI experience and emergent themes, as described by most of the women in the current study, also appeared to resemble a similar trajectory. The process of living with disease began with women experiencing an illness awareness in a similar fashion to Jensen and Allen's notion of "comprehending." Co-researchers then appeared to begin "managing" or coping with the events of
illness and hospitalization. Emotional reactivity including a sense of loss appeared to be part of this process. For these women, "belonging" referred more to the experience of care and support than to the process of renegotiating inter-personal relationships in the capacity of a person living with chronic illness as identified by Jensen and Allen. "Normalizing" and "valuing" parallels the way women in the current study made sense of their MI experience, and contemplated the future direction of their lives. This latter phase marks the end of the trajectory as well as the end of the acute illness phase and the hospitalization process.

Unlike most of the studies in Jensen and Allen's (1994) synthesis of grounded research, most of the co-researchers in this study had not yet had the opportunity to fully integrate their experience of MI into the larger context of their lives as interviews took place during hospitalization. Nonetheless, the trajectory described by Jensen and Allen in many ways is an appropriate meta-structure describing the experience of the women in this study. Perhaps this suggests that the process of living with illness is comprised of not one, but a series of trajectories that begin with a lack of understanding of the illness and end with a sense of having coming to terms with the experience.

Jensen and Allen's (1994) synthesis of phenomenological studies (none of which examined the experience of MI) identified common themes that described the lived experience of health and disease. For the purpose of this discussion, I focus on the phenomenological themes that relate to the lived
experience of disease only, which include loss of vitality, sense of imbalance or uncertainty, sense of alienation, hopelessness, pessimism, and transcendence. Similarities were evident between these themes and aspects of themes that emerged from the current research. For example, loss of vitality described many women's experience of loss of physical and emotional integrity. The sense of imbalance paralleled the experience of feeling emotionally overwhelmed, fear, and anxiety. Although several co-researchers described feeling a sense of uncertainty towards their future and towards their recovery process, most of the women maintained a somewhat positive, hopeful, and realistic attitude about their MI experience and towards the future. This resonated with Jensen and Allen's theme of transcendence as opposed to the theme of pessimism.

Several themes emerged from the current research that were not addressed in Jensen and Allen's phenomenological synthesis included having difficulty asking for and receiving help from others, the experience of needing information, and the experience of care and support.

Curative versus Caring

Another area of previous research examines issues related to women, medicine, and health (Oakley, 1993). Oakley differentiates between medicine's curative model of health and illness, with the caring and environmental model found in nursing. Curative denotes a focus upon physical repair and is informed by the belief that good medical practice is based upon a rational, detached attitude. Inherent to this approach
is the patriarchal doctor/patient relationship where the professional is solely responsible for making judgments and treatment decisions about the welfare of patients. In contrast, caring has become synonymous with the nursing profession, which supports the belief that caring for the individual is a necessary condition for restoring one's health. Oakley (1993) further suggests that rates of patient satisfaction with nursing care are generally higher than patient satisfaction with the care derived from physicians for two reasons. First, nurses tend to offer emotional support, and second, nurses often provide information to patients who have difficulty obtaining sufficient information from their doctors. This is consistent with the findings of the current study where co-researchers described the relationship to health care professionals as being an influential factor in their experience of MI.

More specifically, women in the current study typically distinguished between the care they received from nurses and the care received from doctors while hospitalized. All of the women expressed their appreciation for the compassionate and respectful quality of care and attention they received from the nursing staff. In contrast, women described having mixed rapport with their doctors, although a few described feeling very satisfied. These women felt that rapport was based on the degree to which their doctors provided satisfactory treatment and information, as well as the manner in which doctors related to them as individuals. These factors are important in as much as the perceived sense of care and the amount of
information women were given contributed to how they made sense of their MI experience.

Importance of Communication

Other research in the area of communication and patient satisfaction appears to support these latter findings. In general, effective communication between patients and healthcare professionals has been widely cited in the literature as a prerequisite to patient satisfaction with health care (Spiro & Heidrich cited in Burgoon, et al., 1987).

Weisman and Teitelbaum (1985) argue that factors significant for patient satisfaction include the communication of information, and the negotiative quality and affective tone of the doctor-patient relationship. Similarly, Buller and Buller (1987) found that patient's evaluations of medical care were based on physician's communication and technical competence. In other words, patient's evaluations of communication styles were strongly associated with receiving satisfactory medical care. Buller and Buller also found that physicians who adopted a more affiliative style of communication with their patients, which comprised of person-centered qualities such as empathy, genuineness, authenticity, warmth, and a non-judgemental attitude, generally produced more favourable evaluations than did communication styles based on dominance and control. This finding has been documented by several other researchers (Ben-Sira, 1980; Burgoon et al., 1987; Hall, Irish, Roter, Ehrlich, & Miller, 1994; Street & Weimann, 1987). Moreover, the qualities that patients identified as being favourable in physician
evaluations (Buller & Buller, 1987), closely resembled the person-centered qualities that many co-researchers identified in the nursing staff while hospitalized.

Considering the extent to which communication is an inherent factor in so many tasks within health care settings, it should not be surprising that the communication style of medical professionals plays an important role in perceived medical competence. In general, the manner in which medical professionals communicate with their patients may be more important than the content of the communication (Buller & Buller, 1987). Consequently, communication style should be a major concern for physicians in order to help facilitate the quality of perceived medical care and the satisfaction of their patients. Moreover, it would likely be beneficial for physicians to tailor their communication styles to meet the needs of the individual patient.

Importance of Information

Study findings suggested that women's need for information was crucial to their MI experience, not only in terms of understanding symptoms and treatment, and appraising the quality of care received from health care professionals, but also in terms of seeking health information. Information allowed several co-researchers to have a greater sense of involvement in their illness process. Moreover it enabled them to make informed decisions about treatment, lessened the uncertainty of what to expect in the future, and in general, served as a means to facilitate a greater understanding of their MI experience. Although the importance of obtaining
information emerged in previous research (Dunn, 1985), it was not reported as being as urgent as in the current study. Perhaps the need for concrete information may appear more critical for women in the hospitalization phase of illness than during post-hospital discharge where the acuteness of the emergency and the likelihood of death is not as imminent.

Co-researcher accounts suggested that some women were more active and successful at seeking information than others. Miller's research (cited in Miller, Brody, & Summerton, 1988) on information processing styles may also be useful in terms of making sense of these findings. Miller suggested that when individuals are threatened by unfavourable events, their information-processing behavior will likely follow one of two main dimensions. Subsequently, individuals will tend to either seek out and monitor for information relevant to the threat, or distract from and blunt threat relevant information. In the case of MI, relevant information may include the perception of bodily symptoms, as well as information acquired from health care professionals. Most of the women in the study, like monitors, appeared to seek out information related to their MI, while other women, like blunters, tended to distract from acquiring direct information related to their condition.

Miller, et al., (1988) suggested that a medical professional's management of acute medical problems might include a specific and routine assessment in order to identify and respond to a patient's preferred information processing style and subsequent need for information. Following this assessment, the physician could then tailor the degree of
information disseminated to the individual based on that person's identified needs. This highlights the importance of maintaining a collaborative relationship between physicians and their patients.

It is likely that other factors may influence women's propensity for information seeking including previous experiences, socio-cultural factors, the knowledge to ask for and discuss specific information and concerns, and the ability to challenge treatment decisions. Several of these factors allude to the power differential inherent in the socially constructed doctor-patient relationship whereby male doctors frequently assume they know what is best for female patients. Whereas co-researcher accounts suggested that doctors interpreted women's lack of information seeking as either understanding, indifference, or permission, women's silence was often related to fearfulness and disentitlement around speaking out. For example, Gina, who described herself as being "normally outspoken," was certain that she did not want to "criticize" the surgeon "who [was] going to be holding [her] heart in his hand" despite feeling sceptical about the recommendation for bypass surgery. Similarly, Anne described herself as being a "pretty good patient" because she did not "complain very much" despite feeling "furious" with doctors on a few occasions. More specifically, she described one incident where "[she] didn't say a word and kept very quiet" after a specialist had been excessively insensitive in his delivery of a discouraging surgical prognosis.

Future research examining the kind of information most
wanted by female cardiac patients, as well as the most effective means to communicate this information would have important implications for future health care for women.  

**Stressors Associated with MI**

Other research in the area of heart disease suggests that the stressors associated with MI are diverse and may vary depending of their meaningfulness to the individual (Cohen & Lazarus, 1979; Compas & Orosan 1993; King, 1985). Co-researchers described varying degrees to which they were impacted by physical and emotional stressors. The cause of distress varied greatly amongst the women and ranged in severity from feeling anxious to emotionally overwhelmed in response to physical symptomology, treatment procedures, the process of receiving care, and the worry surrounding the need to manage personal affairs. Multiple factors that influenced how women made meaning of their MI experience included the severity of MI and the resulting degree of functional impairment, previous experience of MI, or other cardiac history, direct or indirect experience of previous hospitalization or other illness, history of rapport with doctors, perceived quality of medical care and social support, current life stress, sociocultural factors, and personality traits such as coping style and self esteem.  

**Appraisals and Coping**

An indirect finding of the current study demonstrated that co-researchers utilized various strategies in order to cope with the potentially life threatening experience of MI. For example, although Hilda maintained a positive focus and
described feeling changed as a result of her MI and experience of cardiac arrest, Lydia appeared to distance herself from the severity of having suffered a MI. In contrast, one of Penny's strategies involved directly asking her doctors for information and resulted in alleviating feelings of anxiety. Co-researcher accounts demonstrated that individual differences were evident in the way that women assessed the severity of their cardiac event.

This process appears to provide support for Lazarus and Folkman's (1984) model of stress and coping, which suggests that appraisals are an evaluative cognitive process through which an individual judges the personal significance of a transaction with the environment. Subsequently, individuals appraise both the situation with respect to its importance for their well-being, as well as in terms of their available coping resources.

Lazarus and Folkman further suggest that understanding a person's appraisal of meaning, or what is personally at stake in a stressful encounter, provides relevant information for understanding why the situation has been appraised as stressful. Moreover, the degree of stress that an individual experiences will depend on how much of a stake that person has in the outcome of the stressful encounter or event. Typically, stressful encounters are appraised as being either related to loss, threatening, harmful, or challenging.

For women in the current study, appraisals significantly effected the impact of the MI event, as well as the resulting subjective reactions and choices of coping. Although some co-
researchers appeared to appraise their MI more as a threat and expressed anxiety about the anticipated negative impact of the illness, other women seemed to appraise MI more in terms of immediate harm and loss. For example, although Penny described not feeling immediately "traumatized" by her MI, she appeared to be concerned about future ramifications of the event and wondered what she could do to prevent another attack. In contrast, Kaye appraised her MI as being a "terrible thing" and appeared more adversely effected, both physically and emotionally, by the experience.

Sykes (1994) suggested that individuals who made negative cognitive appraisals of MI and of their ability to cope were likely to experience greater levels of resulting anxiety, whereas individuals that maintained more positive cognitive appraisals (saw some benefit stemming from their MI), subsequently demonstrated lower levels of morbidity (Affleck, Tennen, Croog, & Levine cited in Sykes, 1994). This provides support for Lazarus and Folkman's (1984) belief that appraisals and coping processes effect adaptational and health outcomes.

This has important implications for medical practice as an individual's appraisal of their illness condition is influenced by many factors including their perceived sense of care from health care professionals. As this study has demonstrated, obtaining concrete information from doctors and nurses is an important aspect of this care. Subsequently, providing patients with clear and comprehensive information is likely one factor that will influence how they appraise their
illness as well as various aspects of the hospital experience. Keckeisen and Nyamathi (1990) suggest that increased knowledge and information for the MI patient may promote feelings of having a greater sense of control over one’s health, and may positively influence their psychological well-being. It is important to emphasize that a patient’s information needs are specific to that person and will be influenced by their appraisals or what is at stake for the person. For example, Roslynn appraised the effects of memory loss as being a threat to her identity as a professor, and actively sought information that would enable her to offset aspects of the memory loss and help to alleviate feelings of powerless around this experience.

Current study findings also appear to support the literature’s contention that the threat to personal health is not always the most stressful aspect of one’s illness (Compas & Orosan, 1993). Co-researchers most frequently identified feeling concerned about relationships and the well being of significant others as being what was most at stake with the onset of MI. A few other women identified their ability to manage personal affairs as being most threatened by their illness. These concerns appear to parallel the categories of affiliation and achievement-power that were identified in Compas’s (cited in Compas & Orosan, 1993) work with cancer patients as being aspects of their illness or treatment that they considered to be most stressful. In general, other concerns identified by co-researchers appeared to be subsumed under Compas’ comprehensive framework and paralleled
categories including altruism-humanitarianism, life and mortality, and autonomy.

Gilligan’s (1982) work in the area of women’s development may be useful in terms of making sense of co-researchers concern for others despite their illness event. According to Gilligan, female identity is rooted in connections to others and relationships as a result of the socialization process beginning in infancy. More specifically, adult women define themselves in terms of their relationships, and in terms of judging their ability to care for others. Subsequently, women’s traditional roles have typically been that of caretaker, nurturer, and helper, in their networks of relationships with men and the family. As the current study and previous research demonstrates (Boogard, 1984, 1985; Dunn, 1985), women often have difficulty negotiating their roles after recently experiencing a life threatening event such as MI.

These findings have clear implications for health care professionals in terms of providing cardiac care and rehabilitation services that are more germane to women. An important factor in this care involves adopting a perspective of health care that acknowledges women’s relational and familial concerns.

Future research in the area of appraisals and coping strategies will provide health care professionals with more information about what aspects of MI are felt to be stressful to women, and to more fully understand the relationship between coping and adjustment in women with MI. Moreover,
longitudinal research may be better suited to examine the adaptational outcome of MI patients.

Developmental Considerations

Other findings from the current study suggest that although the emergent common themes were observed across co-researchers, women's experience of these themes often varied in the manner in which they were expressed. Individual differences contributed to how these themes were expressed. For example, because co-researchers ranged in age between 40 and 75 years, their developmental maturation and corresponding developmental issues also varied according to age. According to stage theorists such as Erikson or Levinson (cited in Kimmel, 1990), the primary developmental tasks for a 40-year-old woman differ significantly than for a 75-year-old woman. Whereas midlife transition is often characterized by crisis and re-evaluation of earlier life, late adulthood may be characterized by issues surrounding retirement, a growing awareness of the finality of life, and an evaluation of one's life and accomplishments. The variability in developmental issues was evident in concerns expressed by several co-researchers including Gina and Kaye. Whereas, Gina was at a crossroads in terms of making critical decisions about the future direction of her life, Kaye described the importance of feeling prepared for the final stages of her life. Undoubtedly, differences in developmental maturation and corresponding issues, as well as one's experience of historical events impacted the meaning that co-researchers attributed to their MI experience.
Similarly, other researchers (Parchert & Creason, 1989; Rankin, 1995) emphasize the importance of considering developmental context as it relates to women’s recovery from MI. More specifically, Rankin (1995) argues that normative age and history factors are influential components in the process of recovery from MI. Subsequently, younger and older cohorts of women are likely to experience MI differently due to developmental and cohort differences. To reiterate, this was demonstrated in the current study as developmental context appeared to influence how women made meaning of their MI experience. Understanding the potential effects of developmental factors are important in giving health care professionals more information about the types of issues and concerns that may be relevant to women experiencing MI. Future research in this area might focus on examining cohorts of women where factors related to age, socialization, and social context are more homogeneous.

Debriefing the MI Experience

Study findings also suggested that almost all of the co-researchers responded positively to having the opportunity to talk about their MI experience as well as to the opportunity of potentially helping other female heart patients by discussing their experience. Although many of these women had repeatedly described the events and symptoms leading to their MI to various medical professionals, the hospitalization process does not typically have the resources that would allow women (or men) to therapeutically debrief their experience of a potentially life threatening event.
In recent research, Pennebaker (1988, 1993) demonstrated the potential health benefits of disclosing traumatic experiences. More specifically, Pennebaker proposed that either talking or writing about an upsetting experience could be psychologically and physically beneficial. Pennebaker's findings suggested that health improvements in terms of immunological function were observed in individuals who constructed a coherent story of disclosure consisting of a high proportion of words that expressed negative emotions (such as anxiety or sadness).

In other research, Gruen (cited in Byrne, 1990) examined the effects of brief hospital-based psychological intervention throughout the acute recovery phase of a first MI on a predominantly male sample. The intervention focused on the resolution of emotional distress, and the facilitation of adaptive behavior during the rehabilitation phase. Findings from Gruen's study suggested that intervention patients experienced a range of physical and emotional benefits including fewer days in intensive care, fewer days in the hospital, and significantly less anxiety and depression than control patients.

Both Pennebaker (1988, 1993) and Gruen's (cited in Byrne, 1990) research supports the implementation of early psychological intervention following MI. Future research might examine the health benefits of including counselling or other therapeutic work in the treatment plans for female MI patients.

Unlike most of the previous research that has examined
women's experience of MI post hospital discharge, the current study focused on the initial phase of women's MI experience while still hospitalized. As adjustment to MI is an ongoing and dynamic process, future research, focusing on both the acute and recovery phases of MI would be ideal in terms of more thoroughly capturing the entirety of women's MI experience. Longitudinal studies that follow women's experience of MI throughout the phases of illness, including hospitalization, post hospital discharge, and recovery at home could be useful in achieving a greater understanding of this process.

Misdiagnosis or Dismissal of Symptoms

Another indirect study finding revealed that over half of the co-researchers in the current study reported some experience of having cardiac symptoms either dismissed or misdiagnosed by doctors. Several of these women reported seeking medical help prior to being diagnosed with MI, as they intuitively sensed that something was wrong with their health, but were told by physicians that their presenting symptoms were either not cardiac in origin or nothing to be concerned about.

Several researchers have suggested that physicians have pursued a less active or aggressive approach to the diagnosis and management of heart disease in women than in men (Ayanian & Epstein, 1991; Steingart, et al., 1991; Wenger, 1990, 1992). For example, Wenger (1992) suggests that because chest pain is usually associated with normal coronary arteries in women, as compared to men, physicians often still believe that these
symptoms in women will not likely be followed by serious cardiac events, or are attributed to non-cardiac causes (Steingart et al., 1991).

Rankin (1995) suggests that because the medical community has maintained the belief that heart disease is a serious health concern only for men, it is not surprising that women, particularly older women, have also adopted the belief that they are not at risk for CHD and MI (Rankin, 1995). Women need to become more educated regarding the incidence of heart disease in females, and to the importance of early cardiac symptom identification. Hopefully, this will result in women becoming more proactive health care consumers and insistent that their doctors take a more serious stance towards the assessment of cardiac symptomology.

Finally, although this study focused on examining women's experience of MI, there is currently a lack of research documenting men's experience of MI. Future research examining the personal meanings and perceptions of men's experience of MI has significant implications for treatment and rehabilitation, and could lead to the identification of gender similarities and differences within this area.

Barriers to Conducting the Study

The process of conducting this study has been time consuming and dotted with unforeseen challenges. At times, I felt that this process was almost as informative and educational as the stories of MI gleaned from the women themselves. In a odd sort of way, I feel fortunate to have experienced, first hand, some of the attitudes that have been
and continue to be counter productive to facilitating cardiac research on women. At the same time, I have gained a better sense of the depth to which traditional and patriarchal attitudes are still embedded at a systems level in the medical profession, and the extent to which these attitudes continue to serve as barriers to women's health care.

Some of the challenges I experienced conducting this research appeared to be related to friction stemming from the maintenance of dual roles, working in the hospital in the position of cardiology technologist, and as graduate student researcher. Not only is the position of cardiology technologist mostly confined to women, it is a fairly low ranking position in the hierarchy of hospital status. In contrast, the position of graduate student researcher offers the luxury of more independence, responsibility, and decision making. The transition from the position of cardiology technologist, who is subordinate to most other medical staff, to that of researcher, who requested help from specific hospital staff in order to facilitate my project, resulted in a power conflict. Although most of the health care professionals responded to the project in a supportive manner, there were a few incidents which I briefly describe.

The first challenge arose when approval for the study had to be obtained from the hospital ethics committee, a process similar to the requirements of the university ethics committee. Once approval was obtained from hospital officials, I was required to obtain further approval from the head of the cardiology department. The department head greeted the
research proposal with overt and blatant scepticism towards the worthwhileness of the project, the credibility of qualitative research, and towards the ability to obtain a graduate degree using this methodology. Until I had actually received approval to proceed with the study, I felt that the project was in jeopardy solely based on the department head's initial response. His posture paralleled the attitudes that have contributed to the minimal degree of visibility that women have been allotted in cardiac research.

Another challenge arose while I was trying to organize a system whereby cardiac care nurses acted as an initial liaison between potential co-researchers and myself for purposes of confidentiality. Although most of the nurses were willing to offer their assistance, one of three head nurses reacted adversely to my request for assistance. In an indirect manner, she made it clear that she would not facilitate the project. Again, I sensed that power dynamics were operating. Moreover, I felt there was irony in having difficulty encouraging a female nurse to help facilitate a health related project examining the experiences of women with heart disease (often thought of as a lifestyle disease), particularly when the majority of health care workers or nursing staff are women who typically work under highly stressful conditions.

Finally, I was acutely aware of my own reluctance to refer to the research as being feminist in nature in order to circumvent potential discrimination from hospital officials and/or medical professionals. Intuitively, I felt that a feminist label might potentially discredit the research
project itself and myself as a researcher.

Study Limitations

The qualitative and phenomenological nature of the study required that co-researchers participate in terms of articulating their thoughts and feelings related to their experience of MI. Despite feeling confident that co-researcher’s were able to articulate their experience of MI, and that these stories closely reflected their understanding of their experience, the study is limited by the extent to which women were willing and able to disclose their experience. For example, although an interview script was used to create consistency across data collection interviews, there was significant variation in the depth to which women expressed themselves. While some women were intensely introspective, other women focused on telling more descriptive stories of their experience. Despite this limitation, my efforts to establish rapport with co-researchers, in terms of trust, comfortableness, and respect, helped to facilitate women’s storytelling.

A second limitation relates to the generalizability of qualitative research. As one of the goals of qualitative research is to examine the fundamental processes of a specific group of individuals, it does not support the generalization of study results to other groups of individuals. The purpose of this study was not to generalize study results to all female MI patients, but to examine the experience of a small sample of women hospitalized with MI.

In addition, the sample of women in this study was one
primarily of convenience. Due to the limited numbers of women hospitalized with MI, all female MI patients were assessed in order to determine study eligibility and then approached to participate in the study. Subsequently, only 1 of the 10 co-researchers was non-Caucasian. Study findings may have differed with more diverse multi-cultural representation.

An additional limitation relates to the manner in which co-researchers were asked to relate their experience of MI. Asking co-researchers to relate their MI experience in the form of a story with a beginning, a middle, and an end, provided them with a framework with which they could organize the sequence of their illness events. Although women adapted these guidelines to accommodate their storytelling, this sequential approach may have occurred at the cost of allowing women to determine their own process around how to allow their experience to emerge.

The final limitation involves the validation interviews. Due to the unpredictable nature of heart disease, I was concerned that co-researchers may have died before the completion of data analysis. As a result, validation interviews were conducted following interview transcription and a preliminary review of the data. Moreover, these interviews reflected a confirmation of the information obtained from the women, as opposed to the validation of the identified nine themes.

**Implications for Counselling Practice**

The findings of this study suggest that the concerns experienced by women with MI are often varied and complex, and
often extend beyond the disease process itself. Health care professionals need to work together in order to provide women with care that is specific and germane to their particular issues and needs throughout the process of treatment and recovery from MI. Counselling psychologists working in this area need to adopt roles both as counsellors and as educators.

A key implication in this study is the important role for counsellors to assist other health care professionals, particularly doctors and nurses, in developing the communication skills that will better enable them to understand the process of women's illness experience and treat their patients. This training may include rapport building, empathy, and reflective listening skills, as well as highlighting the psychosocial implications of experiencing a life threatening event such as MI. Not only will this enable health care professionals to be able to implement more patient centered care, but may also provide them with the ability to better understand patient's responses and behaviors in the context of their illness and treatment.

Another important area of education for counsellors is to sensitize health care professionals to the potential needs of female MI patients. For example, to educate doctors on the importance of women's need to acquire concrete information, as well as to barriers that have often prevented women from challenging or more firmly seeking information from their doctors. These barriers may include previous experiences of being discounted by physicians, experiences of misdiagnosis, the power imbalance often prevalent in traditional male
doctor-female patient relationships (issues of powerlessness), the inability to assert one's rights (fears around asking), a lack of familiarity with medical language to know what questions to ask, and women's concerns around not taking up too much time or space with physicians. Subsequently, it is important that health care professionals do not assume that women are satisfied with the quality of information and care they have received despite the lack of feedback or questions that may suggest the contrary. As mentioned earlier, part of this work may involve the implementation of active listening and communication skills training sessions with health care professionals.

Because one of the key areas of concern identified by co-researchers was the issue of needing information, it is important that counsellors adopt the role of educator with female clients with heart disease. Results from the current study suggest that there would be great value in providing individual as well as group counselling for women that have suffered from MI. This would entail having information and a clear understanding of the process of MI recovery including physical and emotional reactions that are often characteristic to this experience. As well, it would important for counsellors to have some awareness of the more existential issues that women may experience related to loss, transition, the evaluation or re-evaluation of significant relationships, the process of rebuilding of identity, issues of self esteem, and issues surrounding mortality and death. As mentioned earlier, with respect to the work of Miller et al. (1988), the
extent of information interventions provided by counsellors would be based on the individual needs of each client.

Initiating the development of hospital and community based support and/or psychoeducational groups would not only provide women with a forum in which to learn more about the physical and emotional effects of their illness, but would provide women with the opportunity to share their experiences of MI with others and help alleviate feelings of isolation. Important to the development of such a group would not only be information germane to the female cardiac patient, but also a group format that would accommodate women’s needs and facilitate their group experience. Belenky, Clinchy, Goldberger, and Tarule (1986) propose that women learn and gain knowledge in a different manner than do men. Moreover, Belenky et al. suggests that women tend to learn best in collaborative groups and in situations that provide the opportunity for experiential learning that is geared towards a personal orientation. Incorporating these factors into the design of group work for women living with heart disease would likely be valuable in terms of facilitating women’s group experience as well as promoting a sense of well-being.

Conclusion

Current literature within the area of women and cardiac health fails to fully capture the nature of women’s experience with MI. The purpose of this phenomenological study was to explore and describe women’s experience of MI while still hospitalized in order to more fully understand how women make sense of this life threatening event.
Study results demonstrated the presence of nine common themes that described women’s experience of MI and were evident in almost all of the co-researcher accounts despite the uniqueness and variability of their experiences. These emergent themes included the following experiences: illness awareness, feeling emotionally overwhelmed, fear and worry, loss, difficulty asking for or receiving help from others, the need for information, care and support, making sense of the MI experience, and planning for the future.

Although similar themes have directly emerged or been subsumed under other themes in previous research conducted on post-hospital discharge, the examination of women’s experience of MI from a subjective perspective during hospitalization has not previously been documented. Subsequently, how women experienced several of these themes including loss, the difficulty asking for or receiving help from others, the need for information, and care and support, appeared differently as a result of occurring during the acute phase of illness. As a result, valuable information was gleaned about co-researcher’s experiences and needs while hospitalized with MI, and reflects an aspect of the recovery process that has been overlooked by previous research.

In general, the primary contribution of this study relates to the examination of an area that has not previously been researched, thereby adding an extensive description to the small existing body of literature on women and MI, and providing the basis for future research. The richness of women’s subjective stories serves to help health care
professionals more fully understand the importance of being sensitive to the experiential quality of the MI experience, to the unique nature of women's recovery from MI, and to the need for a balance between curing and caring in hospital care.
References


APPENDIX A

Interview Format

Interview Time: 30-90 minutes for each interview.
Guiding Question: What has it been like for you to have had a heart attack?

Preliminary Meeting

Introduce myself as a graduate student in Counselling Psychology at UBC, and as a Cardiology Technologist at the hospital. Introduce and explain the rationale for the study, requirements of study participation, confidentiality and anonymity, and answer any questions about what is involved or expected by co-researchers. Give information letter and obtain informed consent. Arrange a time for the first interview.

First Interview

I acquainted co-researchers with the nature and approximate duration of the first interview. As well, I advised each woman to inform me if she did not feel well, that she could take a break if necessary, that she could refrain from answering any questions that she did not feel comfortable with, and that she could ask me to turn off the audio-tape if she did not want a particular part of the interview recorded.

Script

During this meeting, I am interested in developing an overall perspective, based on your experiences, of what it has been like for you to have had a heart attack.

I would like you to think back to when you first realized that you were having a heart attack, your experience when you arrived at the hospital, and what your experience has been like since. While you think about this experience, also think
about the feelings that you have had, what your thoughts have been, and how you have behaved. It is important to remember that there are no right or wrong ways of experiencing your illness - what is important is how you personally experienced this event.

Could you now begin to describe to me some of these experiences, as though you were telling a story that has a beginning, a middle, and an end. Telling your story like this may help you describe the sequence of events and your experiences since the heart attack.

While you tell your story, I encourage you to include as many details as possible that are related to your feelings, thoughts, and behaviors, as they occur during each part of your MI experience. You may have experienced different feelings, thoughts, or behaviors, during the beginning, middle, and end of your experience.

While the co-researchers were telling their stories, I asked each woman the following questions in order to help facilitate the description of her MI experience, as well as to help discover any personal meanings associated with the experience. When necessary, prompts similar to those listed below were used to help co-researchers further articulate, elaborate, or clarify their descriptions and responses to questions.

At the end of each interview, co-researchers were asked demographic type questions in order to gain a better sense of their social and cultural context (see Appendix B).
Questions
(a) When were you first aware that you were having a heart attack?
(b) What does it mean to you to have experienced a heart attack?
(c) What is the significance of the event?
(d) Tell me more about your feelings, your thoughts, and your behaviors since having the heart attack.
(e) How do you feel about returning home?
(f) Is there anything else you would like to tell me about your experience of having a heart attack?

Prompts
Tell me more about that.
What were your feelings when that happened?
What went through your mind when that happened?
What did you do when that happened?
What did that mean to you?
How did that affect you?

Once the co-researcher finished telling her story, I asked she wanted to add any other relevant details to her story that would help me understand her experience of MI, but that I had not asked about. As well, I asked each woman what her experience was to be interviewed and to talk about her MI experience. The interview was finished only when the co-researcher had offered her final comments. At this point, the audio-tape was turned off.

Before ending the session, I briefly described my forthcoming process of transcribing and reviewing the
interview in order to gain a better understanding of the co-researcher’s story and for preliminary themes. I thanked the co-researcher for sharing her personal story, and arranged to contact her for the second interview.

**Second Interview**

I presented the co-researcher with my preliminary understanding of her story from the transcribed interview. Next, I explained to the co-researcher that she has the opportunity to clarify any material that appears vague or incomplete, or provide me with additional information that will help me further understand her illness experience.

At this time, I also asked the co-researcher for permission to contact her briefly in the near future if I needed to seek further clarification regarding the interview material. The co-researcher was informed that a copy of the study results will be available upon request once data analysis is complete.
APPENDIX B
Background Information Form

1. Please indicate your age.

2. Where do you currently live?

3. Please indicate your highest education level:
   (a) public school (b) high school (c) some college or university courses (d) undergraduate university degree
   (e) master's degree or above.

4. Marital status?

5. Number of children: (a) living at home b) not living at home.

6. How do you currently spend your time?
   (a) employed (b) unemployed (c) homemaker
   (d) retired (e) volunteer (f) other (please explain).

7. What is your current or previous occupation?

8. What is your own or family income?

9. What is your ethnic background?

10. Have you had any previous illnesses? Briefly describe what illness and when were you hospitalized at this time?

11. Does your illness experience remind you of another experience you have had in your life?

Co-researchers were also asked the following question relating to a research project proposed to provide psychoeducational support services to women living with heart disease.

* If you had the opportunity to be part of a support group for women living with heart disease what sorts of issues or concerns do you think would be important to address?
You have been asked to participate in a research study. Participation in this study is entirely voluntary. You may decide not to participate or may withdraw from the study at any time without affecting your normal medical treatment.

Purpose
Most of the research that has focused on women and heart attack, has not examined women’s illness experience from a patient perspective. As a result, there is little understanding of women’s perceptions of their experience with heart attack, and how women make meaning of this experience.

The purpose of this study is to examine the nature of women’s illness experience with heart attack from their perspective, in order to explore and describe these experiences and to understand how women make sense of heart attack.

Procedures
If you decide to take part in this study, you will be contacted by the researcher three times. The first meeting will take place after you have been transferred from the coronary care unit to the heart floor. The first interview will take place a day or two after the initial meeting, but before you are discharged from the hospital. The interview will take place in your hospital room, and will take between thirty and sixty minutes to complete. You will be asked to describe what your experience of having a heart attack has been like. This interview will be audio taped. The second interview will take place via telephone once you return home from the hospital. The study should not take up any more time beyond the time taken for the interviews. There will not be any interruption of your regular medical treatment or medications.
Risks and Significant Side Effects
There are no anticipated risks or significant side effects resulting from participation in this study.

Potential Benefits
This study should add to our understanding of how women make sense of their experience with heart attack. You may find it helpful to have the opportunity to discuss some of your feelings and concerns related to having a heart attack and being hospitalized.

Monetary Compensation
There will be no monetary compensation for participation in this study.

Confidentiality
Any information resulting from this research study will be kept strictly confidential and will be accessible only to Michele Bowers and the members of her thesis committee which comprise of faculty members at the University of British Columbia. Audio tapes will not be used for any purpose other than for Michele Bowers' thesis. These tapes will be stored securely, and coded by number only as the names of study participants and any identifying information will not be included in the final report.

If you have any questions or concerns at any time during the study, you may contact Michele Bowers at 687-6828.

***************

I have read the above information and I have had an opportunity to ask questions to help me understand what my participation would involve. I freely consent to participate in the study and acknowledge receipt of a copy of the consent form.

__________________________________________  __________________________
Signature of Participant                        Date

__________________________________________
Signature of Witness
APPENDIX D

Participant Information Letter

One of our technical staff (ECG tech), Michele Bowers, is also graduate student at University of British Columbia in counselling psychology. Michele is conducting a research study, at St. Paul’s hospital in consultation with cardiologist Dr. Marla Kiess. The research project examines **Women’s experience with myocardial infarction**.

Michele is interested in learning more about women’s experience with heart attack, and would be interested in listening to your thoughts and feelings regarding your experience.

She feels that the knowledge gained from your participation in this study could make a valuable contribution to the future care of female cardiac patients.

If you decide to participate, Michele will meet with you to explain the project in more detail after you have been transferred from the CCU to the heart ward. If you are interested in volunteering for the study, Michele will arrange a time, while you are still hospitalized, when you can discuss your experience of having a heart attack. During this interview, she will ask you what some of your thoughts and feelings have been during this experience.

There are no risks if you participate in this study, and in no way will participating in the study affect your current or future medical treatment. Some women may find it helpful to be able to talk about their experiences of heart attack.

Any information gathered during this research study will be kept strictly confidential and will be accessible only to Michele Bowers, Dr. Kiess, and the other three UBC professors on her research team.

If you think you might want to participate in the study or would like more information, I would like to get your permission to forward your name to Michele.

Thank-you!
## APPENDIX E

### Co-researcher Background Information

<table>
<thead>
<tr>
<th>Age</th>
<th>Lydia: 75</th>
<th>Kiko: 65</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Kaye: 73</td>
<td>Gina: 44</td>
</tr>
<tr>
<td></td>
<td>Anne: 63</td>
<td>Brynn: 51</td>
</tr>
<tr>
<td></td>
<td>Roslynn: 47</td>
<td>Noreen: 58</td>
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<td></td>
<td>Penny: 40</td>
<td>Hilda: 64</td>
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<table>
<thead>
<tr>
<th>Marital Status and Number of Children</th>
<th>Lydia: Single/0</th>
<th>Kiko: Widowed/2/2 step</th>
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<tbody>
<tr>
<td></td>
<td>Kaye: Widowed/1</td>
<td>Gina: Married/2</td>
</tr>
<tr>
<td></td>
<td>Anne: Married/2</td>
<td>Brynn: Remarried/3</td>
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<td></td>
<td>Roslynn: Divorced/2</td>
<td>Noreen: Widowed/7</td>
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<tr>
<td></td>
<td>Penny: Married/0</td>
<td>Hilda: Married/9</td>
</tr>
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<table>
<thead>
<tr>
<th>Education</th>
<th>Lydia: college equivalent</th>
<th>Kiko: high school</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Kaye: some college</td>
<td>Gina: high school</td>
</tr>
<tr>
<td></td>
<td>Anne: high school</td>
<td>Brynn: university</td>
</tr>
<tr>
<td></td>
<td>Roslynn: university</td>
<td>Noreen: some high school</td>
</tr>
<tr>
<td></td>
<td>Penny: post secondary certificate</td>
<td>Hilda: high school</td>
</tr>
<tr>
<td>Name</td>
<td>Current Employment</td>
<td>Ethnicity</td>
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<tr>
<td>--------</td>
<td>----------------------------</td>
<td>----------------------</td>
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<tr>
<td>Lydia:</td>
<td>retired/nurse</td>
<td>Canadian</td>
</tr>
<tr>
<td>Kiko:</td>
<td>retired/produce wholesaler</td>
<td>Japanese/Canadian</td>
</tr>
<tr>
<td>Kaye:</td>
<td>property manager</td>
<td>Canadian</td>
</tr>
<tr>
<td>Gina:</td>
<td>retail clerk</td>
<td>Canadian</td>
</tr>
<tr>
<td>Anne:</td>
<td>homemaker</td>
<td>Canadian</td>
</tr>
<tr>
<td>Brynn:</td>
<td>unemployed/nurse</td>
<td>Canadian</td>
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<td>Roslynn:</td>
<td>engineer/management</td>
<td>Canadian/Belgium</td>
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<tr>
<td>Noreen:</td>
<td>cook-waitress</td>
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<tr>
<td>Penny:</td>
<td>housing appraiser</td>
<td>Canadian</td>
</tr>
<tr>
<td>Hilda:</td>
<td>retired/cook-baker</td>
<td>Canadian</td>
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### Previous Illness

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<tr>
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<th>Illnesses</th>
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<tbody>
<tr>
<td>Lydia</td>
<td>mastectomy; pulmonary fibrosis; appendectomy</td>
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<tr>
<td>Kiko</td>
<td>gallstones removed; uterine clotting</td>
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<tr>
<td>Kaye</td>
<td>high blood pressure; coronary bypass surgery</td>
</tr>
<tr>
<td>Gina</td>
<td>tonsillectomy; hysterectomy; sciatica</td>
</tr>
<tr>
<td>Anne</td>
<td>neck cysts removed; benign tumour removed; 3 MIs; coronary bypass surgery</td>
</tr>
<tr>
<td>Brynn</td>
<td>dysplasia; gall bladder removed</td>
</tr>
<tr>
<td>Roslynn</td>
<td>2 MIs; kidney stone removed</td>
</tr>
<tr>
<td>Noreen</td>
<td>appendectomy; cardiac arrhythmia</td>
</tr>
<tr>
<td>Penny</td>
<td>vertigo</td>
</tr>
<tr>
<td>Hilda</td>
<td>appendectomy; high blood pressure</td>
</tr>
</tbody>
</table>