

**WHEN A LEG ULCER BECOMES CHRONIC: A PHENOMENOLOGICAL  
STUDY OF THE OLDER ADULT'S EXPERIENCE OF LIVING  
WITH A CHRONIC VENOUS LEG ULCER**

**By**

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## **ABSTRACT**

### **When A Leg Ulcer Becomes Chronic: A Phenomenological Study Of The Older Adult's Experience Of Living With A Chronic Venous Leg Ulcer**

Chronic venous insufficiency has been recognized as one of the most common health problems experienced by the older adult. Unfortunately, an all too frequent complication of this circulatory disorder is the development of a venous leg ulcer. Chronic venous leg ulcers can have a negative impact on the general well-being of the older adult and costs to the health care system associated with the treatment of chronic venous leg ulcers are substantial.

A review of the literature revealed that no qualitative research studies have been conducted in relation to the older adult's experience of living with a chronic venous leg ulcer. Rather, there are a few anecdotes in relation to the venous leg ulcer experience that have been written from a health care professional's perspective. Thus, in the context of chronic venous leg ulcers, the explanatory model of the client has not yet been documented.

The purpose of this study was to gain an understanding of the chronic venous leg ulcer experience from the perspective of community-dwelling older adults. The phenomenological approach to qualitative methodology was used for this study. This approach seeks to describe human experience as it is lived. Six individuals, over sixty-five years of age, agreed to participate in this study; they were currently being seen or had been seen on a regular basis by a home care nurse for treatment of their chronic venous leg ulcers. Participants were each interviewed twice and these interviews were guided by open-ended questions. Analysis of the data revealed that participants moved

through three sequential phases of a "living with a chronic venous leg ulcer continuum" as they lived with chronic venous insufficiency and chronic venous leg ulcers. In the first phase of the continuum, participants experienced the effects of living with their chronic circulatory disorder. They encountered losses in relation to physical endurance, gratifying activities, companionship, and predictability in their lives. In addition to experiencing loss, the participants encountered a gain as a result of having a chronic venous leg ulcer: the emotional support afforded them by home care nurses and homemakers involved in their care. In the second phase of the continuum, participants evaluated how significantly their chronic venous leg ulcers had affected their lives. In so doing, the participants either appraised their leg ulcer as having been detrimental to their quality of life, or inconsequential with regard to living a satisfying life. The key factor that influenced the appraisal that participants made of their leg ulcers was whether or not their circulatory disorder had impacted on a primary source of satisfaction in their life. In the third and final phase of the continuum, the participants coped with their circulatory disorder in one of two ways. Each participant either "put their life on hold" if they had appraised their leg ulcer as being detrimental to them, or they "got on with life" if they had appraised their leg ulcer as being inconsequential. The implications for nursing practice, education, and research were identified in light of the research findings.

## TABLE OF CONTENTS

<b>ABSTRACT</b> .....	<b>ii</b>
<b>TABLE OF CONTENTS</b> .....	<b>iv</b>
<b>ACKNOWLEDGEMENTS</b> .....	<b>vi</b>
<b>DEDICATION</b> .....	<b>vii</b>
<b>CHAPTER ONE: INTRODUCTION</b> .....	<b>1</b>
Background And Significance Of The Problem .....	<b>1</b>
Theoretical Framework .....	<b>4</b>
Problem Statement And Purpose Of The Study .....	<b>5</b>
Definition Of Terms .....	<b>6</b>
Introduction To The Study's Methodology .....	<b>7</b>
Assumptions .....	<b>9</b>
Limitations .....	<b>9</b>
Summary .....	<b>10</b>
<b>CHAPTER TWO: LITERATURE REVIEW</b> .....	<b>11</b>
Introduction .....	<b>11</b>
Living With A Venous Leg Ulcer .....	<b>11</b>
Living With Other Types Of Wounds .....	<b>15</b>
The Stoma Experience .....	<b>16</b>
The Burn Experience .....	<b>19</b>
Living With Chronic Illness .....	<b>21</b>
Aging And Body image .....	<b>23</b>
Summary .....	<b>24</b>
<b>CHAPTER THREE: METHODOLOGY</b> .....	<b>26</b>
Introduction .....	<b>26</b>
Selection And Recruitment Of Participants .....	<b>26</b>
Selection Criteria .....	<b>27</b>
Recruitment Procedure .....	<b>29</b>
Characteristics Of The Participants .....	<b>32</b>
Data Collection .....	<b>35</b>
Data Analysis .....	<b>40</b>
Scientific Adequacy Of The Research .....	<b>41</b>
Credibility And Fittingness .....	<b>42</b>
Auditability .....	<b>43</b>
Ethical Considerations .....	<b>43</b>
Summary .....	<b>46</b>

<b>CHAPTER FOUR: FINDINGS AND INTERPRETATION</b>	<b>47</b>
Introduction	47
Experiencing The Effects Of The Chronic Venous Leg Ulcer	48
Encountering Loss	49
Loss Of Physical Endurance	49
Loss Of Gratifying Activity	50
Loss Of Companionship	53
Loss Of Predictability	54
Encountering Gain	55
Evaluating The Significance Of The Chronic Venous Leg Ulcer	58
Appraising The Chronic Venous Leg Ulcer As Detrimental	59
Appraising The Chronic Venous Leg Ulcer As Inconsequential	65
Coping With The Chronic Venous Leg Ulcer	70
Putting Life On Hold	71
Getting On With Life	73
Summary	74
<b>CHAPTER FIVE: DISCUSSION OF THE FINDINGS</b>	<b>77</b>
Introduction	77
Appraising The Significance Of The Chronic Venous Leg Ulcer	83
Coping With The Chronic Venous Leg Ulcer	87
Summary	91
<b>CHAPTER SIX: SUMMARY, CONCLUSIONS, AND IMPLICATIONS</b>	<b>94</b>
Summary	94
Conclusions	96
Implications For Nursing	97
<b>REFERENCES</b>	<b>104</b>
<b>APPENDIX A</b>	<b>109</b>
<b>APPENDIX B</b>	<b>110</b>
<b>APPENDIX C</b>	<b>113</b>
<b>APPENDIX D</b>	<b>114</b>
<b>APPENDIX E</b>	<b>115</b>

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**For Sally,  
who always believed in me.**



## **CHAPTER ONE**

### **INTRODUCTION**

#### **Background And Significance Of The Problem**

Chronic venous insufficiency of the legs has been recognized as a significant health problem in the general adult population (Coon, Willis & Keller, 1973; Lamont, 1991) and as one of the most common health problems experienced by the older adult (Fitzpatrick, 1989). An estimated 5.9 percent of older adults in the United States experience chronic venous insufficiency of the legs (Beauregard & Gilchrest, 1987). Unfortunately, an all too frequent complication of this circulatory disorder is the development of a venous leg ulcer (Fitzpatrick, 1989; Kunimoto, 1991; Prebble, 1990).

Although writers such as Fitzpatrick (1989), Kunimoto (1991), and Prebble (1990) have noted that venous leg ulcers are a frequent occurrence in North American and European adult populations, it is difficult to grasp the actual prevalence of this condition for a number of reasons. First, published estimates of the prevalence of venous ulceration are few and the estimates that are available paint a confusing picture. More specifically, a search of the literature resulted in two greatly differing estimates of the prevalence of venous leg ulcers. David (1986) approximated the prevalence of venous leg ulcers in the general North American population as ten percent. Coon and colleagues (1973), in an earlier study conducted in the United States, found that between 0.1 and 0.3 percent of their study population experienced venous ulceration. Similarly, Lamont (1991) estimated that between 500,000 and 850,000 individuals in the United States, or approximately 0.2 percent of the population, have venous leg ulcers. Coon and

colleagues (1973) have also noted that it is difficult to accurately estimate the incidence and prevalence of venous related conditions.

Another reason for uncertainty in relation to the prevalence of venous leg ulcers is that a number of researchers have published estimates which group both arterial and venous leg ulcers in the estimate (e.g., Callam, Ruckley, Harper & Dale, 1985; Dale, Callam, Ruckley, Harper, & Berrey, 1983; Prebble, 1990). In this type of statistical reporting it is impossible to know what proportion of the leg ulcers are of venous origin. This story is made even more perplexing when authors such as Kunimoto (1991) cite estimates of the prevalence of venous ulceration from original studies (e.g., Dale, Callam, Ruckley, Harper & Berrey, 1983) that referred to leg ulceration in general (arterial and venous leg ulcers combined) and not to venous ulceration in particular.

When reviewing literature on the prevalence of venous leg ulcers, it is also important to note that writers have not specifically discussed prevalence of venous ulceration among the older adult population. It is commonly thought, however, that this circulatory disorder is most prevalent among the elderly (e.g., Fitzpatrick, 1989; Merry, 1989). Additionally, there is no sense of whether prevalence estimates refer to acute or chronic venous ulcers. Consequently, although it is widely believed that chronic venous leg ulcers are a significant problem among the older adult population, and although this researcher's clinical experience holds this to be true, it is difficult to support this belief with the statistics that are available. Future research findings in the area of wound care will most likely support the notion that chronic venous leg ulcers are a significant health problem among the elderly.

During the past few decades, there has been increased interest in documenting the incidence and prevalence of various types of tissue damage. Further, there has been a

tremendous growth in the number of allied health writings that relate to the care of the individual with tissue damage. These writings, both theoretical and research based in nature, have focused primarily on the assessment, classification, and local treatment of the tissue damage. For the most part, literature specific to the care of the individual with a venous leg ulcer has provided detailed descriptions of the clinical presentation of a venous ulcer and associated pathogenesis, the differences between venous and arterial leg ulcers, and recommended treatment for the local tissue damage (e.g., Doyle, 1983; Fitzpatrick, 1989; Kunitomo, 1991; Lanyon, Van Nieuwenhuyzen & Wearing, 1987; Tretbar, 1987).

Interestingly, a literature review that was conducted in relation to both acute and chronic venous leg ulcers showed no research in relation to psychosocial responses to this circulatory disorder and furthermore no research related to the lived experience of the older adult with a chronic venous leg ulcer. The lack of research in this particular area has implications for the community health nurse who often provides nursing care in a home setting to older adults with chronic venous leg ulcers. Kleinman (1978), in an explanatory model of transactions in health care relationships, notes that difficulties in health care relationships arise when the health care professional has a different explanatory model or view of a sickness episode than does the client. If the community health nurse is to work effectively with the older adult who is living with a chronic venous ulcer, it is essential that s/he have some understanding of what this experience is like from the client's perspective. In the context of chronic venous leg ulcers, the explanatory model of the client has not yet been documented.

### **Theoretical Framework**

The theoretical framework which provided direction for this study was Kleinman's (1978) explanatory model of transactions in health care relationships. In his conceptualization of the health care system, Kleinman (1978) suggests that this system is comprised of three sectors or social arenas within which sickness is experienced and responded to: professional (health care professionals involved in traditional healing practice), popular (individual, family, social network, and community), and folk (non-professional healing specialists). In each of these arenas, differing explanatory models may be elicited in regard to a particular sickness episode. For example, the health care professional often understands the sickness episode within the context of a western biomedical science paradigm; the sickness is viewed in terms of a disease process with emphasis on malfunctioning or maladaptation of biologic or psychophysiologic processes within the client. The client, on the other hand, views the sickness episode within the context of personal meaning, that is meaning that has been constructed from personal, interpersonal, and cultural reactions to sickness; the sickness is viewed primarily in terms of illness, which is the everyday human experience of living with sickness.

Kleinman (1978) urges health care professionals to explore the client's explanatory model in relation to a sickness episode and notes that difficulties in health care relationships arise when explanatory models conflict or when clinical realities are constructed in differing ways. More specifically, when explanatory models among the professional and popular arenas, for example, are substantially dissimilar, there will be less effective communication in health care relationships and more clinical management difficulties. Furthermore, Kleinman (1978) notes that the health care professional must

consider the client's illness experience as well as the disease if holistic health care is to be provided.

The foregoing theoretical framework provided useful direction in relation to various aspects of this research study. More specifically, Kleinman's (1978) work validated the researcher's beliefs that it is essential for nurses to understand the older adult's subjective experience of living with a chronic venous leg ulcer and that a significant problem does exist if there is a dearth of knowledge in relation to this lived experience. Thus, a research method aimed at describing human experience as it is lived was thought to be ideal for such a study as the researcher wished to understand the participant's explanatory model and illness experience.

#### **Problem Statement And Purpose Of The Study**

Within the community setting, nurses are providing care to older adults who are living with chronic venous leg ulcers. If the nurse is to work effectively with these clients, there must be some understanding of what the client's experience is like. More specifically, the older adult's subjective experience with a chronic venous ulcer must be understood within the context of everyday living. To date, no research studies have been found which explore the experience of living with a chronic venous leg ulcer from the perspective of the older adult.

Therefore, the purpose of this study was to explore and describe the experience of the older adult who is living with a chronic venous leg ulcer. This purpose was accomplished by answering the following research question: "What is the lived experience of the older adult, residing in a home setting, who has been identified by a health care professional as having a chronic venous leg ulcer?"

### **Definition Of Terms**

A number of key terms used in this study were defined as follows:

**Older adult:** a male or female individual, sixty-five years of age or older, who is residing at home and is visited by a Burnaby Health Department home care nurse at least once per week for treatment of a chronic venous leg ulcer. The individual is able to communicate, in English, his/her experience of living with a chronic venous leg ulcer. As well, the individual must not be experiencing a coexisting physiological/psychiatric condition that would significantly alter his/her perception of the experience of living with a chronic venous leg ulcer or impact significantly on the lived experience (e.g., delusional thinking, paraplegia, chronic respiratory difficulty that the individual is continually aware of and trying to manage).

**Chronic venous leg ulcer/chronic venous ulcer:** tissue damage, manifesting as an ulceration or open lesion of the skin of a lower extremity, related primarily to venous insufficiency. The diagnosis of a venous leg ulcer is made by a health care professional and is based on clinical presentation and client history data that would indicate that the leg ulcer is related primarily to venous insufficiency. Additionally, as part of the diagnostic process, the possibility that the leg ulcer is related primarily to arterial insufficiency is ruled out (see Appendix A for a summary comparison of characteristics of arterial and venous leg ulcers). In terms of chronicity, the ulceration is of at least two months duration and has been treated by a Burnaby Health Department home care nurse at least once per week for a minimum of two months.

**Lived experience:** the older adult's perception or subjective experience of everyday life.

**Health care professional:** a home care nurse (employed by the Burnaby Health Department) or a physician (family practice, specialist) involved in the care of the older adult who is living with a chronic venous leg ulcer.

### **Introduction To The Study's Methodology**

In their discussion concerning the selection of a research methodology, Field and Morse (1985) noted that "For each question, there is a best or most appropriate method, and selecting the method is the most important decision in the research process" (p.29). According to these writers the researcher needs to consider a number of factors when selecting the "best" or most appropriate method for a research study. Factors to be considered during selection of a research method include: (i) the nature of the research question; (ii) expected outcomes of the research; (iii) constraints of the setting; (iv) characteristics of the participants; and, to a lesser degree, (v) resources available to the researcher (Field & Morse, 1985).

Phenomenology was the research method selected for this study subsequent to the researcher's consideration of the aforementioned factors as well as the direction provided by the theoretical framework. The following discussion provides a rationale for the selection of phenomenology as the research method for this study. Further discussion of the phenomenological method and a description of the ways in which this method was applied are presented in Chapter Three.

To begin, the expected outcome of this study was a description of the subjective experience of the older adult who is living with a chronic venous leg ulcer. This outcome was to be accomplished by answering the following research question: What is the lived experience of the older adult, residing in a home setting, who has been identified by a health care professional as having a chronic venous leg ulcer? Both the expected

outcome of the study and the nature of the research question directed the researcher to select a research approach which is qualitative in nature. In a discussion of the differences between qualitative and quantitative research, Knaack (1984) noted that the traditional scientific method of quantitative research seeks to objectify human behavior through the actions of "observing" and "explaining"; the phenomenon of human behavior is observed, quantified, and verified by independent observers. A qualitative approach to research, on the other hand, has as its aim the "interpreting" and "understanding" of the subjective meaning of human experience which is congruent with this study's expected outcome and research question (Knaack, 1984; Oiler, 1986; Omery, 1983).

Phenomenology was the specific qualitative research method thought to be most appropriate for this study for a number of reasons. First, phenomenology has as its aim the description of human experience as it is lived (Oiler, 1986). The phenomenological researcher endeavours to understand phenomena from the perspective of those being studied (Riemen, 1986). Bruyn (1966) noted that "phenomenology serves as the rationale behind efforts to understand individuals by entering into their fields of perception in order to see life as these individuals see it" (p.90). Thus, the phenomenological aim was consistent with the researcher's goal in this study, that was, to explore and describe the human experience of living with a chronic venous leg ulcer. The phenomenological method was also consistent with the direction that this study's theoretical framework provided. More specifically, the theoretical framework directed the researcher to select a research method which furthers understanding of the participants' explanatory models of sickness and their illness experiences through exploration of their lived human experiences. Finally, the phenomenological method was found to be appropriate when considering such factors as participant characteristics and resources available for the



study. Specifically, participants in this study had the ability to share their experiences and the researcher had both the time and resources required to conduct a phenomenological study.

### **Assumptions**

The researcher assumed that each participant had a desire to share his/her experience of living with a chronic venous leg ulcer. It was also assumed that each participant's views represented reality for that individual and that this reality was reported as accurately as possible. Further, the researcher assumed that while no lived experience is the same, themes would emerge that were common to all of the participants' descriptions of living with a chronic venous leg ulcer.

### **Limitations**

There were a number of factors which served to limit the generalizability of the study's findings. To begin, participants in the study were selected from one specific urban area (area served by the Burnaby Health Department) and may, therefore, represent a specialized subgroup of the population. Additionally, all of the participants were able to understand and speak English and participated in the study on a voluntary basis. The lived experiences of these participants may not be representative of the lived experiences of older adults, with chronic venous leg ulcers, who do not understand or speak English or who did not volunteer to participate in the study. Finally, each participant described his/her experience within the context of personal meaning, that is meaning that has been constructed from personal, interpersonal, and cultural reactions to sickness. The lived experiences of these participants may differ in significant ways from the experiences of other older adults with chronic venous leg ulcers who, for example, are members of significantly different cultural and social systems.

### **Summary**

The community health nurse often provides nursing care to community-dwelling older adults who are living with chronic venous leg ulcers. Yet, no research studies have been found which explore the experience of living with a chronic venous leg ulcer from the perspective of the older adult. This research problem was presented in this introductory chapter along with the purpose of this study, which was to explore and describe the experience of the older adult who is living with a chronic venous leg ulcer. The theoretical framework and methodological perspective, which provided direction for the study, were also discussed in this chapter. Chapter One concluded with a review of assumptions that were made by the researcher and limitations inherent in the study.

In Chapter Two, selected literature relevant to the phenomenon under study is reviewed. Further discussion of the phenomenological research method and a description of how this method was applied in this study is the focus of Chapter Three. The study's findings and interpretation of the data are presented in Chapter Four. Next, a discussion of the findings is presented in Chapter Five. Finally, Chapter Six includes a summary of the study, conclusions derived from the research findings, and a discussion of the implications of the findings for nursing practice, education, and research.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **Introduction**

In order to further understand what the older adult's subjective experience of living with a chronic venous leg ulcer might be like, the researcher reviewed literature that was thought to be relevant to the phenomenon under investigation. First, literature related to the experience of living with a venous leg ulcer was reviewed. When it was discovered that there was a dearth of knowledge in this area, the researcher then broadened the scope of the literature review and examined writings related to the experience of living with other wounds such as stomas and burns. Second, the researcher briefly reviewed literature addressing the chronic illness experience as it was thought that, quite possibly, the particular circulatory disorder that was the focus of this study could be classified as a chronic illness although it had not been addressed as such in the literature. Finally, writings in relation to the aging process and its impact on body image were briefly examined as it was thought that the older adult's experience with a chronic wound might be influenced by the way in which they perceived their aging body. In this chapter, then, literature that was reviewed in relation to the aforementioned subject areas is presented.

#### **Living With A Venous Leg Ulcer**

Currently, there is no documented research related to the older adult's subjective experience of living with a chronic venous leg ulcer. However, a few authors have briefly described their own perceptions of what the individual with a venous leg ulcer

might experience (Fitzpatrick, 1989; Lamont, 1991; Rolstad, 1991). Fitzpatrick (1989), a dermatologist, noted that chronic venous insufficiency and the complication of a venous leg ulcer can have a devastating effect on the well-being of the elderly individual. He described not only the possible financial hardship associated with extended hospitalizations for treatment of a venous leg ulcer, but also suggested that it is the long-term impairment of ambulation that has the most profound effect on the person. In the enterostomal therapy arena, Rolstad (1991) provided a little more insight into the psychosocial aspects of the chronic venous leg ulcer experience when she advanced the idea that chronic wounds, in general, may affect an individual's body image and self-concept. On a more specific note, she asserted that some individuals who are managing chronic venous leg ulcers feel discouraged with the leakage and odour that is often associated with these wounds and can become disheartened when the ulcers fail to heal. Lamont (1991), another enterostomal therapist, also recognized that an individual's life can be dramatically affected by the presence of a venous leg ulcer but offered reasons for this that were not addressed by the previous two authors. More specifically, she noted that pain and discomfort associated with the ulceration are common problems which may affect an individual's quality of life and she commented that activities of daily living such as bathing may be difficult because of the presence of a dressing and compression stocking. Additionally, frequent visits by a health care provider can interfere with a normal lifestyle and the cost of wound care supplies can be an overwhelming burden. Finally, Lamont (1991) suggested that the venous leg ulcer experience may also involve the management of associated complications. In particular, she noted that chronic anemia, hypoproteinemia, and shortening of the Achilles tendon with the development of

an equinus deformity that further reduces mobility are all conditions that may impact on the individual's experience.

In addition to the writings of Fitzpatrick (1989), Lamont (1991), and Rolstad (1991), three brief anecdotal accounts have been presented in the medical literature by writers who discuss the leg ulcer experience in a more general way, not making the distinction between venous and arterial leg ulcers. Prebble (1990) noted that some individuals with leg ulcers may accept their condition more readily than others because they view their ulcers as being one aspect of the aging process or because the ulcers are seen as a way of ridding the body of "badness" (p.44). As well, Prebble (1990) suggested that an individual may become dependent on home care visits if the nurse is visiting frequently to manage the leg ulcer. In another anecdote, Merry (1989) contended that people with leg ulcers not only experience a loss of mobility but often the loss of a sense of independence and freedom as well. Callam and colleagues (1988) supported the idea that a loss of mobility is a significant aspect of the leg ulcer experience and also noted that work and leisure activities may be negatively affected by this condition.

When considering the literature that has been described above, one cannot help but be surprised by the "piecemeal" nature of the information that is available regarding the experience of living with a chronic venous leg ulcer. Each of the authors has commented on only a few select aspects of the experience and in most instances their opinions have not been substantiated because other writers have chosen to focus on different aspects of the venous leg ulcer experience. When reviewing the literature one does get the feeling that this experience might negatively affect an individual's quality of life and that impaired mobility may be particularly devastating but, for the most part,

the reader is left wondering how all the small pieces of the puzzle fit together and whether all the pieces are in fact parts of this puzzle.

There are issues, in addition to those mentioned above, that make the literature related to the experience of living with a chronic venous leg ulcer problematic. For example, none of the authors have discussed, in any way, the basis for their perceptions. The reader does not know whether an author had actually cared for or talked with an individual who had a chronic venous leg ulcer or whether the author's perceptions of the experience were derived from the speculations of other health care professionals. Thus it is very difficult for the reader to evaluate the tenability of the writer's conclusions regarding the chronic venous leg ulcer experience. As well, it is important to note that an individual's lived experience may in fact be significantly different from the health care professional's perception of the person's experience (Kleinman, 1978).

Another issue that makes the literature related to the experience of living with a venous leg ulcer problematic is that, with the exception of Fitzpatrick (1989), none of the authors identified the characteristics of the individuals they were discussing. More specifically, the reader does not know what age group a writer was commenting on and whether or not the individuals in question had venous leg ulcers which were short term or chronic in nature. The difficulty here is that the younger or middle aged person's experience with a venous leg ulcer may differ from the older adult's experience of the same condition. Similarly, the lived experience of an individual with an ulceration that is classified, by health care professionals, as chronic may differ from that of an individual with the same condition that is not considered to be chronic.

One final concern with regard to the literature reviewed in this section relates specifically to the writings of Callam and colleagues (1988), Merry (1989), and Prebble

(1990). As was mentioned previously, these writers discussed leg ulcers in a general way and did not make a distinction between experiences associated with venous and arterial leg ulcers. Discussing leg ulcers in a generic way is problematic for this researcher as she has found, in her own clinical practice, that clients with arterial leg ulcers have significantly more discomfort and impairment of mobility as compared to those clients with leg ulcers that are related primarily to venous insufficiency. Accordingly, one can argue that it is likely that there is a difference between the venous and arterial leg ulcer experiences and that writers who do not acknowledge that this is the case must be prepared to have the validity of their assertions brought into question.

In sum, the literature reveals that knowledge in relation to the older adult's subjective experience of living with a chronic venous leg ulcer does not exist. A few authors have hypothesized about selected aspects of the experience of living with a venous leg ulcer but their conclusions were not based on research and are problematic for a number of other reasons that have been addressed in this section.

### **Living With Other Types Of Wounds**

The finding that there is a dearth of knowledge related to the phenomenon under study is supported by Albert and Moody (1990) who noted that there is very little literature concerning the lived experience of an individual with a wound and any literature that is found usually relates to the experiences of individuals who are living with chronic wounds such as stomas or burns. A review of selected literature was undertaken in relation to an individual's experience of living with a stoma or burn as it was thought that knowledge in relation to what it is like to live with other chronic wounds such as these might provide insight into the experience of living with a chronic

venous leg ulcer. A summary of the literature that was reviewed is presented in the next two sections.

### **The Stoma Experience**

A variety of clinical conditions exist which necessitate the surgical formation of a stoma, an opening on the anterior surface of the body for the elimination of urine or stool (Klopp, 1990). As one might expect, the psychosocial impact of ostomy surgery and the formation of a stoma can be profound (Shipes, 1987). Indeed, Klopp (1990) reported that individuals with stomas often have poor psychosocial outcomes that range from failure to resume employment, withdrawal from social and intimate contact, to depression and anxiety. These outcomes and other psychosocial aspects of living with a stoma have been addressed in theoretical writings and research studies which are found in the nursing, medical, and social sciences literature.

Unquestionably, much of the comment and scientific inquiry that has been documented in the ostomy literature relates to body image changes that an individual with a stoma experiences (e.g., Cohen, 1991; Gloeckner, 1984; Klopp, 1990). The general findings from the research that Gloeckner (1984) conducted in partial fulfillment of her master's degree in nursing are consistent with many of the findings that are documented by other researchers who have investigated body image changes in relation to individuals with stomas (e.g., Orbach & Tallent, 1965; Sutherland, Orbach, Dyk, & Bard, 1952; Dlin & Perlman, 1971). Gloeckner (1984) investigated body image change by examining individuals' perceptions of their own sexual attractiveness following ostomy surgery. Home interviews were conducted with sixteen women and twenty-four men, where the mean length of time since ileostomy or colostomy surgery had been 4.6 years. Data were collected by means of an investigator-developed questionnaire that used a



Likert scale to rate feelings of sexual attractiveness. Results indicated that sixty percent of subjects felt less sexually attractive one year after ostomy surgery than they had felt one year prior to the surgery. Many subjects made additional negative comments about their body in that one year post surgery; they described feeling "ugly" and "disfigured." However, at the time of the interview 67.5% of subjects felt more sexually attractive than they had felt before surgery; this was possibly due to the fact that many of the subjects had chronic inflammatory bowel disease and had experienced the unpleasant symptoms of this disease prior to surgery. It is noteworthy that this particular finding was not supported by Klopp's (1990) finding that length of time since surgery did not contribute to statistically significant differences in either body image or self-concept. Another finding of Gloeckner's (1984) study was that there was a significant difference between subjects who had management problems (e.g., leakage) with their ostomy and those who had no problems or mild problems. Specifically, those subjects with marked management problems viewed themselves as less attractive than the other subjects. Thus, Gloeckner's (1984) findings, which are generally representative of other body image related findings in the ostomy literature, suggest that it is common for individuals with stomas to experience a body image disturbance. This disturbance in body image exists initially after the formation of a stoma but then, as time passes, many individuals appear to adjust to the change in their body's structure and function. Furthermore, individuals who continue to experience a body image disturbance are often found to have had difficulty with the management of their ostomy.

In an effort to gain a more comprehensive understanding of the stoma experience, Hurny and Holland (1985) conducted an extensive review of the ostomy literature and found that there are certain problems that are commonly experienced by

people with ostomies. They grouped these problems into three categories: physical, emotional, and interpersonal. The first category refers to practical problems related to learning to care for the stoma, irrigation, and managing minor crises such as appliance leakage and skin breakdown around the stoma. These practical difficulties often evoke emotional responses such as anxiety and fear. With regard to emotional problems, these authors found that individuals with stomas often have self-esteem problems associated with an altered body, experience depression and anxiety, and fear that they will be sexually undesirable. Finally, Hurny and Holland (1984) noted that, from an interpersonal perspective, individuals with stomas may experience alterations in sexual function and changes in relationships. As well, social isolation is a common problem which may be related to depression or to an individual's sense of stigma and low self-esteem.

As one considers writings related to the stoma experience, the question arises as to whether this literature offers insight into the chronic venous leg ulcer experience. It certainly seems possible that some of the issues raised in this body of literature might further one's understanding of the experience of individuals who are living with this particular circulatory disorder. For example, one can speculate that individuals with chronic venous ulcers might experience a body image disturbance and, hence, low self-esteem and anxiety or depression. One must acknowledge, however, that there are likely key differences between the ostomy population and the chronic venous leg ulcer population which could make the lived experiences associated with these two types of wounds considerably different. More specifically, individuals with ostomy wounds may have a variety of issues to deal with that would not typically be part of the chronic venous leg ulcer experience. For instance, the person with an ostomy has, in many

cases, been diagnosed with bowel cancer and, consequently, must cope with a potentially life-threatening disease. As well, this individual may be experiencing the effects of major abdominal/perineal surgery and is most likely trying to cope with the stigma that often accompanies an ostomy wound. The findings of this study are certain to shed some light on how similar the ostomy and chronic venous leg ulcer experiences actually are.

### **The Burn Experience**

Burns are considered to be another type of chronic wound as their healing time is often prolonged. In terms of the burn literature, it is surprising to see that many authors have commented on the paucity of research in relation to the psychosocial outcomes of burn injury (e.g., Browne et al., 1985; Ward et al., 1987; Watkins, Cook, May & Ehleben, 1988). Indeed, Browne et al. (1985) noted that the research emphasis has been on determining the pathophysiological sequelae of burn injury and the effectiveness of different treatment modalities rather than on the psychosocial aspects of the injury. Authors have theorized, however, that clinical postburn depression may be one of the most common psychological disturbances following burn injury (Ward et al., 1987). Ward and colleagues (1987) did study the prevalence of depression and variables correlated with this psychosocial outcome in 139 burn injured adults. They found that 9.4% of their subjects were mildly depressed, while 12.9% were moderately to severely depressed. Interestingly, they also found that depression was not significantly associated with the extent and severity of burn injury but, rather, was most strongly linked to a past history of emotional disturbance. The researchers concluded that it is the person, rather than the burn injury, that best predicts postburn depression. Similarly, Browne and colleagues (1985) found that severity of the burn and time since the burn were not related to psychosocial adjustment in a sample of 340 randomly selected burn injured

adults. In their study, they discovered that "maladjustment" among burned adults was related to variables such as avoidance coping behaviour, decreased participation in recreational activities, and a perceived loss of family, friend, and peer support. Brown et al. (1985) noted that their findings tended to refute the commonly held view that post-burn adjustment is associated with burn severity, and instead, do support the idea that psychosocial adjustment after burn injury is a function of both coping responses and social resources.

From a more theoretical perspective, authors such as Watkins et al. (1988) have focused their energies on describing the stages of adaptation that post burn individuals appear to move through as they emotionally heal from their traumatic experience. These authors believe that, for individuals with burns, a return to maximum independent functioning requires a gradual psychological adaptation to losses and changes resulting from the injury. The seven adaptive stages that Watkins et al. (1988) described are as follows: survival anxiety, the problem of pain, the search for meaning, investment in recuperation, acceptance of losses, investment in rehabilitation, and reintegration of identity. The authors have observed that some patients move through all of these stages of adaptation while others skip one or more, but there has never been any variation in the sequence of appearance of stages from that presented here.

As with the literature addressing the stoma experience, it is difficult to know how much insight the writings in relation to the burn experience can provide the reader who is seeking further understanding of what it is like to live with a chronic venous leg ulcer. It certainly seems possible that depression could be associated with the chronic leg ulcer experience. Further, it seems plausible that a person's successful adjustment to a chronic wound may depend more on that individual's coping behaviour and social

support system than on the nature of the wound (e.g., severity or duration of the wound). The question that remains unanswered at this point is whether the traumatic and sudden nature of the burn injury could render that experience significantly different from other chronic wound experiences, particularly in relation to the adaptation process.

### **Living With Chronic Illness**

As was mentioned, the researcher conducted a cursory review of some of the literature related to the experience of living with a chronic illness as it was thought that living with a chronic venous leg ulcer might be a chronic illness experience of sorts. The researcher experienced some indecisiveness around this issue as chronic venous leg ulcers are not normally discussed within a chronic illness context in the literature. As well, the chronic illnesses that are typically referred to in the literature—illnesses such as arthritis and hypertension—are those that most often do not have a foreseeable end in sight. Thus, the goal is very often not to cure the illness but, rather, to live the best life possible with the illness. In terms of living with chronic venous leg ulcers, then, some individuals have taken the view that their ulcers will probably never be cured and that they will simply follow a "maintenance" regime with regard to their care. Much more frequently, however, the scenario is one of leg ulcers being treated in an aggressive manner with the belief that they will eventually heal. Thus, one is left wondering whether this "cure" mindset precludes the experience from being one of chronic illness even though there is an underlying venous insufficiency that is likely chronic in nature. As with the burn and stoma experiences, it is probably not possible to make a decision about this issue until the findings of this study are examined.

With regard to the chronic illness literature, the researcher did narrow her review to select writings in relation to the impact of chronic illness on quality of life or

life satisfaction. One of the reasons for this was that it was beyond the scope of this study for the researcher to consider the voluminous amounts of literature related to every aspect of the chronic illness experience. As well, the researcher reflected on past experiences when she had cared for clients with chronic venous leg ulcers and determined that it was really the client's sense of well-being that was at issue in those situations.

Curiously, assessment of factors that influence the perception of quality of life in the chronically ill has received little attention from researchers until fairly recently (Burckhardt, 1985). As individuals in society have become increasingly concerned not only with the length of life but with the positive and satisfying aspects of life, nurse researchers have responded by conducting more research in relation to quality of life issues (Burckhardt, Woods, Schultz & Ziebarth, 1989). Further, researchers have sought to more fully understand the chronically ill clients' subjective feelings about the quality of the lives they lead while coping with chronic illness (Burckhardt, Woods, Schultz & Ziebarth, 1989).

Life satisfaction and quality of life were the topics of three studies that the researcher reviewed. In a study by Burckhardt (1985), ninety-four adults with various forms of arthritis were interviewed with the use of a semi-structured questionnaire. The purpose of the study was to describe and explain the impact of physical, psychological, and social factors on the perception of quality of life experienced by people with arthritis. Burckhardt (1985) found that the factors that directly contributed to a higher quality of life for these subjects were: positive self-esteem, internal control over health, perceived support, and low negative attitude toward the illness. Laborde and Powers (1985) also studied life satisfaction in osteoarthritis. They found that, although the subjects rated their usual pain as distressing, their degree of pain did not seem to impact

dramatically on their overall satisfaction with life. However, a positive relationship was found between life satisfaction and less joint pain. In addition, Laborde and Powers' (1985) findings supported Burckhardt's finding that life satisfaction was related to an internal locus of control and better health perception. Finally, Burckhardt and colleagues (1989) found that subjects with a variety of chronic conditions—diabetes mellitus, colitis, colon cancer, osteoarthritis, and rheumatoid arthritis—all used very similar terms to describe factors that were important to their quality of life. They reported that quality of life was enhanced by the following variables: independence, being physically active, ability to care for self, feeling healthy, having a sense of security, positive interaction and relationships with others, and feeling as though there was meaning in life. This final study provides one with a little more insight into the myriad of variables that likely contribute to life satisfaction.

### **Aging And Body image**

Currently, there is a great deal of confusion in the medical, nursing, and social sciences research literature with regard to the effects that the aging process has on one's body image (Janelli, 1986a). Specifically, there have been many dissenting opinions voiced with regards to body image changes that occur in the elderly, but the relationship between age and body image has not been clearly demonstrated in the research that has been done in the area (Janelli, 1986b). Janelli (1986a) contends that uncertainty about the relationship between aging and body image has arisen, in large part, because of the nature of the research methods that have been used to study body image in older adults. More precisely, human-figure drawings have been used in the majority of studies which examine the relationship between age and body image; older adults are asked to draw an image of themselves and then the image is analyzed by the researcher (Janelli, 1986a).

Janelli (1986a) argued that this method is very subjective and its reliability could be jeopardized if extraneous variables such as drawing skill and cognitive impairment come into play. She also noted that difficulties have arisen because researchers use the terms "self-concept," "self-esteem," "body schema," "body precept," "body concept," and "self-image" interchangeably with the term "body image" and the meanings of all of these terms are not the same (Janelli, 1986b).

From a more theoretical perspective, Esberger (1978) noted that older adults often experience various age-related physical changes as multiple losses and they grieve these losses as an integral part of the adjustment process. A chronic illness, or other health problem, may represent losses that further intensify the older adult's existing loss experience and, consequently, their grief. Interestingly there are authors who argue that older adults can overcome the despair that can be associated with aging, chronic illness, and disability if they are able to move forward in the developmental process toward expanded self-boundaries (Haase, Britt, Coward, Leidy & Penn, 1992; Reed, 1991a; Reed, 1991b). In other words, it is suggested that these older adults can transcend their chronic illnesses and natural physical decline and experience a sense of well-being if they can reach out beyond self-concern (Haase et al., 1992; Reed, 1991a; Reed, 1991b). When reaching beyond themselves, older adults lose their self-preoccupation and become cognizant of infinite possibilities or sources of purpose (Haase et al., 1992; Reed, 1991a; Reed, 1991b).

### Summary

This chapter reviewed literature that was selected for the purpose of providing insight into the chronic venous leg ulcer experience. The review revealed that there is a paucity of both theoretical and empirical information related to the experience of living



with venous leg ulcers. Further, the literature that is available is anecdotal in nature and does not offer a comprehensive view of what the venous leg ulcer experience might be like. Literature in relation to living with other types of wounds may or may not be applicable to the phenomenon under investigation. If it is applicable to some degree, the participants in this study might describe such things as alterations in body image or feelings of depression or anxiety. It would mean, as well, that the severity and duration of the participants' leg ulcers may not be a determining factor in how they respond to their ulcers. It is not known whether the chronic illness literature will be applicable to the chronic venous leg ulcer experience, but the researcher has gleaned insights into some of the factors that may determine whether the participants in this study feel as though they have quality in their lives. Finally, the literature in relation to aging and its effect on body image paints a rather confusing picture. It suggests that participants may grieve in relation to the leg ulcer which will represent another loss or, on the other hand, they may be able to transcend the health problem.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **Introduction**

Phenomenology was the research method selected for this study as this approach best facilitates the exploration and description of the human experience of living with a chronic venous leg ulcer from the perspective of the community-dwelling older adult. Further discussion of the phenomenological method, as it was applied in this study, is presented in this chapter in relation to the following areas: participant selection, data collection, and data analysis. In addition, the researcher provides a brief description of the strategies that were used to promote adequacy or rigor of the research. Finally, this chapter concludes with a discussion of the ways in which the researcher endeavoured to protect the rights of the study's participants.

#### **Selection And Recruitment Of Participants**

The purposive method of nonprobability sampling was used to select the participants for this study. In this sampling design all participants are deliberately selected according to the theoretical needs and direction of the research (Morse, 1986). More specifically, the phenomenological research method requires that the study's participants share information which will facilitate the researcher's understanding of the older adult's experience of living with a chronic venous leg ulcer. To this end, individuals were purposefully selected based on their ability and desire to provide information that contributed to understanding and insight in relation to the phenomenon under investigation. The following is a description of the criteria used for selection of

participants and rationale for this criteria, the procedure for recruitment of participants, and characteristics of the individuals who became participants in this study.

### **Selection Criteria**

The following criteria for selection of participants were developed in order that a sample of individuals be recruited who could best describe the experience of living with a chronic venous leg ulcer from the perspective of the community-dwelling older adult.

Each participant was to be:

1. sixty-five years of age or older;
2. residing in a house or apartment in the area being served by the Burnaby Health Department;
3. diagnosed as having a chronic venous leg ulcer by a Burnaby Health Department home care nurse or a physician;
4. visited by a Burnaby Health Department home care nurse at least once per week for treatment of a chronic venous leg ulcer and has been visited for at least two months;
5. free of coexisting physiological and/or psychological conditions that would significantly alter the individual's perception of the experience of living with a chronic venous leg ulcer;
6. able to understand and speak English and is able to communicate experiences.

The rationale for selecting participants who were sixty-five years of age or older was twofold. First, venous insufficiency and the complication of a chronic venous leg ulcer are conditions which primarily affect the older adult. Second, participants were limited to one developmental stage (older adulthood) because the experience of an illness

or disability may be influenced by stresses or demands specific to a particular stage of the life cycle (Falvo, 1991). Hence, a young adult's experience with illness may differ significantly from the older adult's experience with the same illness because of differing stages of development.

In addition to an age criterion, it was specified that each participant reside in the area being served by the Burnaby Health Department as this agency had consented to participate in the study. All participants were required to reside in an apartment or a house because the focus of this study was the experience of chronic venous leg ulceration from the perspective of the community-dwelling older individual. Facility-dwelling older adults experiencing chronic venous ulceration were not included in this study because it was the researcher's belief that factors such as serious coexisting physiological and/or psychiatric conditions which are usually present in this population and an institutional milieu might significantly influence the leg ulcer experience. Because community-dwelling individuals with chronic venous leg ulcers may also live with significant illnesses that would affect the leg ulcer experience, it was stipulated in this study that a community-dwelling participant must not be experiencing a coexisting physiological and/or psychiatric condition that would significantly alter his/her perception of the experience of living with a chronic venous leg ulcer (e.g., delusional thinking, paraplegia, chronic respiratory difficulty that the individual is continually aware of and trying to manage). All participants were required to understand and speak English so that they could comprehend the researcher's statements and express thoughts and feelings that would be understood by the unilingual English speaking researcher. In addition, it was specified that participants be able to describe what it is like to live with a chronic venous leg ulcer in order that the researcher be able to gain insight into the experience.

The decision that a venous leg ulcer would be considered chronic if it had been treated by a home care nurse for at least two months was essentially an arbitrary one. Literature in relation to chronic venous leg ulcers did not provide any direction in relation to length of time a venous ulcer needed to be present before it was considered chronic in nature. What is known is that the inflammatory and proliferative phases of wound healing (wound has closed but scar tissue is not necessarily mature at this time) are usually complete after approximately three to four weeks (Ignatavicius & Bayne, 1991). Thus, a leg ulcer of at least eight weeks duration may be considered longstanding or chronic. It was also believed by the researcher that it may take this length of time for an individual with a venous leg ulcer to experience chronicity or persistence of the condition. To ensure that participants were in fact experiencing venous ulceration, it was stipulated that a diagnosis of this condition be made by a health care professional (home care nurse or physician) and that the diagnosis be based on clinical presentation and client history data that would indicate that the leg ulcer was related primarily to venous insufficiency. Finally, it was specified that a participant be an individual who had been visited by a home care nurse at least once per week for treatment of a chronic venous leg ulcer. This criterion was developed to ensure that there were relatively similar experiences in relation to frequency of nursing visits.

### **Recruitment Procedure**

The participants in this study were recruited by way of a specific procedure. First, the researcher provided the Administrator of Home Care Nursing for the Burnaby Health Department with a copy of the research proposal which included a description of the selection criteria and recruitment procedure. After discussing the proposal with the researcher, the Administrator communicated the nature of the study, participant

selection criteria, and the recruitment procedure to the home care coordinators who in turn conveyed this information to the home care nurses. In addition, an information letter (see Appendix B) was distributed to the nurses.

Over the course of two to three weeks, home care nurses determined which of their clients met the selection criteria. If a client was eligible for the study, the nurse explained the purpose of the study and asked the individual for permission to be contacted by the researcher. Once an individual agreed to be contacted, the home care nurse referred his/her name to a home care coordinator who in turn submitted the name and telephone number of the potential participant to the researcher. Following this, the researcher contacted the potential participant by telephone and provided further explanation of the study. If the individual was interested in participating in the study an appointment was made for the first home visit. Of the first six potential participants who were contacted by the researcher, two declined to participate in the study. One man's daughter answered the telephone and told the researcher that her father's physical condition had deteriorated recently and he was not feeling well enough to be interviewed. Another potential participant became angry when the researcher called, stating that her physician told her that she did not have to see any more people in regard to her leg ulcer. This incident was shared with a home care coordinator who reported that the client did have a history of paranoia and, therefore, should not have been recommended for this study.

At this point in the recruitment process the researcher determined that, in all probability, the purpose of this study could not be achieved with a sample size of four individuals. Rather, it was thought that at least six to ten participants would need to be interviewed for theoretical saturation to be attained and for the researcher to have a

comprehensive and accurate understanding of the chronic venous leg ulcer experience. For these reasons, the researcher procured the participation of two individuals who had originally been excluded from the study as they were not being visited weekly by a home care nurse at the time that recruitment of potential participants was taking place. One of these individuals was a gentleman who was well known to home care because of a long history of recurrent venous ulceration. Regular nursing visits for treatment of this man's leg ulcers had ended a few weeks prior to the commencement of this study as his ulcers had healed. He was, however, being monitored on a regular basis over the telephone as he was considered to be at high risk for recurrent ulceration. The other individual, who became the sixth participant in the study, was an elderly woman with chronic venous leg ulcers whose home care visits had ended three months earlier when it was decided that she would be treated on a regular basis at the Vancouver General Hospital's Wound Healing Clinic. During the second interview this participant did inform the researcher that home care nursing visits would most likely resume as she had been advised that she would soon be discharged from the Wound Healing Clinic. It is important to note that the aforementioned individuals were asked to participate in this study because it was thought that they would be able to share valuable information about the chronic venous leg ulcer experience even though they did not meet all of the original selection criteria. The recruitment procedure varied slightly in this instance in that when it was decided that these two individuals would be asked to participate in the study, each was initially contacted by a home care coordinator rather than by a home care nurse.

In terms of recruitment procedure, it should also be noted that at the outset of the first home visit and prior to the initial interview, the researcher provided those individuals who were interested in participating in the study with an Introductory Letter

(see Appendix C) and answered any questions that they had about the study. The researcher also formalized an individual's agreement to participate in the study by obtaining written consent (see Appendix D) before the interviewing began.

### **Characteristics Of The Participants**

This description of the general characteristics of the study's participants was derived from data that were collected from the participants themselves, the researcher's observations of the participants and their environments, and the Burnaby Health Department's clinical records. As was mentioned previously, six individuals consented to participate in this study. These individuals, one man and five women, were all Caucasian and ranged in age from seventy-four to ninety-two years, with a mean age of seventy-nine years. All of the participants were widowed and five of them lived alone in either a self-owned apartment or house, or a government subsidized senior citizen's housing project. The sixth participant lived on the main floor of a self-owned house and rented the top floor to a friend who routinely assisted him with care of his legs (e.g., application of lotion and elastic support stockings). Five of the six participants received home support services, the nature of which depended on their individual needs. Of particular note is the fact that three of these five participants attributed their need for home support to the loss of mobility they were experiencing as a result of their chronic venous leg ulcers. With regard to nursing visits for treatment of their ulcers, all of the participants had been or were being seen by a home care nurse at least once per week. In fact, at the time of this study four of the six participants were receiving home nursing care two to seven times per week.

All of the study's participants had been diagnosed by a health care professional as having leg ulcers that were related primarily to venous insufficiency. In addition,



clinical records indicated that three of the participants were also experiencing some chronic arterial insufficiency. The foregoing finding suggests that it is probably not uncommon for both venous and arterial insufficiency to coexist in an individual, but that one of these conditions is likely predominant. With regard to the actual ulcers, four of the six participants in this study had multiple venous leg ulcers, of varying sizes, which were situated on both legs. Differing from the majority of participants, was one woman who had a single large venous ulcer on her right leg and one man who had experienced recurring venous ulcers only on his left leg.

Interestingly enough, a few of the participants had some difficulty recalling how long it had been since they had developed their first venous leg ulcer. One man remarked that it had been "more than five years" and that the "nurses would know" when his leg ulcers began. Another woman replied "too long" when asked how long she had been dealing with leg ulcers. Other participants related their first leg ulcer experience to a particular event in their lives and were able to recollect the number of years of venous ulceration by recalling how long ago the associated event had occurred. For example, one participant stated that "they [venous leg ulcers] broke out after my first son was born forty-six years ago." Another participant explained that a few years ago she developed a "mess" after "squashing" her leg in a storm door. As far as the researcher could determine, the participants in this study had been coping with venous leg ulcers for anywhere from two to fifty years. In addition, all of the participants described a situation in which there was an ongoing cycle of healing followed by recurrence of the leg ulcers. As one woman noted, "It [venous leg ulcer] would heal up and then it would go away for two days and then it would come back ... it wouldn't stay healed." Another participant remarked that some of her healed leg ulcers were "all

ready to break out again" and that the situation was like a "tea kettle that's not quite on the boil." One woman differed somewhat from the others in that two of her venous ulcers had never healed.

During their many years of chronic venous ulceration, four of the study's participants had undergone a myriad of topical treatments aimed at healing their leg ulcers. Hydrocolloid dressings, antimicrobial ointments, saline compresses, gel dressings, and a zinc paste bandage were some of the topical treatments that had been prescribed for these individuals. It was not surprising that each of these four participants had lost track of the number of different topical treatments that had been prescribed over the years. One woman even commented that she felt like a "guinea pig" as a result of having endured so many different topical therapies. Two of the study's participants were not included as part of the aforementioned group as they indicated that they had not paid close attention to how their leg ulcers were being managed and thus could not comment at all on the number and types of topical treatments that had been prescribed over the years. Clinical records for these two individuals were useful in the sense that they offered information about the most recent topical treatment that each had received (saline compresses), but they did not provide data in relation to the number and types of previous topical treatments.

In addition to having their venous leg ulcers cleansed and dressed on a regular basis by home care nurses, five of the study's participants had been hospitalized on at least one occasion for more aggressive treatment of their ulcers. Three of the participants commented that their physicians had hospitalized them and prescribed bedrest and elevation of their affected legs for the purpose of enhancing their venous circulation and decreasing peripheral edema. Several participants had undergone at

least two skin grafting procedures that have proven unsuccessful. Interestingly, only two of the study's six participants had a history of vein ligation surgery, a surgical intervention that is often performed when chronic venous insufficiency cannot be controlled with more conservative medical therapy.

All of the participants were surprisingly knowledgeable with regard to interventions that promote peripheral venous return. For example, they described the importance of elastic support stockings, regular exercise, and periodic rest periods with elevation of the extremities. The majority of participants were also aware of measures that can be taken to preserve intact skin on the legs, namely the application of lotion to dry skin and the avoidance of trauma to the limbs. Having said this, it was curious to find that a majority of the participants seemed to lack a basic and, in some cases, accurate understanding of the etiology of chronic venous leg ulceration. For instance, one man reported that he has recurring venous leg ulcers because "the skin is so weak it tightens up and then splits." Another woman commented that her ulcers started after she broke her ankle and then stated that she must have a "hereditary" condition as her mother "had bad legs way back." Two participants attributed their venous leg ulcers to the effects of pregnancy but were unable to be more specific with regard to the relationship between pregnancy and venous ulceration. Finally, one woman explained that when she was eighteen years old she sustained a "terrible sunburn" to her legs which probably damaged her "blood veins" and as she ages these veins "break down" and venous leg ulcers develop.

### **Data Collection**

Omery (1983) noted that the phenomenological method is an inductive, descriptive research method which provides valuable direction to the researcher who is

exploring the meaning and perceived structure of any event or experience that affects human beings. Essentially, the data collection process that is associated with this method requires that the researcher enter into a participant's "world" or field of perception in order that human experience be understood from the participant's perspective (Bruyn, 1966; Knaack, 1984). The research data, from which the essential structure of an experience is derived are, for the most part, events that are shared by a participant and the subjective meanings that these events have for that individual (Omery, 1983). As well, the researcher's field notes contribute to the data base with respect to observations that the researcher has made in relation to a participant's environment and behavior (Field & Morse, 1985).

In this study, the researcher endeavoured to collect data in a manner that was consistent with phenomenological philosophy and method. This commitment on the researcher's part to be as true as possible to the phenomenological approach had significant implications for the way in which the researcher viewed the participants and the manner in which she related to them during the data collection process. To begin, it should be noted that the researcher viewed the study's participants as partners or co-researchers in this endeavour. The researcher found that this mindset was essential for the development of trusting relationships with participants as it appeared that they felt more comfortable sharing thoughts and feelings in an atmosphere that fostered cooperative dialogue and mutual learning. Indeed, it was only within the context of a genuine and mutual "I-thou" relationship that the researcher could truly be "with" a participant and begin to understand that participant's world. This approach differs significantly from the one advanced by the traditional quantitative method whereby the experimenter is in a position of power and manipulates or controls the subject (Knaack,

1984). In this scenario, the experimenter has an "I-it" association with the subject who is at arms length and is objectively observed, examined, and tested (Livingston, 1971).

In order that the phenomenological researcher more fully understand the meaning that experiences have for participants, s/he must also engage in a process known as "bracketing" (Davis, 1978; Knaack, 1984; Omery, 1983; Pallikkathayil & Morgan, 1991). More specifically, bracketing involves the setting aside of one's own assumptions in order that the phenomena under investigation be met on their own terms and not be forced into a mold of preconceptions (Knaack, 1984). From a slightly different perspective, Peck (1978) noted that bracketing involves the act of "temporarily giving up one's self--putting one's self aside, so to speak--so as to make room for the incorporation of new material into the self" (p.73). In this study, the researcher made every effort to really hear what the participants were saying by consciously approaching each individual with as open a mind as possible and centering her consciousness toward understanding the lived experiences as they were described by the participants. In addition, the researcher continually endeavoured to suspend any *a priori* preconceptions or presuppositions as data were being analyzed and a description of the structure of the phenomenon under study was being developed. Field notes were found to be a valuable aid in the bracketing process as they helped the researcher keep track of the thoughts and feelings she was experiencing in response to the participants' stories.

Each of the six participants in this study were interviewed on two separate occasions. A decision was made to conduct these interviews in the participants' own homes for a number of reasons. First, the researcher speculated that the participants would feel more comfortable and secure in an environment that they were familiar with and because of this would be more at ease when discussing personal experiences. Based

on previous encounters with older adults who were living with chronic venous leg ulcers, the researcher also anticipated that some of the participants might be experiencing difficulties with ambulation and would, therefore, be reluctant to leave their homes for the purpose of an interview. Finally, it was thought that a home visit would provide the researcher with some insight into the nature of the participants' environments and how they functioned in these environments.

The audiotaped in-depth interviews ranged in length from twenty minutes to one and one-half hours and were, for the most part, unstructured so that participants were given the opportunity to discuss issues that were important to them. The researcher did have a set of general open-ended trigger questions available (see Appendix E) and, typically, began the initial interview with a trigger question which, in most cases, elicited a lengthy description of the chronic venous leg ulcer experience. With the exception of one interview, open-ended questions were used throughout the interviews to encourage thorough and rich descriptions of the phenomenon under study. As well, the researcher asked clarifying questions whenever she had any difficulty understanding what was being said or if more specific explanations were necessary in order that she could fully grasp the issues that were being discussed.

In the initial interview with one of the study's ninety-two year old participants, the researcher did fail to facilitate a thorough and rich description of the chronic venous leg ulcer experience. This was due in large part to the fact that the researcher did not respond in an effective manner to the participant's severe hearing impairment. When it became evident that the participant was having great difficulty hearing what was being said to him, the researcher became uncomfortable with the situation and began to use multiple, closed questions in a probing way and did not allow the gentleman much time

to think about or to respond to these questions. The following excerpt from the verbatim transcript of the initial interview with this participant illustrates the difficulty that the researcher was having interviewing this individual:

**R:** So you exercise then everyday?<sup>1</sup>

**P:** That's right.<sup>2</sup>

**R:** So you couldn't go swimming? And did that bother you at that time?

**P:** It sure did.

**R:** So you wanted to go swimming very badly but you couldn't?

**P:** That's right.

**R:** So you went walking but you didn't seem to enjoy that as much as your swimming.

**P:** Oh no.

Fortunately, the second interview with this gentleman was more in keeping with the kind of researcher-participant discussion that is characteristic of qualitative research. Indeed, a much more in-depth description of the chronic venous leg ulcer experience was elicited from this participant when the researcher made every effort to speak loudly and clearly and when she asked open-ended general questions and allowed ample time for responses.

With regard to the data collection process, it should also be noted that second interviews were conducted approximately four weeks after the initial interviews. In a second interview the researcher did take the opportunity to validate findings and clarify information from the first interview to ensure that the data and the researcher's

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<sup>1</sup>"R" is used to identify the researcher in the body of this chapter.

<sup>2</sup>"P" is used to identify the participant in the body of this chapter.

interpretations of the data were accurate. As well, the researcher asked questions related to the themes that were emerging as the data were being analyzed.

Field notes were made following all home visits. In these notes the researcher documented observations related to each participant's physical appearance, mental status (affect, cognition, and mood), home environment, and ability to function in their environment. Additionally, verbal information was documented that had not been audiotaped (e.g., comments that a participant would make before the interview began or as the researcher was leaving the participant's home) as were the researcher's thoughts and feelings in relation to her experience with the participant. These field notes became part of the data base and helped facilitate interpretation of the data.

### **Data Analysis**

In keeping with the phenomenological method, the process of data analysis occurred simultaneously with data collection. Hence, data analysis began after the first interview with the first participant. Following the transcription of an interview by a typist, the researcher replayed the audiotape and compared it to the transcript. Transcription errors were corrected to ensure that the account was verbatim. In addition, the researcher made notes on the transcript with regard to changes in the participant's voice or tone and significant pauses or inflections which may have indicated that an issue was very meaningful or emotionally charged (Field & Morse, 1985).

Following the initial steps that have been described above, the data from the transcripts were analyzed with direction from the constant comparative method of data analysis (Hutchinson, 1986) and Georgi's (1975) interpretation of the phenomenological method. More specifically, a transcript was read through in its entirety so that the researcher could gain a sense of the whole experience for that participant. Subsequent to



this, the transcript was read again in a purposeful manner and significant statements or phrases were extracted, reflected upon, and assigned meaning based on the researcher's creative insight, which remained faithful to the original data. Redundancies among meaning units were eliminated, the units were elaborated upon or clarified as necessary, and then these units were clustered into more abstract themes. Following this, the researcher moved from one transcript to another for the purpose of identifying common themes and variations within these themes. At the same time, common themes and variations that were emerging were validated and clarified with the study's participants. Finally, common themes, with identified differences serving as their boundaries, were then "fleshed out" and synthesized into a description of the chronic venous leg ulcer experience that was representative of all the participants' experiences with this phenomenon. This description of the essential structure of the chronic venous leg ulcer experience is presented in Chapter Four.

### **Scientific Adequacy Of The Research**

Every qualitative research study must address issues related to the rigor or scientific adequacy of the inquiry. Adequacy of the qualitative inquiry indicates that the research processes and outcomes are well grounded, cogent, justifiable, relevant, and meaningful (Hall & Stevens, 1991). More specifically, the standard of adequacy is achieved when it is determined that the processes of the study were appropriate to the problem being explored and when the researcher's description of what reality is for the study's participants corresponds to the reality that they actually perceive and experience (Hall & Stevens, 1991). In an attempt to deal with the standard of adequacy in a fairly specific way, Sandelowski (1986) proposes that Guba and Lincoln's (1981) criteria of credibility, fittingness, auditability, and confirmability be used to judge the rigor of a

qualitative research study. The following is a discussion of the ways in which the researcher endeavoured to achieve credibility, fittingness, and auditability in relation to the study at hand. Confirmability, the fourth criterion that Sandelowski (1986) addresses, relates to neutrality or freedom from bias in the research process and product. This criterion is achieved when credibility, fittingness, and auditability are established (Sandelowski, 1986). It is important to note that conclusions regarding the scientific adequacy of this inquiry are not possible until participants have had an opportunity to comment on the study's findings and colleagues provide feedback in relation to the research findings and this scholarly report.

### **Credibility And Fittingness**

Credibility and fittingness are criteria related to the truth value and applicability of qualitative findings (Beck, 1993; Sandelowski, 1986). Credibility is achieved when the researcher presents a description of the phenomenon that is being studied and the study's participants immediately recognize this description as being faithful to their own lived experience (Beck, 1993; Sandelowski, 1986). As well, other researchers and nurses see "truth" in the analytic interpretations that are presented and find them to be meaningful (Sandelowski, 1986). Fittingness is achieved when readers of the research conclude that the researcher's analytic interpretations are applicable to contexts outside of the study situation (Beck, 1993; Sandelowski, 1986). The following strategies were used to establish credibility and fittingness in this study: (i) ensuring that selection criteria were adhered to as much as possible so that the data are as representative as possible of the older adult's experience of living with a chronic venous leg ulcer; (ii) conducting a second interview with each participant in order that patterns emerge and the researcher is prevented from "emphasizing a nonrecurring, idiosyncratic episode, statement, or

behavior" (Benner, 1985, p.11), and for the purpose of validating the researcher's interpretations of the data with the participants; (iii) documenting personal feelings and reflections throughout the research process in an effort to remain self-aware and to prevent bias when interpreting the study's findings; (iv) presenting data, from the transcripts, that support the analytic interpretations in an effort to demonstrate that the researcher has been "true" to the text and has "not read in meanings that are not supported by textual evidence" (Benner, 1985, p.11); and (v) acquiring validation from thesis committee members and clinical nursing experts that interpretations of the data are supported by the text (Sandelowski, 1986).

### **Auditability**

Auditability is the criterion related to the consistency of qualitative findings (Sandelowski, 1986). A study and its findings are auditable when another researcher or reader can clearly follow the thinking, decisions, and methods used by the original researcher and conclude that they are appropriate and logical (Sandelowski, 1986). Moreover, auditability is demonstrated when another researcher is able to arrive at similar or comparable, but not contradictory conclusions, given the researcher's data and methodological perspective (Sandelowski, 1986). In this study, auditability is established primarily through a written research report which clearly describes and justifies decisions made by the researcher throughout the research process. As well, the report presents analytic interpretations which are well founded in and consistent with the data.

### **Ethical Considerations**

The following is a description of the ways in which the researcher endeavoured to protect and promote each participant's right to respect, dignity, information, autonomy, and privacy.

Prior to data collection, written approval for the study was obtained from the Burnaby Health Department and the University of British Columbia's Behavioral Sciences Screening Committee for Research and Other Studies Involving Human Subjects. Ethical standards that were approved by the Burnaby Health Department and the U.B.C. Screening Committee were adhered to throughout this study.

To ensure that potential participants had the opportunity to make an informed decision regarding their involvement in the research, each was asked to read an Introductory Letter (see Appendix C) before agreeing to participate in this study. The letter provided information about the purpose of the study, the nature of participant involvement, and participant rights. Interestingly, none of the potential participants read the Introductory Letter. One woman told the researcher that she had misplaced her glasses and consequently could not read the letter. All of the other individuals glanced at the letter for a moment and stated that it appeared to be "OK", hence they would not need to read it in any detail. It is not known whether this latter group of elderly individuals had visual impairments which made it difficult for them to read the relatively small black print which was presented on a white background. To ensure that consent would be informed, the researcher read the Introductory Letter to each of the individuals and answered any questions that they had. In order to further promote each participant's right to information, all individuals who participated in this study were verbally advised that they were welcome to study results after the research had been completed and the thesis written.

In an effort to protect each participant's right to autonomy, the researcher ensured that these individuals understood that involvement in the study was strictly voluntary and that non-participation would in no way affect current health care or

health care that may be required in the future. This information was documented in both the Introductory Letter and the Participant Consent Form (see Appendix D), each of which was read aloud to the participants. The foregoing documents also clearly outlined that, if an individual agreed to participate in the study, s/he could refuse to answer any questions asked, request to have information removed from the audiotapes, or withdraw from the study at any time without jeopardizing current or future health care. Finally, the researcher required that each participant provide written consent (see Appendix D) to participate in the study prior to the initial interview.

In this study the researcher also endeavoured to protect each participant's right to privacy in a number of ways. First, all of the audiotapes and transcripts were coded and only the researcher knew the identity of the participants. Second, access to the audiotapes and transcripts was limited to the researcher, thesis committee members, and a typist. Third, participants were informed that audiotapes and transcripts were to be destroyed when all scholarly reports had been written.

Finally, it is important to note that the researcher made a moral commitment to, at all times, act in a manner which was considered to be in the best interests of each of the participants. For example, the researcher felt herself obligated to notify a home care coordinator if information obtained from a participant was considered to have significant health-related implications or was viewed as life-threatening. In addition, the researcher was prepared to listen and to respond therapeutically to a participant if discussion in relation to the participant's leg ulcer experience elicited feelings such as sadness or hopelessness.

### **Summary**

Phenomenology was the research method selected for this study as this method, unlike more empirical approaches, helps the researcher to more fully understand the nature of the chronic venous leg ulcer experience from the perspective of the community-dwelling older adult. Consistent with the phenomenological approach, the purposive method of nonprobability sampling was used to select six elderly individuals who were able to describe the experience of living with a chronic venous leg ulcer from their perspectives. Audiotaped interviews, which were transcribed by a typist, were conducted over a six week period in the participants' homes. The data from verbatim transcripts were analyzed with direction from the constant comparative method of data analysis and Georgi's (1975) interpretation of the phenomenological method. The result of the data analysis process was a description of the essential structure of the chronic venous leg ulcer experience which is presented in the next chapter.

## **CHAPTER FOUR**

### **FINDINGS AND INTERPRETATION**

#### **Introduction**

In this chapter, the findings of the research are presented in the form of an interpretive description of the older adult's lived experience with a chronic venous leg ulcer. This description evolved as the researcher utilized the phenomenological method of data analysis to interpret the participants' explanations of their experiences. Hence, the description of the chronic venous leg ulcer experience that is presented in this chapter represents the collective experience of the study's participants as the researcher understood it. Essentially, the participants in this study described three distinct facets of the chronic venous leg ulcer experience, which together represent the essential structure of the experience. These three facets are presented as three sequential phases of a "living with a chronic venous leg ulcer continuum," as the participants in this study depicted the chronic venous leg ulcer experience as a linear passage, of sorts, with a beginning, middle, and an end.

In the first phase of the continuum, participants experienced the effects of living with this particular circulatory disorder. They encountered losses in relation to physical endurance, gratifying activities, companionship, and predictability in their lives. In addition, the participants experienced a gain as a result of having the leg ulcer, that being the emotional support afforded them by certain health care workers. In the second phase of the continuum, participants evaluated how significantly their chronic venous leg ulcer had made an impact on their lives. More specifically, they made a

judgment with regard to the overall effect that the losses, which were associated with the circulatory disorder, had had on their lives. In so doing, the participants determined that their chronic venous leg ulcer had been either detrimental or inconsequential with regard to their quality of life. Then, in the third and final phase of the continuum, the participants coped with their circulatory disorder in one of two distinct ways. Each participant either "put their life on hold" if they had appraised their leg ulcer as being detrimental to them, or they "got on with life" if they had appraised their leg ulcer as being inconsequential.

As one final point, it is important to note that, in addition to validating findings with the study's participants, the researcher did consult with two expert home care nurses with regard to her interpretation of the chronic venous leg ulcer experience. This was deemed an essential step in the interpretive process when the data suggested that two of the study's participants, although very similar amongst themselves, differed significantly from the other four participants in the study with regard to certain aspects of the venous leg ulcer experience. The expert nurses were of the opinion that this finding was not an anomaly because, in their own clinical practice, they had frequently encountered clients with chronic venous leg ulcers who seemed to fall into one of the two camps described here; they would either "survive" and "carry on" or become "victimized" by their leg ulcer experience.

#### **Experiencing The Effects Of The Chronic Venous Leg Ulcer**

Each of the participants in this study explained that their chronic venous leg ulcer had affected their life in a variety of ways. Some participants commented that they had initially been surprised by the many ways in which one's life could be impacted by this circulatory disorder as they had heard very little about the disorder before they began to



experience the effects of it. As one woman commented, "I never heard of [chronic venous leg ulcers]. I asked around about it [and] nobody had heard of it either." When talking more specifically about the ways in which their lives had been affected by their chronic venous leg ulcers, participants recounted the numerous losses that they had encountered and, in addition, described a positive side to living with this circulatory disorder.

### **Encountering Loss**

When asked about what it is like to live with a chronic venous leg ulcer, participants discussed ways in which their lives had been negatively altered or changed as a result of chronic venous insufficiency and the complication of a venous leg ulcer. Although each participant's story was unique, common themes emerged with regard to the unwanted changes that had occurred in these individuals' lives. More specifically, they talked about a decline in physical ability, having to relinquish valued activities, feeling isolated at times, and having to now live with a medical condition that is so unpredictable. In essence, the participants were describing losses that they had encountered as a result of their circulatory disorder. The following is a discussion of the study's findings in relation to the four types of loss that were described by the participants: loss of physical endurance, loss of gratifying activity, loss of companionship, and loss of predictability.

### **Loss Of Physical Endurance**

Most of the participants in this study reported that their chronic venous insufficiency and venous leg ulcers had contributed in a significant way to their inability to stand for long periods of time or to ambulate for more than short distances without resting. They identified leg discomfort, described as either a "pain" or an "ache" in the

leg, and muscle fatigue as the primary factors that limited their physical endurance or stamina. In terms of muscle fatigue, which was most often talked about in relation to the leg muscles, several participants commented that they were "tuckered out" or "drained" after walking short distances in their homes. One woman effectively communicated the impact that pain has had on her physical endurance when she related what she had told the doctor when he asked her about her ability to get around in her home:

I said I get up [and] walk across the floor and the pain is terrible. You can't get from [the bedroom] out to the kitchen. Oh, I sat down and said, "Oh my God. Put your feet up. Take that weight off your leg." And then [I'm] not satisfied yet.

Another participant commented that because of her "tired and painful legs" she was only able to walk to a nearby mailbox before she had to sit down. For this same reason, she also had difficulty walking to her car in the underground parking lot of her apartment building.

Several participants used mobility aids such as canes or walkers to help them walk greater distances. They found that their leg discomfort and muscle fatigue were alleviated, to some degree, when they were able to shift some of their weight onto the supportive device when walking. One woman, who normally used a cane or walker when ambulating in her home, also found that because of her limited physical endurance the use of a wheelchair was necessary when she left her residence.

### **Loss Of Gratifying Activity**

Each of the participants spent a considerable amount of time talking about activities they could no longer participate in as a result of their circulatory disorder. Discussions centered around relinquished activities that participants wished they could once again engage in as they had been the source of a great deal of pleasure and sense of

accomplishment in the past; they were activities that had been gratifying and contributed to a sense of well-being. Participants talked most frequently about not being able to walk longer distances, shop in malls, travel, attend social functions, donate time as a volunteer, and partake in some of their favorite recreational activities. A few individuals also said that they missed not being able to perform certain basic activities of daily living such as cooking and cleaning.

A lack of physical endurance was the reason given most often for a participant's inability to engage in an activity that had once been gratifying. One woman explained that she couldn't "walk that well" and because of this "you're tied down, certainly. You can't do certain things. I'd love to be able to go out and shop in the stores and all and I can't do that." Similarly, another participant expressed a strong desire to be able to stroll through a shopping mall. She had not been able to do this for many years as her lack of physical endurance had forced her to limit her shopping excursions to one store that had handicapped parking nearby:

Like I've never been in Metrotown [shopping mall]. Just like into Woodward's cause you just go in and out and there's handicapped parking. I have a handicapped sticker of course. And as far as the rest of the place [Metrotown mall], I've never been through it.

Another woman, who had been very active in sports for most of her life but who was now having difficulty ambulating for even short distances because of the discomfort associated with her leg ulcers, commented that she "can't get mobile, like operational" and that she wished she could do simple things like "just go outside and run or jump" or "walk out to the car with [the nurse] or anybody else that comes in." Finally, one participant provided an example of how her inability to stand for long periods of time made it difficult for her to attend certain social functions:

**I don't go to cocktail parties cause if I ever end up with a teacup in my hand...you know people standing around drinking tea...I can't do that. Everybody else is standing around talking. I have to go and get a chair and sit by myself because I can't stand on my feet and people don't understand. They think I'm antisocial.**

**This individual also commented that she really enjoyed being with people but felt embarrassed in social situations such as the one described above; it was this feeling of embarrassment that contributed to her desire to avoid social activities altogether.**

**Several participants explained that they had to forego certain activities because their treatment regime interfered with the activities. For example, one gentleman was not able to go swimming—his favorite pastime—because it had been recommended that he not get his leg ulcer dressing wet. Another participant stated that she very seldom went on a holiday because she found it too difficult to travel with a large box of dressing supplies: "It's chiefly travelling [that I can't do]...you see, you've got to take all your medications and your medicines with you, your bandages and everything...a whole box of things." For yet another participant, a more lengthy bus trip for senior citizens was out of the question because of the recommendation that she keep her legs elevated as much as possible to reduce her edema and leg discomfort:**

**Now today, I could have gone with the what they call a volunteer service and they had a trip out to Elwood Lake you know. And I thought, "Oh that's too long" because [the bus] picked you up before noon and you wouldn't be back home before 4:30. And yes, I could take the wheelchair but you see your legs are not elevated. ...[Your legs] are down all the time you're in [the bus] and it's quite a long trip.**

**This woman also felt that if she could not adhere to the recommendation that she keep her legs elevated as much as possible, her legs would start "paining" and as a result she would not feel "social" or "good" and would not enjoy herself on the bus trip.**

### **Loss Of Companionship**

Many participants commented that at times they felt lonely and isolated as a result of having to relinquish certain activities that had been a source of fellowship with friends and acquaintances. One participant, who rarely left her home anymore, conveyed the impact that her circulatory disorder has had on her ability to socialize with others: "Well, I've always been good at socializing with people. I've never had a problem and now I'm strung up by the heels." Curiously, this woman reported that since she had become isolated in her own home she no longer had the ability to socialize as she once did even if given the opportunity to. For example, she had difficulty tolerating more than a few people in her home at once:

And also I don't like having too many people in the room at the same time. It bothers me. ...Well, I get feeling as if I got noises in my head. It affects my ears. Geez, like having alot of bells ringing all at the same time...buzzing in my ears.

Another participant explained that when he was not able to go swimming every weekday, he not only missed the activity but he missed seeing all his friends in the swimming group as well. It was evident that his relationships with his swimming buddies were important to him as he even expressed concern for what they experienced when he was unable to go swimming. "They just wonder why I'm not there. They miss me," he stated. For this man, then, his venous leg ulcer meant a loss of companionship not only for himself but for his friends as well. As one final example of how the relinquishment of a certain activity resulted in a loss of companionship with others, one woman talked about the sense of isolation and disconnectedness she had experienced when her friends went travelling and she didn't feel that she could go with them: "Well the boat cruises...all my friends have been and I feel I can't and I shouldn't be on those and they go out and do that." This participant refrained from travelling with her friends because

she felt as though she had too much difficulty getting around and it would have been too troublesome for her to transport her large box of dressing supplies.

### **Loss Of Predictability**

All of the participants in this study explained that, in many respects, there was a great deal of uncertainty or unpredictability associated with their chronic circulatory disorder. The recurring nature of the condition was particularly difficult for the participants to come to terms with as they often felt vulnerable, as though they were just waiting for the inevitable to happen. "You never know. It might go for a year or more...but they'll break open some time or other because the skin is too weak," one gentleman stated. Another woman had this to say about the recurring nature of her leg ulcer: "And then it'll go away and maybe it'll come back and maybe it won't...you can't say." Some participants also commented that they were often surprised by the fact that a seemingly harmless occurrence could give rise to the formation of a venous leg ulcer. For example, one woman described feeling shocked when a leg ulcer developed after she "nicked" her skin when applying her elastic support stocking. Another woman explained that on one occasion her cat had scratched her leg and, as a result, she had developed a venous ulcer which took nine months to heal. Other participants reported that they had been surprised when an ulcer developed after they had simply "knocked" their leg against the corner of a chair or a cupboard door.

In addition to not knowing when a venous leg ulcer might develop and what the precursor to its formation might be, the participants had no idea how long their current leg ulcers would take to heal or if they would heal at all. "I thought that [the current venous leg ulcer] would start healing right away but it didn't...so I don't know how long it will take," one woman remarked. This same woman also stated that she felt confused

as she did not know why a "little open spot" just above her leg ulcer had healed within a few days and, yet, her current ulcer had not healed in years. Another participant conveyed her uncertainty in relation to the healing process when she stated:

I thought [the venous leg ulcer] looked as if it was actually getting to the [healing] point. [I thought] maybe in another week or two I'd have a skin on it...it's never happened. Mind you, it's filling in and it is improving. It's not that I deny the nurses when they tell me it's improving [because] I can see that it is...but how long will it take to heal? Is it going to be Christmas before I'm going to be able to walk around without a bandage?

This participant, like many others in the study, emphasized that one of the primary reasons it was difficult to predict healing time was that there was such an air of uncertainty surrounding the effectiveness of the various leg ulcer therapies. Many of these individuals described having had high hopes for a particular topical therapy, only to have had them dashed when their physician discontinued the treatment and prescribed another that was thought to be more effective. In addition, a number of participants had undergone skin grafting procedures that had been highly touted by their physicians as being the "best solution to the problem," only to find that the grafts would not "take." On a final note, it was discovered that, as a result of having to endure many failed leg ulcer treatments, a number of the participants had become rather skeptical of their physicians' advice and abilities. One woman's comment about her experience at the Wound Healing Clinic certainly illustrates the sense of disillusionment that a number of the participants felt: "[One doctor's] got so much he wants to do...then another guy comes along and he wants something else. They don't know bugger all. ...I said [to the dermatologist], 'I'm not going back to the Wound Clinic again.'"

### **Encountering Gain**

As was mentioned, the participants in this study also reported that there had been a gain associated with their chronic venous leg ulcer experience. Specifically, they

explained that their circulatory disorder had not been "all bad" because it had afforded them the opportunity to receive emotional support from home care nurses and homemakers who were involved in their care. Of import was the finding that most of the participants felt that the emotional support they had received from the home care nurses was of far greater importance to them than the physical care they had received in the form of dressing changes to their leg ulcers. Indeed, these individuals wished that the home care nurses would visit more often "just to talk."

When the participants were asked to be more specific about the nature of the emotional support they had received from the nurses, they talked, for the most part, about the fact that the nurses were "good listeners" and seemed to really care about their well-being. One woman stated that she had felt as though the nurses were genuinely concerned about her after her husband had died. She also commented that it had been invaluable for her to share her grief with someone on a regular basis: "[The home care nurse] would visit me in the morning and I'd have somebody to talk to...it helped me [after my husband died]." Another participant remarked that he always enjoyed seeing the home care nurses because he liked their "presence." "I enjoy talking to them" and "[the home care nurses] are so happy and they listen," were some of the other remarks made by participants as they explained why they appreciated having home care nursing visits.

Finally, it should be noted that one of the study's participants appeared to have experienced considerably more gain from her circulatory disorder than did the other participants. This woman, who had become homebound and quite isolated in the last few years, reported that her home care nurses and homemaker fulfilled a "spiritual need" that she had. She was unable to clearly articulate what she meant by the term



"spiritual need," but she did explain that a number of significant people in her life, namely her ex-husband and her mother, had not given her what she "needed." When she made reference to her homemakers and nurses it was clear that she had become "attached" to them and thought of them in a very personal way. For example, she talked frequently about how much she liked one of the home care nurses who would occasionally come to change her dressing: "[The home care nurse] came out to visit and we talked and she and I got along like a house on fire. She's an Aries like me so we understood each other." When this same nurse voiced her disagreement with the participant in regards to a certain issue, the participant felt hurt. "I was a little bit hurt when [the home care nurse] showed that she doesn't always understand me. I thought we had a real thing going between us," she stated. Finally, the participant talked about how important her homemaker had become to her and how close she felt to this woman even though she believed that the homemaker took advantage of her at times:

Now [the homemaker] and I are good friends...I can't have anybody doing things for me that is not my friend. ...I think [the homemaker] takes advantage of that and me but, nevertheless, I realize that she has a very bad background and she's overcome a lot. ...I can't discard her as if she weren't good to me anymore. She's a person and I appreciate her. ...I respect and like [the homemaker] so much and love her as if she were my own daughter, even if I get angry [at her].

With regard to this participant, then, it appeared as though she had benefited significantly from her chronic venous leg ulcer experience as she had been afforded the opportunity to develop the kinds of relationships with others that seemed to fulfill a "spiritual need" that she had.

In sum, the participants in this study experienced various losses in relation to their chronic venous leg ulcers. The losses pervaded many aspects of these individuals' lives and were often interrelated. For example, the loss of physical endurance often

resulted in loss of gratifying activity which, in turn, led to loss of companionship with friends and acquaintances. In addition to encountering loss, the participants also experienced a gain as a result of having a chronic venous leg ulcer. Specifically, they were given the opportunity to have other individuals available who would listen to their concerns and care about their well-being, namely home care nurses and homemakers. It is important to note at this point that even though there was a positive side to having a chronic venous leg ulcer, the experience was still overwhelmingly one of loss. Following, is a discussion of the significance participants attributed to the effects of their chronic venous leg ulcers.

#### **Evaluating The Significance Of The Chronic Venous Leg Ulcer**

A particularly interesting finding of this research was that each of the study's participants had made an evaluation of how significantly their chronic venous leg ulcer had impacted on their life. Furthermore, the data suggest an apparent relationship between the significance that a participant attributed to his/her chronic venous leg ulcer and the coping behaviour that was exhibited in relation to the circulatory disorder. To be more precise, the researcher interpreted the data to mean that the participants in this study appraised their leg ulcers as being either "detrimental" or "inconsequential" with regard to what they termed "living a normal life" and then, based on their appraisal, coped with the circulatory disorder in one of two distinct ways. This section of the report further explores findings in relation to the "appraisal" aspect of the chronic venous leg ulcer experience. Subsequent to this section is a discussion of the ways in which participants coped with their leg ulcers.

### **Appraising The Chronic Venous Leg Ulcer As Detrimental**

In terms of appraising the significance of their chronic venous leg ulcers, two of the study's six participants concluded that developing leg ulcers was the worst thing that has ever happened to them in their lives. "I've had a broken hip and I got over that. I've had a broken wrist. I've had a broken ankle. ...That wasn't bad. ...[But] I think the ulcers are the worst," commented one woman who was evidently concerned about the fact that her leg ulcers had not healed as readily as her fractures had. This woman, who now labelled herself as "disabled," also stated that her life had been "fairly good" and that she had "enjoyed life" before she developed the venous ulcers. Now, her life was "not normal" and was, in fact, "miserable." The other participant talked at great length about how her chronic venous leg ulcer had "ruined" her life because it had prevented her from "living a normal life." Surprisingly, this participant described her leg ulcer as being more devastating to her than the death of her young son in a plane crash many years ago.

At this point in the discussion the reader may be wondering how an individual could perceive of a chronic venous leg ulcer as such a detrimental force in their life. Interestingly, data from interviews with the two participants in this group does offer insight into this matter. Essentially, both of these homebound individuals did not feel as though they were living normally because they could not do what they wanted to do; they could not partake in desired activities. As one woman remarked, "[It's] not a normal life because you don't do things you care to do." Similarly, the other woman commented that she had been "mentally psyched out of doing what [she] wanted to do" in life because she always said to herself: "Oh, I can't do that [because] I'll have to stand." When asked about how her life would be different if she were living what she considered

to be a "normal life," this same participant responded by relating three wishes that she had; dreams that would be fulfilled if she were able to live normally. First, she would take a bus trip up north to Prince George to visit her son's grave because, as she stated, "I might not get another chance. ...I'm getting older and I know that." This woman also remarked that if she were able to live normally she would travel to Banff because she had never seen the icefields or Lake Louise. Finally, this participant envisioned a "normal life" as one that included the occasional outing to a baseball game: "I [would] go to a baseball game. I get it through the TV but I'd love to go and see the Canadians play at Nat Bailey Stadium." When asked the same question, the other participant described a life in which she could bowl and partake in a number of other recreational activities, one of which was jogging: "If I could get rid of the ulcers, boy you'd see me out jogging. You'd see me going down the street..."

From the foregoing discussion, it is apparent that what the participants referred to as "having a normal life" is, in essence, what nurse theorists regard as "having a good quality of life" or "experiencing life satisfaction." Thus, it would seem that these two individuals were conveying to the researcher their feeling that they no longer experienced their everyday lives as having quality or as providing a sense of satisfaction and well-being. This does not seem surprising because for these participants a good quality of life, or being able to live life to the fullest, was inextricably linked to their ability to partake in gratifying activities. Indeed, getting out and doing things is what these individuals believed life to be about. Consequently, when their venous leg ulcers made it difficult for them to be involved in desired activities, they experienced life as being miserable and unsatisfying. From the perspective of these participants, then, their

chronic venous leg ulcers were highly significant in their lives as they were viewed as a detriment to the actual quality of their lives and to their well-being.

Even though each of the participants in this group experienced a number of different losses as a result of their chronic venous leg ulcer—losses in relation to physical endurance, gratifying activity, companionship, and predictability—only a few of these losses were significant enough to the individual so as to be perceived as detrimental to their quality of life. Specifically, the data suggest that the participants in this group believed that losing their physical endurance and, hence, the ability to partake in gratifying activities had been ruinous to their lives, while losses in relation to companionship and predictability had not. It would seem, then, that companionship and predictability were not at the heart of what made life satisfying for these individuals and, consequently, their loss was not perceived to be as injurious as the loss of physical endurance and gratifying activity. Of course, one could argue that the loss of companionship might have been equally as devastating for these individuals but that their energy had been directed toward lamenting the more tangible source of this loss, the loss of gratifying activity. Yet, this proposition seems somewhat unlikely as many of the activities that these individuals wished they could participate in were solitary activities. Furthermore, in their discussions they emphasized the "doing" aspect of a longed for activity more so than the "socializing" aspect of it.

There are two other findings that offer insight into why this group of participants regarded their chronic venous leg ulcers as such a detriment to their quality of life. First, these two participants differed from the other individuals in this study in that they felt that having the leg ulcers had stripped them of a sense of dignity they had once experienced when they did not require assistance with activities. "I hate like hell to be

helpless. ...I don't care to have somebody want to take care of me while I'm out or anything. I like to be independent, you know...more or less on my own," one woman remarked as she described how she felt when others had to push her wheelchair for her or help her ambulate with a walker. The other participant described feeling depressed and useless as a result of having to rely on homemakers to manage her home:

Well one of the reasons I feel so terribly depressed [is that] I get the terrible feeling I'm sitting here, you might say, being subsidized by the government. I can't pay for my homemakers and I have to have 'em seven days a week now. And so here I am. I'm a parasite on society.

For these women, their chronic venous leg ulcers represented not only the losses that have been previously discussed, but they signified a loss of independence and a loss of dignity as well.

It should be noted that, with regard to their loss of independence, both of the participants described above experienced a sense of frustration that was often manifested as criticism towards their homemakers. For example, one woman explained how unhappy she was that her homemaker could not prepare as tasty a meal as she herself had once been able to prepare: "I don't know about you, but the way they cook, they don't cook the way I did." The other participant conveyed her feeling of frustration with homemakers, who had worked for her in the past, when she made the following remark:

My experience has been with homemakers is that most of them are poorly educated or neurotic [and] can't get a job anywhere else. If there were plenty of jobs, then I got the dregs of society...people who don't even keep themselves clean.

This same participant was very fond of her current homemaker but had this to say about her homemaker's housekeeping skills: "[The homemaker] comes in here...and rattles around in [the kitchen] and I hear things dropping and I know very well the next time I

go in that kitchen there's going to be one hell of a mess." Once again, this woman's comment revealed the sense of frustration she was experiencing as a result of needing someone else to clean her kitchen, an activity that she herself had once enjoyed.

The other finding, that sheds a little more light on why the participants in this group appraised their chronic venous leg ulcers as detrimental, relates to their belief that because of their leg ulcers they would have to endure a dismal future. One participant, who claimed that her venous ulcer was improving, still felt that she would never be "finished with" her circulatory problem and that she would never lead a "normal life."

She described her future this way:

And all along I knew what the end was going to be. I could almost see the writing on the wall. I'm not psychic but I got a strong intuition and I could see into the future. And yet, I said to myself "Now stop being morbid."...I just had a vision in my head about twenty, thirty years ago of maybe ending up in a wheelchair and it looks as if I'm heading that way.

The other participant explained that, because of her decreased physical endurance and inability to partake in many activities, her long-term care worker had placed her name on a waiting list for admission to a "home." This participant was very resistive to the idea of entering a facility at this point in time but her comments to the researcher indicated that she had accepted that this may be her only alternative in the future. "[The long-term care worker] said, 'Do you think you want to go into a home?' I said, 'No I don't yet. As soon as I lose my marbles and I'm not copacetic I might, but for now I'll stay here'," she stated on one occasion. It was also apparent that she was quite distressed about the suggestion that she enter a facility that, in her mind, was for people who were mentally incompetent. Another remark that she offered demonstrated the effort she was making to resist succumbing to what she believed would be a dismal future: "[The long-term care worker] asks me when I'm going into the Old Folk's Home

and I say, 'When I lose my marbles I'll go.' But I don't think I'll go yet. I'm going to try and hang on for awhile yet." From the preceding discussion it is evident that the participants in this group experienced their chronic venous insufficiency and venous leg ulcers as a detriment to their quality of life not only in terms of the present, but with regard to their future as well.

The emotional responses that these participants described and demonstrated were certainly consistent with their belief that developing chronic venous leg ulcers is the worst thing that has ever happened to them in their lives. One participant cried frequently throughout the first interview when she described what it has been like to live with a leg ulcer. During this interview many of her comments were delivered in an angry and somewhat fearful tone and at one point she even remarked: "I wish I never had [the venous leg ulcers]. Why did I get them?" She also stated that she often felt "down" and that "some days are a struggle." As well, this woman described feeling frustrated with many aspects of the experience. "I am fed up with this," she stated. The other participant in this group described emotional responses that ranged from fear, anger, and frustration to despair. She also commented that living with her leg ulcer had been a "combination of burden, hardship, and worry." The enormous emotional toll that this experience had taken on this woman was never so evident as when she explained how depressed she had become as a result of having to live with her circulatory disorder for so many years:

I have been so depressed this past year. This [current venous ulcer] started in September but I have been so depressed thinking back to the previous three years. I've been so depressed and I hinted around to several of the nurses that I knew how to take my own life if I got to that point. And I said to [the home care nurse], "You know I'm kind of worried...I don't want to take my own life...I know it's a sin against God and I'm not about to do that...but at the same time I'm afraid that in a



weak moment that I might and I know how to do it...I've got an easy way."

In sum, two of the study's six participants appraised their chronic venous leg ulcers as having had a very significant impact on their lives. Indeed, each of these participants regarded their leg ulcers as having been detrimental to their quality of life and well-being. Interestingly, the data suggest that these individuals were particularly devastated by their circulatory disorder as it had rendered them incapable of participating in many desired activities and, from the perspective of these participants, their quality of life was inextricably linked to their ability to partake in gratifying activities. As well, the chronic venous leg ulcers represented a loss of independence and dignity for these participants and were the primary reason these individuals envisioned a dismal future for themselves. Curiously, the other four participants in this study viewed their chronic venous leg ulcers in a very different light. The following is a discussion in relation to how this second group of participants appraised their venous leg ulcers.

#### **Appraising The Chronic Venous Leg Ulcer As Inconsequential**

It was particularly intriguing, in light of what the other group of participants had discussed, to find that each of the four individuals in this second group had appraised their chronic venous leg ulcer as being inconsequential with regard to what they also termed "living a normal life." "Just normal...I felt just normal," one gentleman stated when asked what it was like to live with a venous leg ulcer. Similarly, the other participants described their lives as being "just normal" and not having changed significantly since they had developed their circulatory disorder. As with the other group of participants, it was apparent that these individuals were using the term "living a normal life" in the same way that nurse theorists might use the terms "living a life that has quality" or "living a satisfying life." Thus, it would seem that these four participants

were conveying to the researcher their feeling that they still experienced their everyday lives as having quality, or as providing a sense of satisfaction and well-being, despite the fact that they were living with a chronic circulatory disorder.

At this point it should be noted that even though these participants viewed their chronic venous leg ulcers as being of little consequence with regard to living a satisfying life, they did report that the leg ulcers were "annoyances" or "inconveniences" in their lives. As one woman remarked, "The only thing I can say is that [the venous leg ulcer] is kind of annoying to have." When asked to elaborate on the annoying or inconvenient nature of their venous leg ulcer, the participants talked primarily about the losses they had experienced as a result of their circulatory disorder. Thus, for these individuals losses in relation to physical endurance, gratifying activity, companionship, and predictability were considered to be annoying or inconvenient rather than devastating or ruinous. It is also noteworthy that, in sharp contrast to the first group of participants, none of the individuals in this latter group indicated that they had experienced a loss of independence or dignity, or a sense of foreboding with regard to the future, as a result of their chronic venous leg ulcers. Rather, they talked about episodically feeling "bothered", "disappointed", or "discouraged" with their leg ulcers. Additionally, a few participants commented that they felt a little worried at times. "Well, [my venous leg ulcer] is not really a big worry you know...it's a little [worry]," one woman remarked. With regard to this second group of participants, then, it was evident that the emotions surrounding their venous leg ulcer experience were much less intense and all-embracing as compared to the emotions experienced by the first group of participants. This discovery, that the latter group of participants did not appear to be emotionally

distressed as a result of their leg ulcers, certainly seems consistent with the finding that these individuals' lives had not been detrimentally impacted by their circulatory disorder.

From the foregoing discussion the reader might assume that the participants who appraised their chronic venous leg ulcers as having little consequence in their lives would have less serious leg ulcers as compared to the participants who had appraised their venous ulcers as being detrimental to their lives. One might also assume that the individuals in the former group would have fewer leg ulcers and that, most likely, the ulcers were associated with less physical discomfort and limitation as compared to the leg ulcers that were endured by the latter group of participants. Surprisingly, these assumptions did not prove to be true in every instance. In fact a few participants, in the group that appraised their venous leg ulcers as being inconsequential, had leg ulcers that could be classified as more clinically serious than those of at least one of the participants in the other group. In addition, a few of the participants in the former group had more leg ulcers than those individuals in the latter group and, as well, they reported similar experiences with regard to ulcer-related physical discomfort and limitations. Finally, it is noted that the individuals within each group varied with regard to how long they had been coping with their circulatory disorder. Thus, a participant's appraisal of how significantly their venous leg ulcer had impacted their life was not necessarily related to the length of time venous ulceration had been present, nor was it necessarily related to the other factors that have been described above.

At issue now is why the participants who appraised their chronic venous leg ulcers as being inconsequential in their lives were able to do so. Data from interviews with these participants and from the researcher's field notes does, in fact, seem to offer some insight into why this may be the case. To begin, the data suggest that each of the

participants in this group derived a great deal of pleasure and satisfaction in life from the close and meaningful relationships that they had with family members. For example, one woman talked frequently and excitedly about how proud she was of her family and how fortunate she was to have close relationships with her son, daughter-in-law, and grandchildren. She had this to say about her son:

My son is my lifeline cause he's just wonderful! ...I got a terrific son...you couldn't beat him. Everybody says, "Where did you get him from?" He's just like his father. His father was that type of caring person, you know, and he takes after his dad. ...I look around me and think, well I'm lucky...I'm so pleased at how he is!

This participant explained that her son visited her frequently, as did her grandchildren. "Oh, those children, he has wonderful little kids. They're so well behaved...they come here and you don't even know they're here. They play, just play away. They're terrific kids," she remarked when describing how happy she felt when she was with her grandchildren.

The three other participants in this group also spoke enthusiastically about their families. In her second interview, one participant spent almost fifteen minutes discussing the personalities of two of her sons and relating what each of her children were doing in terms of their careers. As well, she showed the researcher numerous graduation pictures of her children and grandchildren and commented on how happy she was that one of her sons and his wife would be visiting her that evening. Another participant explained that he talked to at least one of his children everyday on the telephone and that family members would visit frequently. His eyes would light up and he would chuckle as he talked about the family dinners he attended every weekend. With regard to his home environment, the researcher observed that this gentleman had surrounded himself with family memorabilia. For example, in his livingroom, directly across from a chair that he

frequently sat in, was a large console that was blanketed with many photographs of his children and grandchildren. Finally, the fourth participant in this group briefly commented on the content of numerous photographs of her family members. On the whole, she did not talk as much about her family as the other participants had but she did state that her children were very important to her and that she always looked forward to seeing them.

The data suggest, then, that the meaningful relationships these participants had with family members were, very possibly, at the heart of what made life satisfying for these individuals. Thus, for these participants a good quality of life, or being able to live life to the fullest, was inextricably linked to their ability to have meaningful relationships with family members. Therefore, the implication is that the individuals within this group may not have appraised their chronic venous leg ulcers as being detrimental to living a satisfying life as the leg ulcers did not represent a loss that would have threatened their quality of life; in particular, they did not signify the loss of meaningful relationships with family members. For these participants, then, their primary source of satisfaction in life remained unchanged by their leg ulcer experience and the losses that they did experience—losses in relation to physical endurance, gratifying activity, companionship with friends, and predictability—were perceived as "inconveniences" and of little consequence with regard to living a satisfying life. As a final point, it should be noted that the two participants who appraised their chronic venous leg ulcers as being detrimental to their lives had little, if any, family support. One of the participants was divorced and her only son had died many years ago; she spoke of no other family members. The other participant was widowed and had no children. This woman occasionally contacted her nephew to ask him to drive her to an appointment, but she

did not see him socially. She made the following comment in relation to her brother and his wife: "And as far as my people back home...I get a little worried about them...but that doesn't bother me too much because they didn't bother about me anyway too much." Thus, unlike the other four participants, it is doubtful that these two participants derived much satisfaction in life from meaningful relationships with family members. Rather, their sense of well-being was dependent on their ability to partake in gratifying activities. As was mentioned previously, significant differences between the two groups of participants were not limited to the appraisal aspect of the chronic venous leg ulcer experience, but could also be found when one examined the ways in which these individuals coped with their leg ulcers.

#### **Coping With The Chronic Venous Leg Ulcer**

All of the participants in this study recounted ways in which they had tried to manage their chronic circulatory disorder so that they could live as "normal" a life as possible. In essence, these individuals were describing coping strategies they had employed for the purpose of preserving or recovering their quality of life. Interestingly, the data revealed an apparent relationship between a participant's appraisal of the significance of their chronic venous leg ulcer and the types of coping strategies they utilized. In other words, similar coping strategies were used by the two participants who appraised their venous leg ulcers as having been detrimental, but these strategies differed significantly from those used by the other group of participants. Furthermore, the coping strategies that were utilized by a group, when considered in combination, represented a more general coping behavior; a coping behaviour, then, being a behaviour which is comprised of an individual's coping strategies and enduring coping style. Hence, the individuals who appraised their leg ulcers as being detrimental used a more

general coping behaviour which the researcher has termed "putting life on hold." On the other hand, a coping behaviour, which the researcher has called "getting on with life," was utilized by the participants who appraised their circulatory disorder as being inconsequential. The following discussion in relation to coping is organized according to the two general coping behaviours that were utilized by the study's participants.

### **Putting Life On Hold**

The two participants who appraised their chronic venous leg ulcers as having been detrimental to their quality of life appeared to have literally put their lives on hold in an effort to rid themselves of their leg ulcers. Indeed, both of these individuals commented that currently their primary concern in life was that their leg ulcers were managed in the best way possible in order that they would have a chance to heal. Of note is the fact that both of the participants repeatedly commented that they had been "battling" or "fighting" to eliminate their leg ulcers. "I've had to fight [the venous leg ulcers]," one woman remarked. In a very real way, then, it appeared as though these participants had put their lives on hold in order that they could "go to battle" against what they considered to be one of their greatest adversaries in life, that being their chronic venous leg ulcer. Certainly, this aggressive stance in relation to their leg ulcer does not seem astonishing when one considers that, from these individuals' perspective, their leg ulcer had robbed them of quality in their life and had threatened their sense of well-being. What is a little surprising, however, is the fact that these participants had waged a battle against their leg ulcers for many years without ever having come to the point of accepting the chronic venous leg ulcers as being a part of who they are.

In this "battle" to heal their leg ulcers, these participants utilized a number of different coping strategies which, when considered in combination, contributed to the

coping behaviour that the researcher has termed "putting life on hold." To begin, the data suggest that both participants had become very cautious with regard to the activities they would take part in. They talked about being "scared" that they would jeopardize the healing process or cause a setback if they took part in certain activities. Of note is the fact that, indeed, both of these participants had experienced what they believed were setbacks as a result of participating in certain activities. For example, one participant had become reluctant to ambulate for more than very short distances with her walker as she had experienced a fall in the past which she felt had jeopardized the healing of her leg ulcers. "I'm trying to be extra careful now," she remarked when discussing why she was now reluctant to ambulate. The other participant wanted to go and visit her son's grave in Prince George but had decided not to as she claimed that her leg ulcer had started "leaking more" during the last bus trip that she had taken. Interestingly, her physician recommended that she take the trip up to Prince George but as she stated, "I don't feel it's worth taking any chances." This same woman also claimed that she wanted very badly to attend a tenants meeting in her housing complex but thought she might decline in the end because the last time she tried to attend a meeting she became so exhausted trying to get ready that she did not make it to the meeting. "It just wasn't worth it," she said. Thus, the two participants in this group engaged in a strategy the researcher has termed "playing it safe" because they did not want to risk losing ground against their leg ulcers. Ironically, the use of this strategy resulted in them not partaking in some of the very activities that brought them enjoyment in life.

In the "battle" to heal their leg ulcers, the participants also used a coping strategy that the researcher has termed "being vigilant." They were very watchful over their ulcers and demanded that the ulcers be cared for in the best way possible. This meant



that they were often critical of their physicians and home care nurses if they did not feel as though they were getting appropriate care. One participant conveyed the anger and frustration she had felt when her home care nurse did not correctly apply a tensor bandage to her leg:

The nurses that come in here, most of them don't know how to put a bandage on. Well [the home care nurse] at first was resistant. She thought that I was just a prattling patient. ...I got annoyed with her and said, "Look, I've had [the leg ulcer] for years and I've been [applying the bandage] for years. I know what I'm talking about. If you don't put it on right it's not going to be any good at all." So now I've taught her you see. She listens.

Being vigilant also meant that these participants were frequently monitoring the status of their leg ulcers and were phoning their physicians regularly to update them on the status of their ulcers. It was interesting to note that both participants had phone numbers for physicians and other health care agencies handy at all times and carefully kept track of when they had medical appointments or appointments at the Wound Healing Clinic. One woman even asked the researcher to call the physician to discuss the status of her leg ulcer. Thus, by "becoming vigilant" the participants had become focused on their leg ulcers and other things in their lives seemed to take a back seat or were put on hold.

### **Getting On With Life**

The four participants who appraised their chronic venous leg ulcers as having been inconsequential to their quality of life simply got on with their lives. They were able to do this by engaging in a coping strategy that the researcher has termed "doing things differently." These participants could no longer do many things in the way that they once had but that did not seem to stop them; if they really wanted to do something they would just go about doing it in a different way. For example, one participant had

enjoyed volunteering in a local hospital for many years but when she could no longer manage this, because of a loss of physical endurance, she volunteered to be on four different phoning committees. Thus, she still was able to participate in volunteer work which she found very gratifying. Another participant would go walking if he could not go swimming because of his leg ulcer dressing. He missed seeing his swimming buddies but he got the exercise he desired. It was certainly evident that these participants had accepted the leg ulcers as being a part of them and were going to carry on in spite of their presence. The mindset that these participants had in relation to their chronic venous leg ulcers was best expressed by one woman who had very severe leg ulcers: "I can't understand having ulcers so bad they could stop you from doing anything."

### Summary

In this chapter the study's findings in relation to the older adult's subjective experience of living with a chronic venous leg ulcer were presented. The findings revealed that the participants in this study moved through three sequential phases of a "living with a chronic venous leg ulcer continuum" as they lived with chronic venous insufficiency and chronic venous leg ulcers. In the first phase of the continuum, participants experienced the effects of living with their chronic circulatory disorder. They encountered losses in relation to physical endurance, gratifying activities, companionship, and predictability in their lives. These losses pervaded many aspects of these individuals' lives and were often interrelated; one loss often gave rise to another loss. In addition to experiencing loss, the participants encountered a gain as a result of having a chronic venous leg ulcer. Specifically, they had been afforded the opportunity to receive emotional support from home care nurses and homemakers who were involved in their care. Participants enjoyed "just talking" with the home care nurse and felt that

they received emotional support from the nurse by way of being listened to and feeling as though the nurse really cared about their well-being. With regard to the significance of this gain, the data suggest that even though there was a positive side to the chronic venous leg ulcer experience, the experience for these participants was still overwhelmingly one of loss.

In the second phase of the continuum, participants evaluated how significantly their chronic venous leg ulcer had impacted their life. More specifically, they made a judgment with regard to the overall effect that the losses associated with the circulatory disorder had had on their lives. In so doing, two of the study's participants appraised their chronic venous leg ulcer as having been detrimental to their quality of life, while the other four participants appraised their leg ulcer as having been inconsequential with regard to living a satisfying life. The individuals who determined that their venous leg ulcers had been detrimental in their lives were particularly devastated by their circulatory disorder as it had rendered them incapable of participating in many desired activities and, from the perspective of these individuals, their quality of life was inextricably bound to their ability to partake in gratifying activities. Furthermore, the chronic venous leg ulcers represented a loss of independence and dignity for these participants and were the primary reason these participants envisioned a dismal future for themselves. Conversely, the participants who determined that their venous leg ulcers had been inconsequential in their lives perceived of their leg ulcers as "annoyances" or "inconveniences" and were not emotionally distressed by their presence. Interestingly, there were no substantial differences between the two groups with regard to severity of the leg ulcers, ulcer-related physical discomfort and limitations, or length of time the circulatory disorder had been present. However, the participants who appraised their

chronic venous leg ulcers as inconsequential did differ in one significant way from the other participants in this study. For these individuals, meaningful relationships with family members seemed to be at the heart of what made life satisfying; a good quality of life, then, was inextricably linked to these participants' ability to have meaningful relationships with family members. Consequently, they did not appraise their leg ulcers as being detrimental to living a satisfying life as the leg ulcers did not represent a loss that would have threatened their quality of life; in particular, they did not signify the loss of meaningful relationships with family members. For these participants, then, their primary source of satisfaction in life remained unchanged.

In the third and final phase of the continuum, the participants coped with their circulatory disorder in one of two distinct ways. Each participant either "put their life on hold" if they had appraised their leg ulcer as being detrimental to them, or they "got on with life" if they had appraised their leg ulcer as being inconsequential. The participants who put their lives on hold did so because they were "playing it safe" and "being vigilant." Conversely, the participants who got on with their lives were able to do so because the things that they could not longer do as they once had, they just did differently.

## **CHAPTER FIVE**

### **DISCUSSION OF THE FINDINGS**

#### **Introduction**

In this chapter the researcher will further explore some of the study's findings in relation to the older adult's experience with a chronic venous leg ulcer. In particular, findings in relation to the appraisal and coping aspects of the chronic venous leg ulcer experience will be examined. First, however, it is important to revisit some of the literature that was presented at the beginning of this report as it represents, for the most part, the health care professional's explanatory model of the chronic venous leg ulcer experience. What must be determined now is whether there are substantial differences between this explanatory model and the participant's explanatory model of the leg ulcer experience which was documented in Chapter Four.

When one considers the complexity of the experience that was documented in the last chapter, it seems clear that the literature that is currently available in relation to living with a venous leg ulcer offers little to further the reader's understanding of the experience at hand. Not only does it lack complexity but, based on the findings of this study, it could be argued that some aspects of the literature may lack validity as well. For example, Merry (1989) asserted that individuals with leg ulcers not only experience a loss of mobility but often the loss of a sense of independence and freedom as well. The difficulty with this assertion is that a very complex idea is presented in such a simplistic manner that it actually becomes misleading. What the reader of the statement may have difficulty grasping is that the loss of a sense of freedom and independence may not

necessarily follow a loss of mobility and, in fact, may not ensue in the majority of cases if the results of this study are to be taken into account. Rather, the loss of a sense of freedom and independence will only be experienced if the individual perceives that the loss of mobility has been a threat to their freedom and independence. Thus, the idea that individuals vary with regard to the meaning that they assign to a given situation has been left out of Merry's (1989) conceptualization of the "mobility" aspect of the leg ulcer experience. Lamont's (1991) statement that pain and discomfort, in relation to the leg ulcer, can affect an individual's quality of life is yet another example of how the complexity of the experience has been lost. Based on this study's findings, ulcer-related pain and discomfort give rise to a loss of physical endurance which, in turn, gives rise to a loss of gratifying activity, and it is this latter loss that is more likely to impact one's quality of life if the individual does, in fact, appraise this loss as a threat to life satisfaction. Thus, a great deal of the current literature in relation to the venous leg ulcer experience lacks complexity, to the point of possibly being deceptive.

There are also some positive aspects of the literature that is available in relation to the venous leg ulcer experience. For one, it does convey that the experience is one of loss even though authors have not necessarily used the term "loss" to describe the changes that occur in an individual's life as a result of having a chronic venous leg ulcer. In the literature the loss of mobility is identified by a number of authors (Callam, Harper, Dale & Ruckley, 1988; Fitzpatrick, 1989; Lamont, 1991; Merry, 1989) as being a significant loss associated with this experience. The study's findings support this assertion with one qualification, that being that the loss could more accurately be described as a loss of physical endurance or stamina. It is important to note that the

literature does not identify two of the losses that were described by participants in this study, those being the loss of companionship and the loss of predictability in life.

With respect to the venous leg ulcer literature, it is also noteworthy that a few of the assumptions put forth were not supported by the findings of this study. First, a number of authors (Fitzpatrick, 1989; Lamont, 1991) assume that there is financial hardship associated with the venous leg ulcer experience. Certainly, because of a significantly different health care system and a different system of social services this may be the case in the United States, but the findings of this Canadian study did not support this assumption. One further point in relation to this assumption is that all participants in this study were well past retirement age and, hence, received a pension from the government. If they had been younger, some may have experienced difficulties with regard to employment and, consequently, experienced some financial hardship. A second assumption that proved untrue for the sample in this study was one put forth by Lamont (1991). More specifically, she theorized that individuals with venous leg ulcers would regard home care nursing visits as interfering with their daily lives. In fact, the study's findings suggest that this could not be further from the truth; indeed, the participants in this study welcomed home care nursing visits and perceived them to be one positive aspect of the chronic venous leg ulcer experience.

After revisiting the literature in relation to the venous leg ulcer experience, it is evident that there are some significant differences between the health care professional's explanatory model, as presented in the literature, and the client's explanatory model of the chronic venous leg ulcer experience as presented in this report. For example, authors have not recognized that the loss of companionship and the loss of predictability in life are important aspects of the chronic venous leg ulcer experience. Further, they

have identified difficulties that a client with a venous leg ulcer may experience (e.g., financial hardship) that were not evident with regard to this study's participants. Finally, the health care professional's explanatory model does not recognize the complexity of many aspects of the venous leg ulcer experience that are identified and does not address two integral aspects of the experience, those being the appraisal and coping facets of the experience.

At this point, one can also consider whether the related literature that was reviewed did offer some relevant insight into the chronic venous leg ulcer experience. To begin, the findings of this study suggest that there are some similarities between the venous leg ulcer experience and the stoma experience. Specifically, body image disturbances were evident in relation to two participants in the study who were "battling" their leg ulcers, conveying to the researcher, then, that they had not incorporated their chronic circulatory disorder into their body image. But, unlike many individuals with stomas, the disturbance in body image was not resolved with time. The other four participants in this study did not appear to experience body image disturbances. With regard to the three categories of problems that Hurny and Holland (1985) identified—physical, emotional, and interpersonal—the findings of this study suggest that many of these problems are unique to the stoma experience, particularly problems related to management of the ostomy wound and concerns regarding sexuality. Two of the study's participants did experience social isolation but the causes for this were different from those that Hurny and Holland (1985) identified in relation to the individual with an ostomy. More specifically, the two participants in this study experienced social isolation as a result of their loss of physical endurance and because they chose to "play it safe" and to not partake in many activities.



The burn literature also seems to have provided insights which are consistent with the chronic venous leg ulcer experience as described by the participants in this study. As with many individuals who are living with burn-related wounds, two of the study's participants talked about "feeling down" and one of these participants even described feeling "depressed." What is not clear, however, is whether the depression that may be associated with the chronic venous leg ulcer experience is similar in nature to the depression that can be associated with the burn experience. Another interesting similarity between the two experiences relates to the idea that psychosocial adjustment to the wound may depend more on person-related variables than on the nature of the wound. In this study, ulcer-related variables such as severity, duration, and associated symptoms did not appear to be determining factors in relation to how the participants appraised and then coped with their chronic venous leg ulcers. Rather, the data suggest that it is the individual's perception of how significantly the leg ulcer has influenced their quality of life that is a key factor in determining how the individual responds to his/her leg ulcer. Finally, in this study there was no evidence that participants had moved through distinct stages of adaptation such as those described by Watkins et al. (1988) in the burn literature. This does not mean that participants in this study did not move through stages of adaptation but, rather, that further research needs to be conducted in relation to the experience of living with a venous leg ulcer over time.

With regard to the chronic illness literature that was reviewed, the researcher has determined that there appear to be many similarities between the chronic illness and chronic venous leg ulcer experiences. Even though venous insufficiency and venous leg ulcers cannot be considered incurable in all instances, the findings of this study suggest that after the onset of venous ulceration the scenario is primarily one of healing and then

recurrence of the leg ulcer over many years or, in some instances, the venous ulceration may never heal. In effect, then, the individual with a chronic venous leg ulcer experiences a persistent condition, or a condition of long-term duration, that has characteristics typically ascribed to a chronic illness. For example, the participants in this study described adaptive tasks that they engaged in that are consistent with those outlined in the chronic illness literature. Specifically, the participants endeavoured to: (1) deal with symptoms; (2) manage health care regimens; (3) adjust to alterations in body appearance, in many instances; (4) handle the uncertainty of the progression of the disease process; and (5) revise personal and social goals (Lambert & Lambert, 1987).

In terms of quality of life for the participants in this study, the data suggest that there was a significant variable related to these participants' life satisfaction that was not specifically addressed in the literature related to chronic illness and quality of life: whether or not the chronic venous leg ulcer had had a negative impact on a primary source of satisfaction in these individuals' lives. To be more precise, the study's findings suggest that if the leg ulcer had negatively affected a primary source of satisfaction in a participant's life, then s/he experienced a life without quality. Finally, the literature in relation to aging and body image indicates that the older adult may experience the physical effects of a health problem or chronic illness as losses, just as age-related physical changes are experienced as losses. In this study, the participants did experience a decrease in physical endurance as a loss and the data suggest that two of the participants were in the process of grieving this loss in physical ability. It appeared as though the other four participants in this study had come to terms with their loss in physical ability; it is not known whether the process of self-transcendence had a part to play in this acceptance of loss.

### **Appraising The Significance Of The Chronic Venous Leg Ulcer**

As was mentioned, a key finding of this study was the discovery that each of the participants had made an evaluation of how significantly the chronic venous leg ulcer had affected their life and then coped in a way that was consistent with the appraisal that they had made. The discovery that participants engaged in an appraisal process is consistent with current thinking in relation to stress, coping, and adaptation. Lazarus and Folkman (1984), in a complex process-oriented theory of psychological stress and coping, described cognitive appraisal as a process of judgment about the meaning or significance of a situation. In effect, the individual encounters a situation which is perceived as being stressful and makes a judgment concerning the significance of the situation with regard to their well-being and, in addition, considers what might/could be done to manage the demands that are appraised as stressful (Lazarus & Folkman, 1984). Even though each individual will appraise a stressful situation in a unique way, it is commonly thought that an event is usually evaluated as either threatening or challenging and a judgment is made with regard to the magnitude of the threat or challenge (Cohen & Lazarus, 1983). Based on this appraisal, then, and factors such as personal and social resources and situational determinants, the individual chooses a coping strategy which ultimately affects adaptational outcomes (Downe-Wamboldt, 1991).

In this study, two of the participants appraised their chronic venous leg ulcers as having been detrimental to their quality of life. It is evident, then, that their judgment was that the leg ulcers had actually caused these participants harm, rather than simply representing a threat of harm. The other four participants appraised their leg ulcers as having been inconsequential with regard to their satisfaction in life. Of note is the fact that the data did not suggest that these participants construed their leg ulcers as a

challenge in their lives. Thus, the participants in this study did not appear to appraise their experience with chronic venous leg ulcers in a traditional way, that is either as a threat or as a challenge. Lipowski's (1969) work in relation to the psychosocial aspects of disease does shed some light on this finding. More specifically, Lipowski (1969) described the appraisal process as a process whereby the individual ascribes meaning to illness; meaning evolves from the evaluations and beliefs the person has in relation to their illness and its likely consequences to their life and to the lives of significant others. Furthermore, the individual can interpret the illness as being insignificant, a threat, a loss, or a gain (Lipowski, 1969). In this study, the chronic venous leg ulcers represented such significant losses for two of the participants that they interpreted them as having been detrimental to their quality of life. According to Lipowski (1969), the emotional response to loss is a grief reaction which may at times assume a psychopathological form such as a depressive syndrome. Indeed, the findings of this study suggest that the two participants who interpreted their leg ulcers as being detrimental were experiencing a depressive syndrome as a result of their chronic venous leg ulcer experience. Depression occurs, then, in relation to loss of such significance that the person feels overwhelmed, or when the number of losses exceeds the person's capacity to limit his or her experience of helplessness and hopelessness (Schneider, 1984). The interpretation of an illness as being insignificant as opposed to being a challenge was more consistent with what the other four participants in this study experienced. They had experienced losses in relation to their leg ulcers but these losses did not influence their quality of life, so the chronic venous leg ulcer experience was interpreted as being inconsequential or insignificant to them. It is important to note that Lipowski (1969) does not suggest that an illness may be interpreted as insignificant for the reason given above. Rather, he proposes that an

individual interprets an illness as being insignificant because of ignorance or indifference in relation to the illness (Lipowski, 1969).

A number of authors have speculated in relation to the factors that influence the appraised meaning of an illness (e.g., Craig & Edwards, 1983; Lipowski, 1969; McHaffie, 1992). Lipowski (1969) suggests that the following variables may affect the way in which an individual appraises an illness: (1) the client's personality type and past experience in general and with illness in particular; (2) the quality of the client's interpersonal relationships at the time of onset of the illness and during it; (3) the aesthetic quality of the client's surroundings as this variable will affect the client's mood; and (4) characteristics of the illness. With regard to the last variable mentioned above, Lipowski (1969) comments that the greater the value and significance that the body part or function affected by the illness has for the client, the more intense the psychological reaction is likely to be. Moreover, a given organ or biological function is especially significant to a client when it provides a source of pleasure, pride, or self-esteem (Lipowski, 1969). Other authors such as Craig and Edwards (1983) and McHaffie (1992), note that appraisal of an illness is influenced by factors such as the background and personal characteristics of the client, the illness and the degree of challenge or threat that it poses, and the surrounding physical and social environment. In this study, the researcher was not able to determine if and how all of the aforementioned variables influenced the participants' appraisal of their circulatory disorder. However, the findings suggest that there was one key variable that significantly influenced how the participants in this study appraised their chronic venous leg ulcers: whether or not the illness that they were experiencing had a negative impact on a primary source of satisfaction in their lives. Thus, participants appraised their circulatory disorder as

detrimental if it had negatively impacted a primary source of satisfaction or inconsequential if it had had little impact on a primary source of satisfaction. This variable is equivalent to Lipowski's (1969) "characteristics of the illness" variable and is consistent with his assumption that psychological reaction to an illness is more intense if the illness has affected a body part or function that is particularly valuable or significant to the client.

What is particularly interesting about the foregoing finding is the fact that one source of satisfaction appeared to be less vulnerable than another source of satisfaction when the individual was confronted with the circulatory disorder that was the focus of this study. More specifically, participants were able to maintain quality in their lives if their primary source of satisfaction in life was meaningful relationships with family members, as this source had not been negatively influenced by the chronic venous leg ulcers. Conversely, participants whose quality of life was inextricably linked to their ability to partake in gratifying activity experienced a life without quality, as their primary source of satisfaction had been negatively impacted by the chronic venous leg ulcer experience. Thus, it would seem that some primary sources of satisfaction, such as meaningful relationships with family members, are less vulnerable than others to the many physical effects of chronic illness. Having said this, one cannot help but wonder whether it would be possible for the two participants in this study, who had been robbed of their quality of life, to develop alternate sources of satisfaction. As a final point, it is noteworthy that there has been much discussion in the literature about the positive role that social support plays in relation to an individual's ability to have quality in life despite the fact that a chronic illness may be present. Indeed, White, Richter, and Fry (1992) note that people cope more effectively with stressful life events if they have

support, and the lack of social support has been found to contribute to psychological deterioration. Based on the findings of this study, it seems possible that an individual who has a chronic illness may have a better quality of life if s/he has social support because this support may be a primary source of satisfaction in life that is less vulnerable to the physical effects of an illness.

In sum, the finding that participants in this study engaged in an appraisal process in relation to their circulatory disorder is consistent with current thinking in relation to stress, coping, and adaptation. Participants did not appraise their illness as being either threatening or challenging but, rather, as detrimental or inconsequential with regard to their quality of life. The key factor that influenced how the participants appraised their chronic venous leg ulcers was whether or not their illness had impacted their primary source of satisfaction in life in a negative way. The study's findings suggest that some sources of satisfaction (e.g., social support) may be less vulnerable to the effects of chronic illness than other sources of satisfaction.

### **Coping With The Chronic Venous Leg Ulcer**

Another key finding of this study was that participants had engaged in coping strategies for the purpose of preserving or recovering their quality of life. The data also revealed an apparent relationship between a participant's appraisal of the significance of their chronic venous leg ulcer and the types of coping strategies they utilized. As with the appraisal aspect of the chronic venous leg ulcer experience, both of these findings are consistent with current thinking in relation to stress, adaptation, and coping. Lazarus and Folkman (1984) explain that based on their appraisal of a situation, and other factors such as social resources, individual motivation, and situational factors, an individual will engage in problem-solving efforts in an attempt to preserve physical and

psychological integrity, to recover reversibly impaired function and/or to compensate for irreversible impairment. The outcome of a successful coping process, then, is adaptation which involves coming to terms with the reality of chronic illness as a state of being, discarding false hope and destructive hopelessness, and restructuring the environment in which one now functions (Craig & Edwards, 1983). From a slightly different perspective, Feldman (1974) notes that adaptation is essentially the reorganization and acceptance of self so that there is meaning and purpose to living that transcends the limitations that are imposed by the illness.

In this study, it was interesting to find that the two participants who appraised their leg ulcers as being detrimental to them engaged in coping behaviour that was consistent with the appraisal that they had made of their leg ulcers, but would not be effective behaviour with regard to adaptation. Specifically, these participants engaged in coping behaviour that was characterized by vigilance in relation to their leg ulcer and a "playing it safe" approach with regard to activities. This behaviour certainly was not surprising considering that the leg ulcers were perceived to be a very harmful force in these participants' lives; the participants were endeavouring to preserve physical integrity and to regain lost function by "battling" against the leg ulcers. The problem, however, was that their coping behaviour gave rise to further loss in relation to gratifying activity, and it was the ability to partake in gratifying activity that was at the crux of what quality of life meant for these individuals. Consequently, these individuals did not move towards adaptation as they were unable to engage in reorganization and acceptance of themselves with their leg ulcers. Furthermore, their ongoing vigilance made it impossible for them to transcend their illness. It is not known why these individuals engaged in this type of coping behaviour for so long especially when one considers that it did not serve to



reduce their anxiety or distress in the situation. In addition, the behaviour is particularly perplexing when one considers that, according to Lazarus and Folkman (1984), the individual who is coping will periodically engage in a reappraisal process in order to determine whether their coping behaviour has been effective in dealing with the stressful or threatening situation and, then, will usually make adjustments in coping based on this reappraisal. The researcher can only speculate that, possibly, these participants were engaging in coping behaviour that was consistent with their usual coping style, which is their enduring disposition to deal with challenges and stressors with a particular constellation of techniques (Craig & Edwards, 1983). Thus, it is possible that these individuals only had a select repertoire of coping strategies that they engaged whenever necessary and in this situation they were not effective. Indeed, Craig and Edwards (1983) note that each coping behaviour may not be appropriate in every circumstance and behaviours which are beneficial for a short period may be harmful if used excessively.

The findings of this study also suggest that the other four participants had adapted to their chronic circulatory disorder. Specifically, they had come to terms with the reality of their chronic illness as a state of being and, hence, had accepted themselves as they were; in effect, they had transcended their illness and experienced meaning and purpose in their lives. As with the other group of participants, it is not known why these participants were able to cope effectively and adapt to their chronic illness. Certainly, it is possible that these participants also had a repertoire of coping strategies that were different from those of the other group but effective in the management of this particular situation.

In trying to determine why four participants in this study were able to adapt to their chronic circulatory disorder, one might also consider the theory of self-transcendence as explicated by Reed (1991b). This theory is an emerging middle-range theory that was developed through "deductive reformulation" whereby existing knowledge, derived from non-nursing theory, is reformulated using knowledge obtained deductively from a nursing conceptual model. With regard to the theory of self-transcendence, the aim was to construct a nursing theory that incorporated knowledge from life span theories on adult social-cognitive and transpersonal development with Martha Rogers' conceptual model for nursing. In this emerging theory, then, self-transcendence refers generally to a quality of developmental maturity whereby there is an enlargement of self-boundaries and a focus on broadened life perspectives and purposes. More specifically, it involves the expansion of one's conceptual boundaries inwardly by way of introspective activities, outwardly through concern about others' welfare, and temporally by blending perceptions of one's past and future to enhance the present; the individual transcends their physical being and reaches out beyond self-concern. The five possible antecedents that have been identified in relation to self-transcendence are: (1) an inherent tendency of the person to move beyond their own self interest; (2) a spiritual perspective; (3) a pivotal life event or stressful stimuli; (4) human work that enlarges the goals and visions of a person; and (5) acceptance of an inescapable situation. Although the theory of self-transcendence is associated, in large part, with the social-cognitive and transpersonal development of older adults, it is thought to provide important insights into the well-being and mental health of individuals who perceive themselves as facing end-of-life issues, whether through terminal illness, or other issues. Thus, with regard to the four participants in this study who "just got on

with life," one can only speculate that at least some of these individuals may have experienced self-transcendence as a normal part of social-cognitive and transpersonal development in older adulthood.

In summary, the findings of the study suggest that the participants engaged in coping behaviour in relation to their chronic circulatory disorder and that their coping behaviour was consistent with the appraisal that they had made in relation to the significance of their chronic venous leg ulcers. Two of the study's participants engaged in coping behaviour that was ineffective with regard to moving them towards adaptation. It is not known why this was the case, but the researcher hypothesized that they may have been using an enduring style of coping that was not effective in that situation. On the other hand, the other four participants in the study coped effectively with their chronic venous leg ulcers as they had adapted to the circulatory disorder. It was suggested that they may have utilized an enduring coping style that was effective in that situation and that, possibly, some of these individuals experienced self-transcendence in the older adulthood stage of development.

### **Summary**

In this chapter the researcher further explored some of the study's findings in relation to the older adult's subjective experience of living with a chronic venous leg ulcer. It is evident that there are some significant differences between the health care professional's explanatory model, as presented in the literature, and the participant's explanatory model of the chronic venous leg ulcer experience as presented in this report. Even more important, however, is the fact that the health care professional's explanatory model of the chronic venous leg ulcer experience lacks the depth and complexity that is essential if one is to fully understand the experience.

With regard to the appraisal aspect of the chronic venous leg ulcer experience, it was suggested that there was a key mediating factor present that affected the appraisal process: whether or not the chronic venous leg ulcers had negatively impacted on these individuals' primary source of satisfaction in life. For those participants whose primary source of satisfaction was family support, their leg ulcers were perceived as inconsequential and they experienced quality in life even though they were experiencing losses related to the chronic venous leg ulcers. On the other hand, individuals whose primary source of satisfaction was being able to participate in gratifying activities experienced a life without quality since their source of satisfaction had become vulnerable to their circulatory disorder. The researcher hypothesized, then, that there are some sources of satisfaction that appear to be less vulnerable to the effects of chronic illness. It was also suggested that if this latter group of individuals could develop other sources of satisfaction that would be immune to the effects of their illness, then they might have a chance of experiencing some satisfaction in life. Another difficulty for these individuals was that they coped in a way that was consistent with their appraisal of the leg ulcers as harmful, but their coping behaviour contributed to a situation in which they experienced more losses and did not move towards adaptation. It was speculated that these participants might be engaging in behaviours that reflected an enduring coping style that was not effective in the chronic venous leg ulcer situation. Finally, it was suggested that four of the study's participants had adapted to their chronic circulatory disorder and that this may have been because they had a repertoire of coping strategies that was different from the other group but effective in the chronic venous leg ulcer situation. In addition, the researcher hypothesized that at least some of these individuals may have

**experienced self-transcendence as part of normal social-cognitive and transpersonal development in older adulthood.**

## **CHAPTER SIX**

### **SUMMARY, CONCLUSIONS, AND IMPLICATIONS**

#### **Summary**

The purpose of this study was to gain an understanding of the chronic venous leg ulcer experience from the perspective of community-dwelling older adults. Chronic venous insufficiency has been recognized as one of the most common health problems experienced by the older adult. Unfortunately, an all too frequent complication of this circulatory disorder is the development of a venous leg ulcer. Chronic venous leg ulcers can have a negative impact on the general well-being of the older adult and costs to the health care system associated with the treatment of chronic venous leg ulcers are substantial.

To date no research has been conducted in relation to the older adult's experience of living with a chronic venous leg ulcer. Rather, the literature contains a few anecdotes in relation to the chronic venous leg ulcer experience that have been written from a health care professional's perspective. Thus, in the context of chronic venous leg ulcers, the explanatory model of the client has not yet been documented. If community health nurses are to work effectively with these clients there must be some understanding of what the client's experience is like.

The phenomenological method of qualitative research was used for this study. This method was appropriate for this study as the researcher wanted to understand the chronic venous leg ulcer experience from the perspective of the elderly community-dwelling individual. To be as true as possible to the phenomenological approach, the

researcher viewed the study's participants as partners or co-researchers in the endeavour and related to them within the context of a genuine and mutual "I-thou" relationship so that the researcher could truly be "with" a participant and begin to understand that participant's world.

Six individuals participated in this study who were or had been seen on a regular basis by a home care nurse for treatment of their chronic venous leg ulcers. Two audiotaped in-depth interviews were conducted with each participant and the tapes were subsequently transcribed verbatim. The interviews were unstructured, for the most part, so that participants were given the opportunity to discuss issues that were important to them. The process of data analysis occurred simultaneously with data collection through a process of constant comparative analysis. As themes emerged in each transcript, the researcher moved from one transcript to another for the purpose of identifying common themes and variations within themes. At the same time, common themes and variations that were emerging were validated and clarified with the study's participants. Finally, common themes were elaborated on and synthesized into a description of the chronic venous leg ulcer experience that was representative of all of the participants' experiences with this phenomenon.

The findings of this study revealed that participants moved through three sequential phases of a "living with a chronic venous leg ulcer continuum" as they lived with chronic venous insufficiency and chronic venous leg ulcers. In the first phase of the continuum, participants experienced the effects of living with their chronic circulatory disorder. They encountered losses in relation to physical endurance, gratifying activities, companionship, and predictability in their lives. In addition to experiencing loss, the participants encountered a gain as a result of having a chronic venous leg ulcer: the

emotional support afforded them by home care nurses and homemakers involved in their care.

In the second phase of the continuum, participants evaluated the extent to which their chronic venous leg ulcers had affected their lives. In so doing, the participants either appraised their leg ulcer as having been detrimental to their quality of life, or inconsequential with regard to living a satisfying life. The key factor that influenced the appraisal that participants made of their leg ulcers was whether or not their circulatory disorder had negatively affected a primary source of satisfaction in their lives. Thus, a chronic venous leg ulcer was appraised as being detrimental if it had negatively affected a primary source of satisfaction, or inconsequential if it had not affected a primary source of satisfaction.

In the third and final phase of the continuum, the participants coped with their circulatory disorder in one of two ways. Each participant either "put their life on hold" if they had appraised their leg ulcer as being detrimental to them, or they "got on with life" if they had appraised their leg ulcer as being inconsequential. Those who "put their life on hold" did so by "playing it safe" and "being vigilant." The participants who got on with their lives were able to do so because, the things that they could no longer do as they once had, they just did differently.

### **Conclusions**

The study's findings suggest a number of conclusions about the experience of living with a chronic venous leg ulcer:

1. The changes in functional abilities, social contacts, and predictability in life that accompany a chronic venous leg ulcer are experienced as losses;



2. There is a possible gain associated with having a chronic venous leg ulcer, that being the emotional support afforded the older adult by nurses who are treating the chronic venous leg ulcer;
3. Older adults with chronic venous leg ulcers appraise the significance that the leg ulcers have had in their lives;
4. The older adult may appraise their chronic venous leg ulcer as having been detrimental to their life if it has negatively impacted a primary source of satisfaction;
5. The older adult may appraise their chronic venous leg ulcer as inconsequential to their life if it has had little impact on a primary source of satisfaction;
6. Research findings of this study suggest an apparent relationship between the significance that an older adult attributes to his/her chronic venous leg ulcer and the coping behaviour that is exhibited in relation to the circulatory disorder;
7. Research findings of this study suggest that the older adult will "put life on hold" if the chronic venous leg ulcer is appraised as being detrimental; and
8. Research findings of this study suggest that the older adult will "get on with life" if the chronic venous leg ulcer is appraised as being inconsequential.

#### **Implications For Nursing**

A number of implications for nursing practice, education, and research arise from the finding that the older adult's experience with a chronic venous leg ulcer is a

very complex one. To begin, the complex nature of the leg ulcer experience means that it is essential that the nurse make every effort to explore and understand the client's explanatory model in relation to his/her sickness. Without this understanding of the client's explanatory model, the nurse may have difficulty communicating with the client and may not be sensitive to the client's health care needs. In addition, the complex nature of the chronic venous leg ulcer experience implies that the nurse must recognize that a holistic approach to the care of the older adult who is living with a chronic venous leg ulcer is essential. Thus, the elderly client requires psychosocial care in addition to care of the leg ulcer itself.

With regard to psychosocial care, the nurse needs to be aware of the fact that the older adult who is experiencing chronic venous ulceration will be experiencing losses in many areas of their life as a result of their circulatory disorder. Furthermore, these ulcer-related losses may compound a myriad of other losses related to the normal aging process. Thus, the elderly client may be grieving multiple losses and the nurse must be prepared to offer support that is appropriate to any stage of the grieving process. If the grieving process becomes pathological in nature, as it seemed to have become in relation to two of the participants in this study, then the nurse must also be prepared to refer the client to other members of the health care team (e.g., social worker, psychologist) if they have more expertise in relation to mental health issues.

If the nurse is aware of the particular losses that are commonly associated with this circulatory disorder then interventions can be implemented which serve to compensate for some of these losses. For example, in relation to the loss of predictability, the community health nurse may need to talk with a client and their physician about a "maintenance program" for the care of the client's chronic venous leg

ulcer if it appears unlikely that the wound will heal. Too often, clients whose leg ulcers are unlikely to heal will be treated for many years in a very aggressive manner with the underlying expectation that they will heal. As a result of this practice, the client may experience many highs and lows as treatments fail and new treatments are prescribed and, as well, their lives are filled with uncertainty. Thus, a "maintenance program" for clients whose wounds are unlikely to heal would allow them to step off of the emotional roller coaster that they have likely been on for years.

With regard to the loss of companionship, the nurse might consider arranging for a volunteer to visit with the elderly client as appropriate. In addition, the nurse could ensure that the client has appropriate equipment to enable him/her to attend desired social functions outside of the home. For example, a wheelchair or walker may be of great benefit to a client who is reluctant to leave home because of a loss of physical endurance. From a somewhat different perspective, it behooves home care nurses to carefully consider what the self-care movement may mean for the elderly client who derives companionship, and a sense of being care for, from the home care nurse who visits to provide ulcer care. Based on the knowledge that social support positively influences health outcomes, and considering this study's finding that elderly participants regarded the nurse's companionship and emotional support as more beneficial than physiological care, it seems apparent that there could be a negative side to the practice of shifting responsibility for ulcer care to the elderly client if there is no recompense for the psychosocial care that the home care nurse provides. More specifically, elderly clients with chronic illness may suffer more depression, for example, if they do not receive the emotional support they may need to effectively cope with chronic illness. Thus, home care nurses must be cautious in their application of self-care philosophy in circumstances

where elderly client's are coping with chronic illness; they must carefully consider how the client's need for emotional support will be met.

This study's findings in relation to the appraisal aspect of the chronic venous leg ulcer experience indicate that the nurse must recognize that clients will perceive their leg ulcers in different ways; for one client they may be devastating, and not for another. As well, the nurse might be able to predict, to a certain degree, the meaning a client might assign to a leg ulcer if s/he has done an assessment in relation to the client's sources of satisfaction in life. For example, the nurse can anticipate that a client might find a leg ulcer detrimental if that client derives a great deal of satisfaction in life from partaking in recreational activities and now is no longer able to do so.

With regard to the study's findings in relation to the coping aspect of the chronic venous leg ulcer experience, the nurse must recognize that clients will cope in different ways depending on the significance they have attached to their chronic venous leg ulcer. As well, their coping strategies might represent an enduring style of coping that may be effective or ineffective in the chronic venous leg ulcer situation. If coping is ineffective, the nurse may need to help the client explore alternate coping strategies that may be more effective for that individual. In terms of the specific coping strategy which the researcher has termed "being vigilant", if a client is vigilant with regard to the care of their leg ulcers and, at times, critical of the nurse, the nurse needs to be aware that the client is probably not involved in a personal attack against the nurse, but rather the criticism is one aspect of that coping strategy. Finally, the theory of self-transcendence provides a rationale for the nurse to attend to the spiritual and psychosocial expressions of self-transcendence in the older adult client (Reed, 1991b). Potential nursing approaches to helping clients expand self-boundaries include making use of practices

such as meditation, self-reflection, visualization, religious expression, journal keeping, and life review (Reed, 1991b).

To date, basic nursing education in relation to the client with a wound has focused primarily on treatment of the wound. The findings of this study indicate that basic nursing students need to be educated to approach the client with a wound in a very holistic way; that is, they need to know how to assess and intervene in relation to both the physical aspects of wound care and psychosocial aspects of the client's care. With regard to learning what holistic nursing care would mean for the older adult with a chronic venous leg ulcer, nursing students would benefit from a course that addressed issues related to the older adult's experience with a chronic illness. This course would need to explore topics related to: the chronic illness experience, coping and adaptation in relation to chronic illness, physiological changes associated with aging, social-cognitive and transpersonal development in older adulthood, the theory of self-transcendence, and loss and grieving in older adulthood. In addition, students would benefit from examining Kleinman's (1978) explanatory model of transactions in health care relationships and discussing how the nurse explores the client's explanatory model in relation to a sickness episode. Clinical experiences in relation to care of the chronically ill elderly in home, intermediate care, and extended care settings would provide the student with insight into the older adult's experience of living with a chronic illness.

With regard to continuing education, the findings of this study suggest that home care nurses might benefit, as well, from an exploration of Kleinman's (1978) explanatory model of transactions in health care relationships if they did not have an opportunity to explore a theoretical framework such as this in their basic nursing program.

Furthermore, workshops might be conducted in which home care nurses examine some

of the issues that appear to be relevant to the older adult's experience of living with a chronic venous leg ulcer. For example, issues in relation to loss and grieving and self-transcendence in older adulthood could be explored.

In terms of research, epidemiological studies need to be conducted with regard to the prevalence of chronic venous leg ulcers in the older adult population as prevalence estimates that are available paint a very confusing picture. As well, further research is needed to achieve greater understanding with regard to the experience of living with a chronic venous leg ulcer. For example, more qualitative studies such as this one need to be conducted with the purpose of exploring the older adult's experience of living with a chronic venous leg ulcer. It is recommended that larger sample sizes be used, however, in an attempt to ensure scientific adequacy of the research. Quantitative studies need to be conducted in relation to the appraisal and coping aspects of the chronic venous leg ulcer experience. With regard to appraisal, the mediating factors that influence the appraisal process need to be further explored with particular attention given to the mediating factor that was discovered in this study, that being whether or not the chronic venous leg ulcer impacts negatively on a primary source of satisfaction. As well, it would be of benefit to study older adults who are experiencing depression in relation to their chronic venous leg ulcers to determine if, in fact, a primary source of satisfaction has been negatively affected by their circulatory disorder, or if there are other significant reasons for their depression. Additional research also needs to be conducted in relation to coping strategies that are used by older adults who are living with chronic venous leg ulcers. For example, a quantitative study could be conducted which compares the coping strategies of those older adults with chronic venous leg ulcers who have adapted to their illness with those individuals who have not adapted. Furthermore, the notion that

individuals have enduring coping styles needs to be further explored. Finally, further research needs to be done in relation to self-transcendence in the older adult as this phenomenon has the potential of significantly impacting the mental health and well-being of elderly clients who are living with a chronic circulatory condition.

In conclusion, this study has described the chronic venous leg ulcer experience from the perspective of the older adult. The findings of this study will contribute to nurses' understanding of what it is like to live with a chronic venous leg ulcer and will enable them to provide nursing care that is sensitive to the client's needs.

## REFERENCES

- Albert, M., & Moody, K. (1990). Assisting elders to care for wounds. Home Health Care Services Quarterly, 11(3/4), 91-155.
- Beck, C.T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. Western Journal of Nursing Research, 15(2), 263-266.
- Beauregard, S., & Gilchrest, B.A. (1987). A survey of skin problems and skin care regimens in the elderly. Archives of Dermatology, 123, 1638-1643.
- Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. Advances in Nursing Science, 8(1), 1-14.
- Browne, G., Byrne, C., Brown, B., Pennock, M., Streiner, D., Roberts, R., Eyles, P., Truscott, D., & Dabbs, R. (1985). Psychosocial adjustment of burn survivors. Burns, 12(1), 28-35.
- Bruyn, S.R. (1966). The human perspective in sociology. Englewood-Cliffs, New Jersey: Prentice-Hall.
- Burckhardt, C.S. (1985). The impact of arthritis on quality of life. Nursing Research, 34(1), 11-16.
- Burckhardt, C.S., Woods, S.L., Schultz, A.A., & Ziebarth, D.M. (1989). Quality of life of adults with chronic illness: A Psychometric Study. Research in Nursing & Health, 12, 347-354.
- Callam, M.J., Ruckley, C.V., Harper, D.R., & Dale, J.J. (1985). Chronic ulceration of the leg: Extent of the problem and provision of care. British Medical Journal, 290, 1855-1856.
- Callam, M.J., Harper, D.R., Dale, J.J., & Ruckley, C.V. (1988). Chronic leg ulceration: Socio-economic aspects. Scottish Medical Journal, 33, 360-362.
- Cohen, A. (1991). Body image in the person with a stoma. Journal of Enterostomal Therapy, 18(2), 68-71.
- Cohen, F., & Lazarus, R.S. (1983). Coping and adaptation in health and illness. In D. Mechanic (Ed.), Handbook of Health, Health Care and the Health Professions. New York: The Free Press.
- Coon, W.W., Willis, P.W., & Keller, J.B. (1973). Venous thromboembolism and other venous disease in the Tecumseh community health study. Circulation, 48, 839-846.



- Craig, H.M. & Edwards, J.E. (1983). Adaptation in chronic illness: An eclectic model for nurses. Journal of Advanced Nursing, 8, 397-404.
- Dale, J.J., Callam, M.J., Ruckley, C.V., Harper, D.R., & Berrey, P.N. (1983). Chronic ulcers of the leg: A study of prevalence in a Scottish community. Health Bulletin, 41(6), 310-314.
- David, J.A. (1986). Wound management: A comprehensive guide to dressing and healing. London, England: Martin Dunitz.
- Davis, A.J. (1978). The phenomenological approach in nursing research. In N. Chaska (Ed.), The nursing profession: Views through the mist (pp. 186-196). New York: McGraw-Hill.
- Dlin, B.M., & Perlman, A. (1971). Emotional response to ileostomy and colostomy in patients over the age of 50. Geriatrics, 26, 113-118.
- Downe-Wamboldt, B. (1991). Coping and life satisfaction in elderly women with osteoarthritis. Journal of Advanced Nursing, 16, 1328-1335.
- Doyle, G.E. (1983). All leg ulcers are not alike: Managing & preventing arterial & venous ulcers. Nursing83, 13, 58-63.
- Esberger, K. (1978). Body image. Journal of Gerontological Nursing, 4(4), 35-38.
- Falvo, D.R. (1991). Medical and psychosocial aspects of chronic illness and disability. Gaithersburg, Maryland: Aspen Publishers.
- Feldman, D.L. (1974). Chronic disabling illness: A holistic view. Journal of Chronic Disease, 27, 16-27.
- Field, P.A., & Morse, J.M. (1985). Nursing research: The application of qualitative approaches. Rockville, Maryland: Aspen Publishers.
- Fitzpatrick, J.E. (1989). Stasis ulcers: Update on a common geriatric problem. Geriatrics, 44(10), 19-31.
- Giorgi, A. (1975). An application of phenomenological method in psychology. In A. Giorgi, C. Fischer & E. Murray (Eds.), Duquesne studies in phenomenological psychology: Vol.2. (pp. 83-103). Pittsburgh: Duquesne University.
- Gloeckner, M.R. (1984). Perceptions of sexual attractiveness following ostomy surgery. Research in Nursing and Health, 7, 87-92.
- Guba, E.G., & Lincoln, Y.S. (1981). Effective evaluation. San Francisco: Jossey-Bass.

- Haase, J.E., Britt, T., Coward, D.D., Leidy, N.K., & Penn, P.E. (1992). Simultaneous concept analysis of spiritual perspective, hope, acceptance and self-transcendence. IMAGE: Journal of Nursing Scholarship, 24(2), 141-147.
- Hall, J.M., & Stevens, P.E. (1991). Rigor in feminist research. Advances in Nursing Science, 13(3), 16-29.
- Hurny, C.H., & Holland, J. (1985). Psychosocial sequelae of ostomies in cancer patients. Ca-A Cancer Journal for Clinicians, 35(3), 170-183.
- Hutchinson, S. (1986). Grounded theory: The method. In P.L. Munhall & C.J. Oiler (Eds.), Nursing research: A qualitative perspective (pp. 111-130). Norwalk, Connecticut: Appleton-Century-Crofts.
- Ignatavicius, D.D., & Bayne, M.V. (1991). Medical-surgical nursing: A nursing process approach. Philadelphia: W.B. Saunders.
- Janelli, L.M. (1986a). Body image in older adults: A review of the literature. Rehabilitation Nursing, 11(4), 6-8.
- Janelli, L.M. (1986b). The realities of body image. Journal of Gerontological Nursing, 12(10), 23-27.
- Kleinman, A. (1978). Concepts and a model for the comparison of medical systems as cultural systems. Social Science and Medicine, 12, 85-93.
- Klopp, A.L. (1990). Body image and self-concept among individuals with stomas. Journal of Enterostomal Therapy, 17(3), 98-105.
- Knaack, P. (1984). Phenomenological research. Western Journal of Nursing Research, 6(1), 107-114.
- Kunimoto, B.T. (1991). How to manage venous leg ulcers. The Canadian Journal of Continuing Medical Education, 3, 45-53.
- Laborde, J.M., & Powers, M.J. (1985). Life satisfaction, health control orientation, and illness-related factors in persons with osteoarthritis. Research in Nursing & Health, 8, 183-190.
- Lambert, C.E., & Lambert, V.A. (1987). Psychosocial impacts created by chronic illness. Nursing Clinics of North America, 22(3), 527-533.
- Lamont, L.J. (1991). Venous ulcers: A nursing challenge. Journal of the American Academy of Nurse Practitioners, 3(4), 158-165.
- Lanyon, S., Van Nieuwenhuyzen, J., & Wearing, J. (1987). Leg ulcers: Frustration or challenge? The Canadian Nurse, 83(6), 33-36.

- Lazarus, R.S., & Folkman, S. (1984). Stress, appraisal and coping. New York: Springer.
- Lipowski, Z.J. (1969). Psychosocial aspects of disease. Annals of Internal Medicine, 71(6), 1197-1206.
- Livingston, J. (1971). Modern Christian thought. New York: Macmillan.
- McHaffie, H.E. (1992). Coping: An essential element of nursing. Journal of Advanced Nursing, 17, 933-940.
- Merry, G.M. (1989). Management of foot and leg ulcers. Drug Protocol, 4(6), 28-32.
- Morse, J.M. (1986). Quantitative and qualitative research: Issues in sampling. In P.L. Chinn (Ed.), Nursing research methodology: Issues and implementation (pp. 181-193). Rockville, Maryland: Aspen Publishers.
- Oiler, C.J. (1986). Phenomenology: The method. In C.J. Oiler and P.L. Munhall (Eds.), Nursing research: A qualitative perspective (pp. 69-84). Norwalk, Connecticut: Appleton-Century-Crofts.
- Omery, A. (1983). Phenomenology: A method for nursing research. Advances in Nursing Science, 5(2), 49-63.
- Orbach, C.E., & Tallent, N. (1965). Modifications of perceived body and of body concept. Archives of General Psychiatry, 12, 126-135.
- Pallikkathayil, L., & Morgan, S.A. (1991). Phenomenology as a method for conducting clinical research. Applied Nursing Research, 4(4), 195-200.
- Peck, M.S. (1978). The road less traveled: A new psychology of love, traditional values and spiritual growth. New York: Simon & Schuster.
- Prebble, S.M. (1990). The patient with leg ulcers: Essential points of nursing. Geriatric Medicine, 20, 41-44.
- Reed, P.G. (1991a). Self-transcendence and mental health in oldest-old adults. Nursing Research, 40(1), 5-11.
- Reed, P.G. (1991b). Toward a nursing theory of self-transcendence: Deductive reformulation using developmental theories. Advances in Nursing Science, 13(4), 64-77.
- Riemen, D.J. (1986). The essential structure of a caring interaction: Doing phenomenology. In C.J. Oiler and P.L. Munhall (Eds.), Nursing research: A qualitative perspective (pp. 85-108). Norwalk, Connecticut: Appleton-Century-Crofts.

- Rolstad, B.S. (1991). Treatment objectives in chronic wound care. Home Healthcare Nurse, 9(6), 38-44.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.
- Schneider, J. (1984). Stress, Loss, and Grief: Understanding Their Origins and Growth Potential. Baltimore: University Park Press.
- Shipes, E. (1987). Psychosocial issues: The person with an ostomy. Nursing Clinics of North America, 22(2), 291-302.
- Sutherland, A.M., Orbach, C.E., Dyk, R.B., & Bard, M. (1952). The psychological impact of cancer and cancer surgery. I. Adaptation to the dry colostomy: preliminary report and summary of findings. Cancer, 5, 857-872.
- Tretbar, L.L. (1987). Chronic venous insufficiency of the legs: Pathogenesis of venous ulcers. Journal of Enterostomal Therapy, 14(3), 105-108.
- Ward, H.W., Moss, R.L., Darko, D.F., Berry, C.C., Anderson, J., Kolman, P., Green, A., Nielsen, J., Klauber, M., Wachtel, T.L., & Frank, H. (1987). Prevalence of postburn depression following burn injury. Journal of Burn Care & Rehabilitation, 8(4), 294-298.
- Watkins, P.N., Cook, E.L., May, S.R., & Ehleben, C.M. (1988). Psychological stages in adaptation following burn injury: A method for facilitating psychological recovery of burn victims. Journal of Burn Care & Rehabilitation, 9(4), 376-384.
- White, N.E., Richter, J.M., & Fry, C. (1992). Coping, social support, and adaptation to chronic illness. Western Journal of Nursing Research, 14(2), 211-224.

## APPENDIX A

### ARTERIAL AND VENOUS LEG ULCERS: A SUMMARY COMPARISON

	ARTERIAL ULCERS	VENOUS ULCERS
<b>Predisposing factors</b>	<ul style="list-style-type: none"> <li>. arteriosclerosis</li> <li>. advanced age</li> <li>. diabetes mellitus</li> </ul>	<ul style="list-style-type: none"> <li>. history of deep vein thrombophlebitis</li> <li>. valvular incompetence in the perforating veins</li> </ul>
<b>Associated changes in leg or foot</b>	<ul style="list-style-type: none"> <li>. thin, shiny, dry skin</li> <li>. thickened nails</li> <li>. absence of hair growth</li> <li>. temperature variations</li> <li>. pallor on elevation</li> <li>. dependent rubor</li> <li>. pedal pulses usually absent</li> </ul>	<ul style="list-style-type: none"> <li>. firm ("brawny") tissue related to long-standing edema and superimposed cellulitis</li> <li>. reddish brown discoloration</li> <li>. typical "bottle leg" or gaiter area</li> <li>. dilated and tortuous superficial veins</li> <li>. pedal pulses usually present</li> </ul>
<b>Ulcer location</b>	<ul style="list-style-type: none"> <li>. between toes or at tip of toes</li> <li>. over phalangeal heads</li> <li>. on heel</li> <li>. above lateral malleolus</li> <li>. (for diabetic persons) over metatarsal heads, on side or sole of foot</li> </ul>	<ul style="list-style-type: none"> <li>. anteromedial malleolus</li> <li>. pretibial area</li> </ul>
<b>Ulcer characteristics</b>	<ul style="list-style-type: none"> <li>. well-demarcated edges</li> <li>. black or necrotic tissue</li> <li>. deep, pale base</li> </ul>	<ul style="list-style-type: none"> <li>. uneven edges</li> <li>. ruddy granulation tissue</li> <li>. superficial</li> </ul>
<b>Pain</b>	<ul style="list-style-type: none"> <li>. extreme: decreases with leg dependency, increases with cool environment or elevation of leg</li> </ul>	<ul style="list-style-type: none"> <li>. moderate: increases with leg dependency, decreases with cool environment or elevation of leg</li> </ul>

#### **NOTE:**

Some arterial insufficiency may be present with venous leg ulcer but history and clinical presentation indicate that venous insufficiency is primary etiology.

#### **REFERENCE:**

Doyle, J.E. (1983). All leg ulcers are not alike: Managing & preventing arterial & venous ulcers. Nursing83, 13, 58-63.

**APPENDIX B****INFORMATION FOR BURNABY HEALTH DEPARTMENT HOME CARE NURSES****Title Of Study:**

**"When A Leg Ulcer Becomes Chronic: A Phenomenological Study Of The Older Adult's Experience Of Living With A Chronic Venous Leg Ulcer"**

**Purpose Of Study:**

**The purpose of this study is to explore and describe the experience of the older adult who is living with a chronic venous leg ulcer.**

**Investigator:**

**Kathleen Liebelt, R.N., M.S.N. Student, Phone: xxx-xxxx**

**Faculty Advisor (U.B.C. School Of Nursing):**

**Sally Thorne, R.N., Ph.D., Phone: xxx-xxxx**

**Procedure For Recruitment Of Participants:**

**The home care nurse will:**

- 1. identify a potential participant for the study (see criteria for selection of participants below)**
- 2. explain the purpose of the study to the potential participant and ask permission for the investigator to contact the client by telephone**
- 3. inform the home care coordinator of a potential participant if the client agrees to speak with the investigator**

**The home care coordinator will:**

- 1. contact the investigator with the name and telephone number of a potential participant**

**Criteria For Selection Of Participants**

1. 65 years of age or older
2. male or female
3. resides in a house or apartment
4. understands and speaks English and is able to communicate experiences
5. has been diagnosed as having a chronic venous leg ulcer by a home care nurse or physician (see definition of chronic venous leg ulcer below)
6. is visited by a home care nurse at least once per week for treatment of a chronic venous leg ulcer and has been visited for at least two months
7. does not have a coexisting physiological/psychological condition that would significantly alter the client's perception of the experience of living with a chronic venous leg ulcer or impact significantly on the lived experience (e.g. delusional thinking; paraplegia; chronic respiratory difficulty that the individual is continually aware of and trying to manage)

**CHRONIC VENOUS LEG ULCER:****Definition**

Tissue damage manifesting as an ulceration or open lesion of the skin of a lower extremity, related primarily to venous insufficiency. The ulceration is of at least two month's duration and has been treated by a home care nurse at least once per week for a minimum of two months.

**Diagnosis**

The diagnosis of a venous leg ulcer is made by a home care nurse or physician and is based on clinical presentation and client history data that would indicate that the leg ulcer is relate primarily to venous insufficiency. Additionally, as part of the diagnostic process, the possibility that the leg ulcer is related primarily to arterial insufficiency is ruled out.

**Diagnostic Guide**

See attached document outlining a summary comparison of characteristics of arterial and venous leg ulcers. This document may be used as a guide in the diagnostic process but its use is not required.

## **DIAGNOSTIC GUIDE**

### **ARTERIAL AND VENOUS LEG ULCERS: A SUMMARY COMPARISON**

	<b>ARTERIAL ULCERS</b>	<b>VENOUS ULCERS</b>
<b>Predisposing factors</b>	<ul style="list-style-type: none"> <li>. arteriosclerosis</li> <li>. advanced age</li> <li>. diabetes mellitus</li> </ul>	<ul style="list-style-type: none"> <li>. history of deep vein thrombophlebitis</li> <li>. valvular incompetence in the perforating veins</li> </ul>
<b>Associated changes in leg or foot</b>	<ul style="list-style-type: none"> <li>. thin, shiny, dry skin</li> <li>. thickened nails</li> <li>. absence of hair growth</li> <li>. temperature variations</li> <li>. pallor on elevation</li> <li>. dependent rubor</li> <li>. pedal pulses usually absent</li> </ul>	<ul style="list-style-type: none"> <li>. firm ("brawny") tissue related to long-standing edema and superimposed cellulitis</li> <li>. reddish brown discoloration</li> <li>. typical "bottle leg" or gaiter area</li> <li>. dilated and tortuous superficial veins</li> <li>. pedal pulses usually present</li> </ul>
<b>Ulcer location</b>	<ul style="list-style-type: none"> <li>. between toes or at tip of toes</li> <li>. over phalangeal heads</li> <li>. on heel</li> <li>. above lateral malleolus</li> <li>. (for diabetic persons) over metatarsal heads, on side or sole of foot</li> </ul>	<ul style="list-style-type: none"> <li>. anteromedial malleolus</li> <li>. pretibial area</li> </ul>
<b>Ulcer characteristics</b>	<ul style="list-style-type: none"> <li>. well-demarcated edges</li> <li>. black or necrotic tissue</li> <li>. deep, pale base</li> </ul>	<ul style="list-style-type: none"> <li>. uneven edges</li> <li>. ruddy granulation tissue</li> <li>. superficial</li> </ul>
<b>Pain</b>	<ul style="list-style-type: none"> <li>. extreme: decreases with leg dependency, increases with cool environment or elevation of leg</li> </ul>	<ul style="list-style-type: none"> <li>. moderate: increases with leg dependency, decreases with cool environment or elevation of leg</li> </ul>

#### **NOTE:**

Some arterial insufficiency may be present with venous leg ulcer but history and clinical presentation indicate that venous insufficiency is primary etiology.

#### **REFERENCE:**

Doyle, J.E. (1983). All leg ulcers are not alike: Managing & preventing arterial & venous ulcers. Nursing83, 13, 58-63.



**APPENDIX C****INTRODUCTORY LETTER**

**My name is Kathleen Liebelt. I am a Registered Nurse and a student in the Master of Science in Nursing program at the University of British Columbia. I am interested in learning about the experience of older adults who are living with longstanding leg ulcers. It is important for nurses to understand what life is like for individuals in this situation so that appropriate nursing care can be planned.**

**My study will involve:**

- 1. two interviews, each lasting from thirty to sixty minutes, conducted in your home at your convenience;**
- 2. a discussion of what it is like for you to live with a longstanding leg ulcer;**
- 3. audiotaped recording of the interviews.**

**All the information that you share with me will be confidential. Your name will not appear on the audiotapes, any transcripts, or the completed study. Access to the audiotapes and typed transcripts will be limited to my thesis advisors, my typist, and me. The audiotapes and transcripts will be destroyed when all scholarly reports have been written.**

**Your participation in this study is strictly voluntary and your refusal to participate will not affect any care you currently receive or may require. If you agree to participate in the study, you may refuse to answer any questions asked, request to have information removed from the audiotape, or withdraw from the study at any time. Again, this will in no way jeopardize the care that you currently receive or may require.**

**If you have any questions about the study or the interviews, please feel free to contact me or my faculty advisor at the telephone numbers listed below.**

**Thank you.**

**Kathleen Liebelt, R.N., B.S.N.**

**Kathleen Liebelt, R.N., B.S.N., xxx-xxxx  
Sally Thorne, R.N., Ph.D., Faculty Advisor, xxx-xxxx**

**APPENDIX D****PARTICIPANT CONSENT FORM****Title Of The Study:**

**"The Older Adult's Experience Of Living With A Longstanding Leg Ulcer"**

**Purpose Of The Study:**

The purpose of this study is for the investigator to explore and describe the older adult's experience of living with a longstanding leg ulcer.

**Investigator:**

**Kathleen Liebelt, R.N., B.S.N. - Telephone: xxx-xxxx**  
Graduate Student in Nursing; School of Nursing,  
University of British Columbia

**I understand the purpose of this study, as outlined above, and I understand that this study involves:**

- 1. two visits to my home by Kathleen Liebelt for interviews that will last from thirty to sixty minutes each;**
- 2. discussion of what it is like for me to live with a longstanding leg ulcer;**
- 3. audiotaped recordings of the interviews.**

**I understand that the information that I share with the investigator will be confidential and that my name will not appear on the audiotapes, transcripts, or scholarly reports. As well, I understand that all information will be destroyed once scholarly reports have been written.**

**I understand that my participation in this study is voluntary. I may refuse to answer any questions asked, request to have information removed from the audiotape, or withdraw from the study at any time. I understand that my refusal in any of these areas would not jeopardize any care that I currently receive or may require in the future.**

**I consent to participate in this study as explained by the investigator and acknowledge receipt of an introductory letter and a copy of this consent form.**

**Date \_\_\_\_\_**

**Signature \_\_\_\_\_**

**APPENDIX E****INTERVIEW GUIDE**

**I understand that you have been living with this leg ulcer for some time now.**

- . What has this been like for you?**
- . What has it been like to live with an ulcer that is taking a long time to heal?**
- . If you have looked at the ulcer, how do you feel about the way it looks?**
- . In what ways has this leg ulcer affected your daily life? If daily life has been affected, how does this make you feel? How have you dealt with the changes in your life?**
- . Is there anything that you can't do now that you would like to do?**
- . What is your major concern now in terms of living with this leg ulcer?**
- . What is it like for you to talk with me about your experience of living with this leg ulcer?**