

LOSS AS EXPERIENCED BY SPOUSES  
OF  
MYOCARDIAL INFARCTION PATIENTS

by

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This exploratory study examined the phenomenon of loss as expressed by the spouses of myocardial infarction patients. The purpose of the study was to describe the thoughts, feelings, actions and observable behaviours of the spouses from the initial impact of illness to six weeks post myocardial infarction and to develop a framework, based on the literature, which related the concept of loss to the experience of spouses of M.I. patients.

The study was conducted with a convenience sample of 12 spouses, ten women and two men, whose partners had experienced their first myocardial infarction. Using a semi-structured interview guide with open-ended questions, the investigator interviewed each subject four times over a six week period; from the initial impact of illness to approximately six weeks post myocardial infarction. Each interview covered three content areas: thoughts, feelings and actions. Broad open-ended questions were used to elicit data on the spouses thoughts, feelings and actions. During the interview the investigator observed the verbal (type, quality, characteristics of speech, focus of conversation) and non-verbal (activity, eye contact, body language, appearance) behaviours of the spouses.

An empirical inductive approach was used as the methodology for this study. Data coding and analysis were approached using the constant comparative method, an inductive method of discovering grounded theory developed by Glaser and Strauss (1967). The findings

revealed that the spouses experienced behaviours in response to loss that were common and formed a pattern through time. Three distinct phases were identified: Phase I The Event and Initial Spousal Response; Phase II Reaction to the Event; Phase III Impact of the Event. The phases were described further in light of the constructs formulated from the literature review: (1) Reactions to Loss; (2) The Elements of Loss; (3) The Meaning of Loss.

This study was designed to provide insight into understanding the event of a myocardial infarction within the context of the phenomenon of loss. The findings supported the use of a loss framework for assessing the reactions of spouses who are threatened with the death of their partner. Nurses are in a critical position to assist spouses experiencing loss. Implications and recommendations for nursing education, practice and research were delineated in light of the conclusions of the present study.

# TABLE OF CONTENTS

v

Page

ABSTRACT . . . . .	iii
TABLE OF CONTENTS . . . . .	v
LIST OF TABLES . . . . .	ix
LIST OF FIGURES . . . . .	x
ACKNOWLEDGEMENTS . . . . .	xi

## CHAPTER 1

Introduction . . . . .	1
Background of the Study . . . . .	1
Significance of the Study . . . . .	1
Statement of the Problem . . . . .	2
Assumptions . . . . .	3
Limitations . . . . .	3
Definition of Terms . . . . .	4

## CHAPTER 2

Review of the Related Literature . . . . .	6
Reactions to Loss . . . . .	6
The Elements of Loss . . . . .	16
The Meaning of Loss . . . . .	17
Nursing Studies Related to Loss . . . . .	19
Reactions to Loss by Spouses of Myocardial Infarction Patients	22
Summary . . . . .	28

## TABLE OF CONTENTS (Continued)

vi

Page

## CHAPTER 3

Methodology . . . . .	30
Introduction: An Overview . . . . .	30
The Research Setting . . . . .	32
Sample Selection . . . . .	32
Data Collection . . . . .	34
Data Coding and Analysis . . . . .	40
Reliability and Validity Issues . . . . .	41

## CHAPTER 4

Findings of the Study . . . . .	44
PHASE I The Event and Initial Spousal Response . . . . .	44
PHASE I--Thoughts . . . . .	45
PHASE I--Feelings . . . . .	52
PHASE I--Actions . . . . .	56
PHASE II Reaction to the Event . . . . .	62
PHASE II--Thoughts . . . . .	62
PHASE II--Feelings . . . . .	69
PHASE II--Actions . . . . .	71
PHASE III Impact of the Event . . . . .	75
PHASE III--Thoughts (Group A Findings) . . . . .	75
PHASE III--Feelings . . . . .	78
PHASE III--Actions . . . . .	82
PHASE III (Group B Findings) . . . . .	84
PHASE III--Thought . . . . .	85

# TABLE OF CONTENTS (Continued)

vii

Page

PHASE III--Feelings . . . . .	88
PHASE III--Actions . . . . .	89
Summary . . . . .	93

## CHAPTER 5

Discussion . . . . .	94
PHASE I The Event and Initial Spousal Response . . . . .	94
PHASE II Reaction to the Event . . . . .	104
PHASE III Impact of the Event (Group A) . . . . .	108
PHASE III Impact of the Event (Group B) . . . . .	115
Summary . . . . .	118

## CHAPTER 6

Summary, Conclusions, Implications and Recommendations . . . . .	119
Overview of the Study . . . . .	119
A Loss Framework . . . . .	122
Implications . . . . .	124
Recommendations . . . . .	129

BIBLIOGRAPHY . . . . .	130
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## APPENDICES

Appendix A: Consent Form . . . . .	135
Appendix B: Information Relted to Cardiac Research Study . . . . .	137
Appendix C: Data Collection Tool . . . . .	139

# TABLE OF CONTENTS (Continued)

viii

Page

Appendix D: Sample of Data Coding and Analysis Procedure . .	141
Appendix E: Overview of the Findings . . . . .	143
Appendix F: Overview of the Interpretation of the Findings .	145



# LIST OF TABLES

ix

Page

Table 1	Age and Sex of Patients and Spouses . . . . .	35
2	Number of Days after Myocardial Infarction that Interview Took Place . . . . .	38

## LIST OF FIGURES

x

	Page
Figure 1 The Meaning of Loss . . . . .	109
2 A Loss Framework for Spouses of Myocardial Infarction Patients . . . . .	125

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# CHAPTER 1

## INTRODUCTION

### Background of the Study

Nurses in their practice are continually caring for patients and family members who have faced some degree of loss ranging from a minor disruption to the death of a loved one. This study used a phenomenological approach to examine loss as expressed by the spouses of myocardial infarction (M.I.) patients. Because of the importance of the patient's relationship to a spouse, the need to examine further the impact of the patient's illness upon M.I. spouses provided the impetus for this study.

### Significance of the Study

Nurses have many opportunities to help persons anticipating, or already experiencing loss (Carlson, 1978). Studies have shown that a myocardial infarction has considerable influence on the spouse, usually the wife, and her reactions, capacities and attitudes are generally critical to the patient's rehabilitation (Gulledge, 1975).

Little research was found, however, which related the phenomenon of loss to spouses of myocardial infarction patients. A need to identify reactions that spouses experienced in response to loss was evident. This knowledge may assist the nurse in providing spouses with the necessary guidance and support with subsequent beneficial effect on the patient.

### Statement of the Problem

Loss was described as "a state of being deprived of or of being without something one has had" (Peretz, 1970, p. 4).

While differences in the magnitude of loss may change the quality of the subsequent emotional reactions, there was considerable evidence to suggest similarities in the recovery process following major losses (Bowlby, 1961; Engel, 1962; Fink, 1967; Kubler-Ross, 1969, Parkes, 1972; Shontz, 1975).

Further, a number of additional studies have verified that spouses of myocardial infarction patients react significantly to their partner's illness, as evidenced by anxiety, guilt, depression, hostility and overprotective behaviour (Adsett and Bruhn, 1968; Royle, 1973; Crawshaw, 1974; Larter, 1976). Therefore, for the nurse practitioner, more knowledge was required of spousal behaviour in order to better understand the phenomena of loss, and thus care more effectively for heart attack patients.

Within the context of this problem statement, the purpose of this study was:

- to elicit descriptions from spouses of M.I. patients of their reactions in response to loss from the initial impact of illness to six weeks post myocardial infarction.
- to observe spousal reactions in response to loss from the initial impact of illness to six weeks post myocardial infarction;
- to develop a framework, based on literature, which related the concept of loss to the experience of spouses of M.I. patients;

- to make recommendations for change in nursing education, practice and research drawn from the study.

### Assumptions

It is assumed that the husband-wife dyad is significant and that loss experienced by one person in the relationship has considerable impact on the partner (Lindemann, 1944; Marris, 1958; Parkes, 1969). Spouses of heart attack patients share common needs and concerns in response to their partner's illness (Adsett and Bruhn, 1968; Royle, 1973; Skelton and Dominian, 1973; Larter, 1976; Mayou, Foster and Williamson, 1978). The spouse's reactions, capacities and attitudes are generally critical in the M.I. patient's rehabilitation.

It is also assumed M.I. spouses experience similar reactions to loss. These generalizations about a phenomenon can provide nurses with knowledge and direction for practice. However, adequate recognition of individual differences among spouses in response to a loss event such as a heart attack were acknowledged.

### Limitations

The emphasis of the study was on qualitative data rather than on relationships between variables. The purpose was to discover and describe loss as experienced by spouses of M.I. patients rather than prove or disprove a given hypothesis.

The selected sample was limited to spouses whose partners had experienced their first myocardial infarction. A convenient

non-random sample of twelve spouses was selected. No attempts were made at representativeness in the statistical sense.

### Definition of Terms

The following terms are operationally defined in the discussion of the data presented.

#### Reactions

The thoughts, feelings and actions as described by the spouses of myocardial infarction patients.

#### Observable behaviours

The responses of the spouses as observed by the investigator during the interview. These responses are categorized as verbal (type, quality and characteristics of speech, focus of conversation) and nonverbal (e.g. activity, eye contact, body language and appearance).

#### Loss

The deprivation of any object, person, possession or ideal that was considered valuable and had an investment of self. Loss was considered actual, potential or symbolic (Pranulis, 1972). Loss could be total, partial, permanent, temporary, predictable, unpredictable, sudden or gradual (Peretz, 1970). Loss was understood as having an objective quality related to an event and a subjective quality related to the meaning given a loss event by an individual.

#### Grief

The psychological, emotional and somatic responses experienced following the perception of loss. Reactions include feelings of shock

and disbelief, helplessness, hopelessness, anxiety, sadness, guilt, despair, anger and aggression (Lindemann, 1944; Engel, 1962; Kubler-Ross, 1969; Parkes, 1972). Somatic symptoms include dyspnea, deep sighing, lumps or tight sensation in the throat, weakness, feelings of emptiness, exhaustion, decreased appetite and insomnia (Lindemann, 1944; Peretz, 1970).

#### Initial impact of illness

The first ninety-six hours of the patient's myocardial infarction. This time represents the acute phase of the patient's illness and occurs during the hospitalization period in the coronary care unit (Roberts, 1978).

#### Patient with an uncomplicated myocardial infarction

A patient admitted to the coronary care unit with a diagnosis of myocardial infarction who responds favourably to the prescribed coronary regime. The patient maintains a stable physiological status and does not develop cardiac failure, thromboembolism, extension of infarction, shock or cardiac rupture.



## CHAPTER 2

### REVIEW OF THE RELATED LITERATURE

A review of the literature revealed few discussions of the concept of loss as experienced by the spouses of myocardial patients. There were numerous empirical and theoretical - even controversial - studies of loss from an emotional, psychological and physiological perspective. This chapter will examine the concept of loss as found in the literature and will outline a framework for understanding the phenomenon of loss. The purpose of this theoretical background is to provide the intellectual context for the conduct of this study.

Loss has been studied extensively from a behavioural viewpoint: much of the loss research has emerged from clinical psychoanalysis and has been developed by psychiatrists and social psychiatrists (Freud, 1917; Lindemann, 1944; Marris, 1955; Bowlby, 1961; Engel, 1962; Parkes, 1969; Kubler-Ross, 1969). In the last two decades further research and theory have been developed focusing on some of the concepts central to loss (Marris, 1958; Parkes, 1965; Averill, 1968; Lipowski, 1969; Peretz, 1970; Schoenberg, 1970). More recently nurse researchers have studied the impact of illness on the spouse (Hampe, 1975; Vachon, 1977; Dracup and Breu, 1978).

#### Reactions to Loss

A person may experience grief and mourning regardless of the degree of loss or its implication (Freud, 1917; Bowlby, 1961;

Lipowski, 1969). To understand loss it is helpful to consider the behavioural response to loss, which often takes the form of a grief reaction.

The literature revealed differences in the use of the word grief and related terms. Grief, grieving, mourning, grief work, and bereavement were applied interchangeably: however, theorists commonly categorize grief and its related terms into three major components: the psychological processes, the emotional responses and the somatic symptoms experienced at the time of loss.

The historical development of loss began with the psychodynamic aspects of loss and grief. In 1917, Freud first published Mourning and Melancholia which viewed mourning as a regular characteristic following the loss of a loved one. Freud felt that mourning was a process that normally continued to a predictable outcome. The process of mourning was a continuum of mental features that were symptomatic to every person who grieved. These features were painful dejection, abrogation of interest in the outside world, loss of the capacity to love, and inhibition of all activity.

Freud felt, however, that if certain factors were present in the character structure of the grieving person, the process of mourning could turn into the pathological state of melancholia. He identified three factors that influenced this type of outcome: loss of self-esteem, strong dependency needs and ambivalence toward the lost object. According to Freud, the development of melancholia is not an exaggerated grieving process; rather it is a phenomenon which arises because of inherent traits in the individual.

Stemming from Freud's attempts to link mourning and melancholia, writers have studied the effects of bereavement in adult life as well as the effects of separating children from their mothers.

Lindemann (1944) published one of the most definitive papers on grief which described the characteristic signs of grief based on an American study of 101 bereaved. He described acute grief as a definite syndrome with psychological and somatic symptoms including somatic distress, preoccupation with the image of the deceased, guilt, hostile reactions, loss of habitual patterns of conduct, and with some frequency, the appearance of traits of the deceased. Lindemann found that persons in acute grief demonstrated quite a uniform picture and stated:

Common to all is the following syndrome: sensations of somatic distress occurring in waves lasting twenty minutes to an hour at a time, a feeling of tightness in the throat, choking with a shortness of breath, need for sighing, an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain (Lindemann, 1944, p. 141).

Lindemann found individuals moved through a course of normal grief reactions. He described this process as grief work, namely emancipation from the bondage to the deceased, readjustment to the environment in which the deceased is missing, and the formation of new relationships. He found duration of the grief reaction depended upon the success with which a person completed the grief work.

Lindemann was the first to describe the concept of anticipatory grief. In his study of families of servicemen who had departed for

war, he found that these individuals threatened with the loss of a loved one experienced genuine grief reactions which he labelled as anticipatory grief. Lindemann suggested that individuals who experienced anticipatory grief moved through the same process of grief work as those who experienced grief after an actual loss.

The patient is so concerned with her adjustment after the potential death of father or son that she goes through all the phases of grief depression, heightened preoccupation with the departed, a review of all the forms of death which might befall him and anticipation of the modes of readjustment which might be necessitated by it. (Lindemann, 1944, p. 147).

The reactions observed in Lindemann's (1944) study were similar to those described in bereaved individuals. Most of the reactions were associated with depression, somatic symptoms of exhaustion, lack of energy, sighing, respirations, and digestive symptoms. Other feelings of anger, irritability, guilt and restlessness were reported.

Lindemann noted that heightened preoccupation with the deceased was experienced by the bereaved as well as those anticipating the loss of a loved one. This need for intense preoccupation was first discussed by Freud (1917). He indicated that it was a method which enabled the individual to eventually give up the lost person. Werner (1970), in a study of fatally ill children, observed that the parents had an insatiable need to know everything about their child's condition. This search for information became an all consuming preoccupation. The child became a constant focus in their lives and little interest was shown for other activities.

Reviewing the forms of death that might befall the individual was

the third characteristic described by Lindemann. This reaction is similar to that experienced in an actual loss, where the bereaved reviewed the events leading up to and surrounding the death of a loved one (Marris, 1958; Parkes, 1972). Although Lindemann stressed the similarities between the reactions of the bereaved and the reactions of those anticipating a loss, an important difference was mentioned by Aldrich (1975). Conventional grief generally dissipates with time, whereas anticipatory grief will often intensify as the expected loss comes closer.

Several authors have studied the meaning of loss to individuals at various stages of the life cycle from infancy to senescence (Anthony, 1940; Piaget, 1952; Rochlin, 1959; Nagy, 1959; Bowlby, 1961; Gesson, 1968; Burnside, 1969). John Bowlby (1961) referred to mourning as the psychological processes that follow a loss of a significant or valued object, or that follow the realization that such a loss may occur. The working through of these processes usually leads to a giving up of the lost object. He has spelled out in great detail the way in which young children respond to the loss of a mother or mother substitute. Bowlby believed that the ego is developed before the age of one year and, therefore, the child is capable of mourning at an early age. In drawing a direct relationship between separation loss and grief, Bowlby argued that children and adults show similar responses to the experience of loss whether actual or anticipated.

Some writers have described phases or stages that follow the death of a loved one or major life-threatening event (Marris, 1958; Engel, 1962; Fink, 1967; Parkes, 1969; Kubler-Ross, 1969; Shontz, 1975).

Despite the theoretical and descriptive differences between the various approaches, these writers appeared to have many thoughts in common about the nature of grief. They described the same elements although they gave different "labels" to the phases or stages. Their grief theories have provided a framework for understanding the phenomenon of loss.

Marris (1958) described grieving or grief work as the psychological sequence or process required to adjust to loss. The process is evoked when abilities are threatened. Marris conducted a systematic study of the effect of bereavement on seventy-two London widows, ranging in age from 25 to 56. The widows complained of deterioration in health, insomnia, loss of contact with reality, obsessive memories and a sense of their dead husband's presence. Marris described the widows' prevailing mood as apathetic. He identified a characteristically ambivalent response in the behaviour of the bereaved where the women withdrew from people and tried to escape from all reminders of the loss yet in the same breath seemed desperately lonely and complained if people avoided them. The widows cultivated memories of the dead, desiring people to nurture those memories, yet rebuffed that sympathy when it was offered. They insisted that their life was meaningless now that they had lost their husbands, however, they hurried back to their jobs while caring for their children and homes with practical efficiency.

According to Marris, it is difficult for others to know how to assist the new widows: sympathy aggravates the distress; exhortations to be practical and look to the future seem glib and insensitive; solicitousness seems officious. Nothing seems right, causing friends

and family to withdraw further.

Closely linked to the works of Lindemann and Marris are the documented studies of grief in adult life by Colin Murray Parkes, (1965, 1972). Parkes has described grief reactions in detail, and has attempted to measure bereavement reactions using indicators such as rates of physical and mental illness along with mortality statistics. In 1959, following his dissertation on morbid grief reactions, Parkes (1965) began a systematic investigation of 115 bereaved psychiatric patients whose illness had developed within six months after the death of a close family member. He compared the reactions of the bereaved to typical grief reactions as described by Marris (1958) in his London widow study. Parkes found that his patients had symptoms that differed in intensity and duration which led him to classify grief into categories: typical grief, chronic grief, inhibited grief and delayed grief.

Subsequently, Parkes (1971) undertook a longitudinal study of the typical grief reactions of London widows to the death of their husbands. Parkes described the components of typical grief as alarm, searching, mitigation, anger, guilt and gaining a new identity. During the alarm phase, the widows reported restlessness and increased muscle tension, episodes of feeling panicky, irritability, insomnia, loss of appetite, stomach upsets, and headaches. Following the alarm phase, the widows experienced acute and episodic "pangs" which were episodes of severe anxiety and psychological pain. Parkes termed this phase searching, and found it occurred within a few hours or days of bereavement and usually reached a peak of severity within five to fourteen

days. The widows strongly missed their husbands, and would sob or cry aloud for them, often preoccupied with thoughts of the lost person. Parkes felt the widows experienced pining, "... the subjective and emotional component of the urge to search for a lost object" (Parkes, 1972, p. 40).

The third phase described is mitigation, which many of the widows achieved by maintaining a feeling or impression that the bereaved person is nearby, although he may not be seen or heard. The widows felt the pain was lessened if they had a clear sense of the continued presence of the deceased and became preoccupied with the thoughts of him. An opposite reaction was observed with other widows, who chose to mitigate the pain by denial. They tried to believe that the loss had not occurred and attempted to avoid people and situations that would remind them of the loss.

Parkes found that most widows expressed anger at some time during the first year of bereavement. Sometimes the anger was directed towards the hospital staff often it was expressed over a wide variety of matters, many of them quite trivial. He found reports of anger tended to be at a height during the first month, and to be reported only intermittently thereafter.

Parkes termed the last component of grief "gaining a new identity," and reported the widows gradually learned a new repertoire of problem-solving skills in order to cope with the unfamiliar tasks facing them. Widows reported their roles changing to include principal wage earner, family administrator and disciplinarian of the children. At times the widows identified closely with their former husbands, for



this seemed to facilitate the role changes and in some way allowed them to keep a hold on their lost husbands. This coping mechanism, however, was only intermittently effective. Episodes of comfortable closeness were followed by periods of grieving and loneliness. The widows gradually found their new identity emerging from the altered life situations which they had to face, and new friends and workers provided the role models. Several widows remarked that talking to other widows was most helpful because they shared a common experience.

Although many of the bereavement studies concentrated on the loss of a loved one, Marc Fried (1963) examined the concept of loss from a different perspective when he studied the reactions of 789 Boston slum-dwellers who were moved from the west end of Boston under an urban renewal scheme. The families were interviewed before the compulsory rehousing took place and again two years later. In his paper entitled "Grieving for a Lost Home", Fried has drawn a concise comparison between bereavement and the destruction of a neighbourhood and dispersal of its residents. He stated that the majority gave evidence of fairly severe grief reactions. Intense pining for the lost home along with psychological, social and somatic distress and outbursts of anger were typical and there was a tendency to idealize the old environment and to denigrate the new.

Following Fried's work, Parkes (1972) and Marris (1975) have expanded the research on grief by conducting studies to determine the reactions to significant losses, other than the death of a loved one. Parkes interviewed thirty-seven men and nine women under the age of 70, at one and thirteen months after experiencing the loss of an arm or a

leg. He found that the grief at the loss of a loved person resembled the reactions felt by the amputees:

It does seem that the psychosocial transition from being an intact person to being an amputee is a painful and time consuming process, which is in many ways similar to the transition from a married person to widow or widower (Parkes, 1972, p. 189).

In a review article, Marris (1975) discussed his various studies dealing with such diverse themes as the effects of bereavement on London widows, slum clearance in America and Nigeria, students' experience of university education and American experiments in social reform. In each study the individuals were faced with a crucial transition. Marris found the concept of grieving applicable to many situations of change other than the death of a loved one. Whenever individuals experienced loss, even though they might desire change, their reactions expressed internal conflict. The nature of this conflict was fundamentally similar to the working out of grief. The anxieties of change centered upon the struggle to defend or to recover a meaningful pattern of relationship. Marris concluded that "the impulse to defend the predictability of life is a fundamental and universal principal of human psychology" (Marris, 1975, p. 3).

Studies of the reaction to loss by death of a loved person have thrown considerable light on the nature of grief and the process of adjustment which normally follows a major bereavement. The transition begins with denial or numbness through a bitter pining and frustrated search for the lost person. This is succeeded by depression and apathy when the bereaved person finally gives up the desire of recovering the lost person or object. Next, a final phase of reorganization when new

plans and assumptions about the world and the self are built up.

### The Elements of Loss

Loss was characterized as a gradual predictable event and as a sudden traumatic experience. Loss, whether in the past, present or future, could be felt as actual, symbolic, or anticipated (Lindemann, 1944; Schoenberg, 1970; Peretz, 1970; Carlson, 1970). Loss was also conceived as two events occurring simultaneously. To the observer there was a specific objective or real event that signaled an actual or potential loss; to the individual experiencing the loss the event was a very subjective one (Peretz, 1970).

In a narrow context, loss was categorized as biological. Biological loss included loss of function, part or whole, and ranged from temporary alteration of a system's function to complete removal or loss of that system. Psychosocial loss occurred in conjunction with biological loss or, in some cases, independently yet both were equally significant (Parkes, 1972; Shontz, 1975; Roberts, 1978).

Illness, loss of a limb or death, are concrete and observable whereas loss can also take a more abstract form and perhaps only be known to the individual. Loss of health, for example, may lead to loss of a job as breadwinner resulting in real or anticipated loss of respect from others (Pranulis, 1972). Peretz (1970) identified abstract loss as loss of positive self meaning the loss of attractiveness, pride, esteem, independence and control. Marris (1958) cited the loss of freedom, happiness, hope, dreams, certainty, and predictability as abstract in nature.

Lipowski (1969) voiced the same thoughts. He said loss referred not just to body parts and functions actually lost, but also to deprivations of personally significant needs and values. The latter, he continued, were related chiefly to self-esteem, security and satisfaction.

Pranulis (1972) viewed this combination of concrete and abstract loss with a broader focus. She felt individuals were assailed with loss on several levels at different points in time. Peretz stated, with an even broader perspective, that "Each loss carries with it the threat of additional or future losses" (Peretz, 1970, p. 4).

### The Meaning of Loss

Unlike the studies discussed in the previous section, a substantial number of writings were found that presented less definitive opinions and theories related to loss. Although theorists varied in their definitions of loss, there was agreement that an element, object or event must be endowed with some significant meaning in order to be perceived as a loss.

Further discussion on grief, mourning, separation and other related concepts has contributed to the development of the theory of "object relations" which relates mental illness to the development of unsatisfactory modes of coping with loss throughout the course of the lifespan (Lewin, 1935; Erikson, 1959; Bowlby, 1961). Peretz (1970) used the term "object loss" to refer to the loss of an object which has special value and emotional meaning to a person. Peretz conceived object relationships as the relations between an individual and the

things in his environment which have emotional significance including relations between the individual and other persons, the individual and himself, and the individual and inanimate objects (Peretz, 1970, p. 7). Moreover, loss was any situation either actual or potential in which a valued object was rendered inaccessible to an individual or altered in such a way that it no longer had the qualities that were valued. The loss of a valued object was considered to be the event preceding the subjective states of grief and the psychological processes of grieving (Peretz, 1970; Carlson, 1970).

Only the individual experiencing loss can know its full meaning, although an observer may be able to define some of the objective characteristics of a loss. There was a tendency to assign generalized meaning to objective descriptions of loss even though the experiencing person might define the events quite differently (Carlson, 1978).

According to Lipowski (1969) an individual's emotional and behavioural response to loss was directly related to his perception of the event:

The process of evaluation resulting in meaning begins with the first perception of a pathological process or injury and continues unabated throughout the course of illness and its sequelae. The meaning is the core of the person's psychological response to his disease. It is of crucial importance for his emotional and behavioural response (Lipowski, 1969, p. 1198).

Averill (1968) noted that the nature and meaning of any loss experience was a function of the peculiar history and present circumstances of each individual as well as cultural and biological determinants.

Writers have continued to identify factors that may influence an individual's perception of loss. Age, religion, marital status, personal goals and values, previous losses and external support systems were some of the variables noted in the literature (Freud, 1917; Lindemann, 1944; Marris, 1965; Parkes, 1974).

Parkes (1974) viewed loss as causing disruption in the structuring and predictability of one's view of the world. "Grief work" was the process of re-establishing the congruence of present internal perceptions with the external realities of the loss.

Carlson (1978) defined loss to reflect the importance of an individual's goals in one's perception of loss. The thwarting of desires, hopes or goals seemed to be inherent in most loss events or experiences. Loss was an interruption in goal achievement - a change in the individual's situation that reduced the probability of achieving implicit or explicit goals. As a result, the meaning of loss was experienced uniquely by each individual depending upon the value placed upon the object.

#### Nursing Studies Related to Loss as Experienced by Spouses

Since the early 1970's, nurse researchers have conducted clinical studies exploring the impact of illness on spouses as well as developing and implementing nursing interventions which help spouses cope with loss. These studies offered a new perspective to loss research which highlighted the needs and concerns of spouses.

Hampe (1975) focused on the grieving spouses of chronically ill oncology patients. From a comprehensive literature search of loss and

grief Hampe identified eight needs of the grieving spouses which were classified under two headings. In the first category were those needs centered on the spouses' relations with the dying person. The need to feel helpful to the ill partner, to be assured of the comfort of the dying person, and to be kept informed of the dying person's condition and impending death were found. The second category of needs related to the needs of the grieving spouse: to ventilate emotions, to receive comfort and support from family members, and to receive acceptance, support and comfort from the health professionals.

The majority of spouses interviewed by Hampe identified all eight needs drawn from the literature. Hampe found that although these needs were often recognized, they were inadequately met by nurses.

Dracup and Breu (1978) used Hampe's eight identified needs to design and implement a specific nursing care plan to meet the needs of grieving spouses of critically ill cardiovascular patients. The researchers interviewed twenty-six men and women to obtain base-line data and found that the eight needs identified by Hampe were also reported by this population. Using the base-line data and theoretical knowledge of loss and grief, they designed and implemented specific nursing interventions for one-half of the sample. The remaining thirteen spouses received the usual nursing interventions, which were unstructured and inconsistent at times. The researchers found the needs of the spouses in the experimental group were met more consistently and completely. These findings were attributed to the success of the standardized nursing care plan intended for the grieving spouses of cardiovascular patients.

Vachon (1977) explored the problems of grief and bereavement of wives of terminally ill cancer patients. Seventy-three women whose husbands had died of cancer at the age of sixty-seven or less were interviewed five times over a twenty-four month period following bereavement. Vachon categorized the women into two groups depending on how they viewed the illness. One group saw their husbands' final illness as terminal leading slowly but inexorably to death. Other women viewed their husbands' illness as primarily chronic wherein death was not anticipated and came as a shock. In both groups, the widows reported the stress of living with cancer was far worse than the stress of widowhood.

During the final illness there were many patterns of emotional reactions reported by the cancer widows. Widows reported great anxiety over how much to discuss with their husbands about the illness and its outcome. Widows reported feeling guilty for wishing their husbands would die so as to end the suffering for all concerned. As well, anger was directed towards husbands and health professionals.

Some limitations were noted with these studies. The research focused mainly on spouses of cancer patients. There was a need to explore the reactions of spouses in many different illness situations.

More qualitative data needs to be obtained about the immediate time-period that follows the loss event. The spouses' descriptions in Vachon's study were obtained up to two years after the death of their husbands. Retrospective data have limitations in terms of validity when one can not actually observe and describe the reactions at the time of the loss.



### Reactions to Loss by Spouses of Myocardial Infarction Patients

During the last ten years, several investigators have studied the spouses of myocardial patients in more detail. This research was precipitated by a growing awareness that a heart attack has a significant impact upon the spouse.

In response to the recognition that some myocardial infarction patients have special psychological adjustment difficulties, Adsett and Bruhn (1968) instituted a short-term psychotherapy program for post-myocardial infarction patients and their wives.

The researchers found the myocardial infarction patients were predominantly concerned with the loss of self-esteem whereas the spouses were concerned with guilt feelings. They questioned what they might have done to contribute to their partners' heart attack. Many of the wives felt inhibited about expressing their feelings since the heart attack. They felt guilty about past negative or aggressive feelings and behaviours towards their partners. The women saw themselves as feeders and protectors of their husbands and behaved in an overly protective, non-demanding manner. Adsett and Bruhn found the wives to be anxious regarding the uncertain future while showing as much or more depressive feelings as their husbands. Although the spouses' reactions during the acute phase of their partner's illness were not reported in detail, reactions of considerable anxiety and depression were described by the spouses one year or more after their husbands' illness. The results of the study showed that both the patients and spouses appeared to achieve an improved psychosocial adaptation but the clinical follow-up was too brief to evaluate the long-term effects.

The study was further limited by the small sample and the selection of patients already demonstrating psychological maladjustment to the heart attack. One researcher who focused more on the acute as well as convalescent phases of a myocardial infarction was Royle (1973). She studied what myocardial infarction patients and their spouses understood and felt about the illness and the treatment prescribed.

Royle found that during the acute phase the patients and their spouses showed an awareness of the diagnosis but their abilities to accept this were influenced by feelings of fear, anger, and denial. Although patients and spouses showed attitudes of acceptance during the convalescent period at home, a continuing element of fear was felt. Spouses reported anxiety in regard to their own ability to follow the prescribed dietary measures. A major source of apprehension for the patients was the limitation in physical activity.

Royle found that the needs of the patients and spouses for relevant information about heart disease, hospital environment, therapy, as well as preparation for transfer and discharge were not adequately identified or met during their hospitalization or initial period at home. Patients and spouses reported receiving variations in specificity of instructions. Medication information was clear and specific, dietary restrictions were described in general terms but accompanied by printed instruction sheets. Instructions about physical activity were very vague.

Royle concluded that nurses need to assist patients and their spouses to adapt to heart disease by identifying and meeting patient and spousal learning needs at all the stages of illness and recovery.

This conclusion is restricted in scope since none of the spouses were interviewed during the hospitalization phase of their partners' illness. A descriptive study examining the reactions of wives of myocardial infarction patients from the early hospitalization phase to one year post-myocardial infarction was conducted by Skelton and Dominian (1973). The subjects studied were a representative sample of sixty-five wives. Their husbands were consecutive patient admissions to a coronary care unit with their first myocardial infarction. Interviews were conducted at least twice during the husband's stay in hospital, then at three, six, and twelve months follow-up.

Wives reacted to the initial impact of the husband's illness with considerable distress. The suddenness of the illness left them with a sense of numbness and panic; many stressed a feeling of unreality at this time. Grief reactions and psychosomatic symptoms were common during this period of initial impact. The women experienced feelings of loss, depression and anxiety and frequently complained of sleep and appetite disturbances. Psychosomatic symptoms were felt which the wives related to their husbands' illness and reported as heart symptoms: chest pains, tightness across the chest, palpitations, fainting and nausea.

Many wives found the early convalescent period - before the husbands' return to work - very stressful. Spouses suffered from feelings of great anxiety, depression, tension and sleep disturbance. They related their distress to their sense of loss, fear of recurrence and the problems caused by the husbands' reactions after returning home.

The women felt guilty and fearful of losing their husbands and thus behaved in an over-protective manner. They reported their husbands as being more dependent and irritable. Skelton and Dominian described the tension these factors caused:

This combination of dependency and irritability resulted in feelings of tension sometimes hostility in the early weeks. If the wives showed concern they were accused of being overprotective and smothering but if they showed less concern they were felt to be unsympathetic. When they showed sympathy some husbands became more helpless and demanding but if they responded by firmness then they felt guilty (Skelton and Dominian, 1973, p. 102).

At one year post-infarction, over one-third of the sample had made satisfactory adjustment. The wives reported that their own mood, attitude and relations with their husbands were similar to their pre-illness experience. A further one-third of the spouses were reasonably adjusted and still felt there were changes in their feelings and way of life causing some anxiety and apprehension. Less than one-third reported considerable depression, anxiety and sleep disorders after one year. This poor adjustment caused appreciable distress, both to themselves and to their families.

Skelton and Dominian succeeded in gathering a wealth of descriptive data concerning spouses reactions to their partners' heart attack. Some limitations were noted. The study sample was exclusively female. Little research was found which examined male spousal reactions to their partners' heart attack. Further, data were gathered from early hospitalization to one year post-discharge yet the time span of "early discharge" from hospital was not studied until three months

post-discharge. The researchers did not use a theoretical framework relating to loss research or loss theory.

Larter (1976) examined the attitudes of "M.I. Wives" toward the changes brought on by the husband's illness. Larter found many worries plagued the women. Concern regarding the partner's overexertion, fear of recurrence and possible death were voiced. The women felt they would unintentionally precipitate the husband's death. They worried about the effect of sexual intercourse and also about their own health.

Larter found that expressions of anxiety were demonstrated in a number of manifestations: worry over anticipated problems, irritability, palpitations, shortness of breath, insomnia, worry over trivia, headaches, crying easily and stomach upsets. The wives reported that the two areas of their lives most affected by their husbands' heart attacks were communication and sex relations.

The research examined the wives' reactions anywhere from one to thirty-five months after the occurrence of their husbands' illness through means of a structured questionnaire by telephone or mail. The length of time after the heart attack and the means of data collection may limit the usefulness of this study.

More recently, research has been done by Mayou, Foster and Williamson (1978). Similar to the study done by Skelton and Dominian, the researchers described spousal reaction to their husband's myocardial infarction from the initial hospitalization to one year post-discharge. The influence of wives in determining the quality of outcome for all concerned was also examined. Eighty-two wives whose

husbands had suffered their first heart attack were interviewed during hospitalization, at two months and one year post-discharge. The semi-structured interviews were conducted in the subjects' home and tape recorded. The wives were seen separately from their husbands who were also interviewed in regard to their attitudes.

During their husbands' hospitalization, the wives reported being moderately or severely distressed. Crying and disturbances of sleep and appetite were common reported symptoms but some women described feelings of numbness, unreality and a tendency to cling to other people. During the first few weeks after the patients' discharge, 80 percent of the wives reported anxiety, depression, fatigue, irritability, poor concentration and insomnia. The researchers found the spouses' complaints were as common and as severe as the patients' reports. At one year post-infarction, wives still showed considerable psychological difficulties but were less irritable than their husbands. Forty percent of wives complained of ill health a year after their husbands' infarction.

Practical problems faced by the wives while their husbands were in the hospital included coping with visits to the hospital, accommodating their time to the hospital routine, difficulty in transportation, extra household chores and added responsibilities especially with child care. The women found the practical and emotional support of friends and relatives a great assistance particularly during this hospitalization period. The researchers found that the wives had great influence in the patients' readjustment during convalescence and that the wives' attitudes and behaviour were important determinants of the rate and

extent of the patients' recovery.

This research was similar to Skelton and Dominian's work both in its contribution and limitations. These results emphasize the considerable influence a myocardial infarction has on the spouse. A truism in the literature was that the patient may recover from his coronary but that his wife may not.

### Summary

Investigators and writers have used numerous methods and points of view in their attempts to understand loss. In the past century the study of loss has broadened from a fairly narrow psychological or behavioural focus to encompass a more phenomenological perspective.

Many studies have focused on grief reactions following a major loss and revealed commonalities in individuals' behavioural responses to loss. (Freud, 1917; Lindemann, 1944; Marris, 1958; Bowlby, 1961; Parkes, 1965). In addition to these studies further research and theory have been developed focusing on some of the concepts central to loss with particular emphasis on characteristics of loss and the individuals' perception of the loss event (Averill, 1968; Lipowski, 1969; Peretz, 1970; Schoenberg, 1970).

More recently nurse researchers have studied the impact of illness on the spouse (Hampe, 1975; Vachon, 1977; Dracup and Breu, 1978). These studies have yielded valuable information on loss as experienced by spouses and offered a new perspective to loss research.

Although the concept of loss has been well described in the literature there has been little research done to relate loss to spouses of

myocardial infarction patients. Several researchers have documented the reactions that spouses of myocardial infarction patients experienced in response to their partners' illness (Adsett, Bruhn, 1968; Royle, 1973; Skelton, 1973; Larter, 1976; Mayou, Foster and Williamson, 1978). The spouses' reactions were not specifically related to a loss framework, but the emotional and somatic responses described by the investigators reflected a remarkable resemblance to the grief reactions, as reported in the loss studies.

From the evidence of this literature review it seems reasonable to expect that further detailed descriptions of spousal reactions to the partners' heart attack will constitute a useful and meaningful addition to understanding to the event of a myocardial infarction within the context of the phenomenon of loss.

Nurses need to explore spouses' reactions beginning with a conceptual grasp of loss then moving on to examine the problem from a new and different focal point.

Drawing from the loss literature the investigator outlined three main constructs which described the author's theoretical or conceptual way of viewing loss. These constructs were identified as (1) reactions to loss; (2) elements of loss; (3) meaning of loss. This framework offered a perspective on loss as experienced by spouses of myocardial infarction patients in that it provided a picture of the situation within which the problem under study was viewed.



### CHAPTER 3

#### METHODOLOGY

##### Introduction: An Overview

The empirical inductive approach was used as the methodology for this study. In order to understand loss as experienced by spouses of M.I. patients, detailed data of a qualitative nature were desired. The literature provided a scarcity of information on the phenomenon of loss as experienced by spouses of M.I. patients. More qualitative data were required so that this phenomena could be described, analyzed and conceptualized in more depth.

A non-experimental exploratory design is a method of choice when the purpose is to increase understanding of human behaviour. In fact, discovery of unexpected findings may result from this approach because the researcher uses the perspectives of his subjects on the phenomenon, not his own preconceived notions as operationalized by rigid research techniques (Filstead, 1970). Descriptive, exploratory and formulative studies literally look for ways to categorize, classify or conceptualize situations. Participant and non-participant observations are the predominant primary data collection procedures. Diers stated, "... the notion of richness guides the data collection methods. Participant observation, where the investigator becomes part of the events themselves, provides some dimensions that can enrich the concepts since information on the participants' own feelings become available" (Diers, 1979, p. 112).

The research technique used in this study was the constant comparative method, an inductive method of discovering grounded theory developed by Glaser and Strauss in 1967. This method in its simplest terms is a process of moving from the data to the concept. The intent is to conceptualize a given event or situation as opposed to describing it. Diers (1979) describes this method as a psychological thinking process, one of discrimination, definition and classification often called inference. The constant comparative method simply structures this conceptual process with all its steps so that one can see clearly how the concepts have been developed and thus make judgements about concept validity.

Comparative analysis emphasizes theory as a on-going process. The stages of development involve sequential formulation, testing and redevelopment of propositions until a theory is generated. It may then be operationalized for later testing in quantitative research. Four stages are included in the constant comparative method: (a) comparing incidents applicable to each category, (b) integrating categories and their properties, (c) delineating the theory, and (d) writing the theory. The elements of theory that are generated by comparative analysis are the conceptual categories with their conceptual properties and the generalized relations among the categories with their properties. These formalized steps in the research process result in the development of a theory, which is an abstraction grounded in data with specific definitions.

Ideally with the Glaser and Strauss method data are collected, coded and analyzed so that all concepts and their properties are "saturated". This constant comparative analysis and theoretical sampling implies an infinite time investment. Time constraints in this study were a limitation.

### The Research Setting

The investigation was conducted at a large metropolitan hospital. The intensive care-coronary care unit consisted of twenty beds. The patients admitted with a diagnosis of acute myocardial infarction were treated in the unit. If their recovery was stable and uncomplicated they were transferred in three to five days to an intermediate coronary care unit. The intermediate unit had 25 beds comprised of 15 bed cardiac surgery area and ten beds for myocardial infarction patients. The patients convalesced on this unit until their discharge on approximately day twelve to day fourteen.

### Sample Selection

A convenience non-random sample of twelve spouses were selected from 12 consecutive patient admissions and formed the subjects of this study. Patients selected for the study were required to meet the following criteria: (a) the patient was admitted to the coronary unit of a large Vancouver hospital with the diagnosis of an acute myocardial infarction, (b) the patient had experienced his/her first myocardial infarction, (c) the patient met the coronary care unit's criterion of

an uncomplicated myocardial infarction, and (d) the patient's age is between 40 and 69 years.

Spouses selected for the study were required to meet the following criteria: (a) the subject was legally married and resided with the patient, (b) the subject was geographically located so that follow-up visits are practical, (c) the subject was able to speak and understand English, and (d) the subject's age was between 30 and 75 years.

Both males and females were included in the sample. Based on the selection criteria a sample was obtained within a four-month period. Because of time constraints the criteria were modified for two patient-spouse selections. The first exception was a patient with a recent cardiovascular history who was diagnosed with a triple vessel disease. The last patient and spouse selected did not hold a legal marital status but had been living common-law for two years. These modifications in sample selection were not considered significant with respect to the homogeneity of the total sample. None of the spouses asked to terminate their participation but it was necessary to omit two of the subjects from the study. In one case the subject had a breast lump diagnosed and underwent a radical mastectomy. In the second instance a male subject was dropped because his wife had major cardiac surgery within a month of her initial heart attack. The data from the first two interviews of these spouses were included in the findings as the circumstances that altered their situations did not occur until after the date of the second interview.

The procedure for obtaining the sample involved three steps. A preliminary sort was done by the head nurse in consultation with the

cardiologists. The investigator then reviewed the patients' chart in detail and briefly discussed the study with the patient to determine patient and spouse eligibility. All participants were given a full explanation of the study both verbally and in an explanatory letter prior to obtaining their consent for inclusion in the study sample. An explanation of the study was given at the same time, whenever possible, to both patient and spouse. Once intent to participate was established, written consents were obtained prior to the commencement of the interview. Two spouses refused to participate in the study. The women felt they did not have enough "control" to deal with the interviews due to their "upset feelings at this time".

Demographic data specific to age and sex of the patients and spouses are shown in Table 1. The sample consisted of 12 subjects, 10 women and 2 men. The ages of the patients ranged from 51 to 69 years with a mean age of 57.9 years. The ages of the spouses ranged from 34 to 65 years with a mean age of 54.9 years.

Of the 12 subjects, 4 women and 1 man were working at the time of their partner's heart attack.

Of the 12 patients, 7 men and 1 woman were employed at the time of their illness. There were 4 retired couples. Three of the 12 couples had children residing at home.

### Data Collection

In this study, data collection commenced with the process of observation. Specifically, participant observation was utilized as the data collection procedure. Subjects were purposefully interviewed

Table 1  
Age and Sex of Patients and Spouses

Patient	Age	Sex	Spouse	Age	Sex
1	55	F	1	55	M
2	52	M	2	53	F
3	57	M	3	55	F
4	69	M	4	65	F
5	67	M	5	65	F
6	57	F	6	56	M
7	63	M	7	62	F
8	60	M	8	58	F
9	55	M	9	55	F
10	51	M	10	45	F
11	60	M	11	56	F
12	49	M	12	34	F

with the intent of gathering "rich data" regarding their reactions to loss from the initial impact of their partners' illness to six weeks post-myocardial infarction.

A data collection tool was developed to provide a consistent organized approach with the interview procedure. The initial part of the instrument included demographic data, the initials, age and sex of the spouse and the patient's age and number of days post M.I. The content areas of thoughts, feelings, actions and observable behaviours were addressed in the tool. Observable behaviours were examined in terms of verbal (type, quality, characteristics of speech, focus of conversation) and non-verbal (activity, eye contact, body language, appearance). Four broad open-ended questions were used to elicit data on the spouses thoughts, feelings and actions. A copy of the data collection tool is provided in Appendix C.

Since the purpose of the study was to explore the reactions of spouses of heart attack patients the interview guide proved to be an effective tool. The semistructured interview provided enough direction so that specific content areas were covered in each interview, thus data could be compared from one interview to another. At the same time there was flexibility in structure allowing for shift in sequence or topics in keeping with the moods or needs of the spouses.

All the interviewees' responses were audio taped. The subjects were assured their replies would be kept in strict confidence and their anonymity respected. None of the subjects objected to the taping. The investigator initiated contact with a few minutes of social talk in order to develop rapport and ease any apparent tension.

The investigator was concerned that the impact of this critical illness would create too great a strain for the spouses and they would be reluctant to discuss their reactions so soon after the event. In fact, the opposite was found. The spouses were indeed willing respondents. Many of the subjects expressed surprise and pleasure that they were being recognized and that their reactions were considered of some importance. The researcher approached the interview in an informal supportive manner. The subjects were encouraged to freely discuss their reactions, with the assurance that there was no right or wrong answer.

Four interviews were conducted with each subject in the study. The spouses were interviewed from day three to day fifty-two of their partner's heart attack. This period covered the time of the initial impact of illness to approximately six weeks post myocardial infarction. At the time of the last interview all patients had been discharged for at least three to four weeks. (See Table 2)

The first interview was scheduled within ninety-six hours of the heart attack and the second interview followed during week two of the patient's hospitalization. These two interviews were arranged to coincide with the spouses' normal hospital visiting schedule. The researcher chose the setting of a private office to conduct the interviews. The third and fourth interviews were scheduled for one and three weeks post discharge of the patient. During this post hospitalization period the researcher interviewed the spouses privately in the familiar and comfortable setting of their own homes. The interviews ranged from 12 to 75 minutes with an average time of 35 minutes.



Table 2  
 Number of Days After Myocardial Infarction That  
 Interview Took Place

Subject	Number of Days			
	First	Second	Third	Fourth
	Interview	Interview	Interview	Interview
1	6	17	26	43
2	3	15	27	40
3	3	11	21	34
4	5	11	24	38
5	3	9	26	40
6	6	12	26	46
7	3	14	31	52
8	3	8	28	43
9	6	11	22	42
10	4	9	27	43
11	4	10	23	37
12	4	10	19	33

During the interviews the investigator observed the verbal and non-verbal behaviours of the spouses. Notes of these observations were made in private immediately after each interview. The forty-eight semistructured interviews yielded an abundance of data. After conducting an interview with each subject the investigator listened to the tape to get a general overall impression of the material. Notations were made of any ideas and themes. The investigator used this time to jot down spontaneous ideas that came to mind while listening to the tapes. Notes from the spouses' observable behaviours were referred to conjointly with the audio tapes, thus providing an accurate impression of the interview.

In fact, the data collection phase was not isolated from the data processing and analysis. The researcher had many abstract thoughts about the events observed and recorded. Glaser and Strauss advocate the writing of "analytic memos" at specified intervals throughout the data collection period. Summaries of one's developing thoughts about the data from which concepts begin to emerge or directions for future data collection start to form (Glaser and Strauss, 1967).

The data collection period took approximately five months to complete. Ideally in the grounded theory approach, data collection is said to end when the factors or categories are "saturated", when new data no longer reveal new dimensions (Glaser and Strauss, 1967). This was not possible in this study due to the time constraints of the researcher. With this approach there are infinite possibilities for developing new concepts as more data become available. Even with the

volume of data collected in this study only a finite aspect of the phenomenon or situation were examined.

### Data Coding and Analysis

Following the data collection phase of the study the audiotapes were transcribed and the raw data was examined, sorted and coded into as many categories as possible. In order to systematize the coding process each item of data was allotted a colour. For example, spouses commented on their physical disturbances e.g. headaches, loss of appetite, insomnia, etc. This raw data were then coded with a yellow dot. Initial category construction was a simple process of collecting all the data with the same colour (e.g. the yellow dots). To facilitate data compilation data were entered on reference cards. Three numbers were noted after each item of data, indicating the respondent, the number of the interview and the exact page number of the transcribed data. The colour of the category was marked in the upper right-hand corner of the card.

The investigator then proceeded to define and describe the categories. These beginning set of categories were applied to the data. Often the same data were used to generate the category to check for "fit" or consistency. The categories were reworked over and over until the concepts and their properties became clearer. The descriptions of the categories were also transcribed onto reference cards. The colour coding system was used to quantify the data. The frequency of specific categories was noted by simply counting colours. The qualitative and quantitative data obtained were transcribed onto a large matrix with

each respondent representing a row and each category representing a column. The colours of the category and its definitions were entered in the columns and the frequency of the category entered in each respondents row.

The investigator continued to examine the data, comparing and contrasting categories with a purpose of threading the concepts and properties together into some meaningful pattern. As the process evolved, more and more data were encompassed meaningfully under larger abstract concepts. To further clarify the process of data coding and analysis an example has been included in Appendix D. This overview illustrates the application of the Glaser and Strauss method of constant comparative analysis. Diers (1979) defined this method in its simplest terms as a process of discrimination, definition and classification.

#### Reliability and Validity Issues

The selected methodology raises several issues related to reliability and validity. Diers (1979, p. 112) stated that the usual concerns about reliability and validity of the instruments used in the study do not apply with this study design. There is more concern for the reliability of the sources of data and or the recorder ..." that is the concern whether the sources of data represent well the developing concepts and whether the person recording the data gets it all down".

To test the validity of the data gathering instrument two subjects were interviewed in a pilot study. The data gathered from this pilot were adequate for the purpose of the study. To ensure reliability of

the findings a data gathering instrument was utilized and all interviews were audiotaped. In addition, immediately following the interview the investigator made notes of the spouses' observable behaviours in order to maintain accurate recall. The problem of poor or selective memory was minimized by interviewing the subjects on four separate occasions, in a short span of time, from the initial impact of the illness to six weeks after the heart attack. The concern that the respondents would hesitate to disclose their reactions because of the sensitive nature of the study did not materialize. The spouses were in fact willing respondents and freely discussed their thoughts and feelings. Sellitz, Wrightsman and Cook (1976) pointed out that the most important factor in determining the frequency and validity of response is the salience of the interview topic.

With participant observation the investigator's personal experiences and biases can be a threat to the objectivity of the study. Diers (1979) stated that the creative use of personal insights can greatly enrich this type of study as long as proper precautions are taken to balance those kinds of data with other data which might disconfirm one's own impressions. The investigator was aware of her personal biases and utilized the thesis committee as objective resources to "test" personal impressions.

A standardized procedure was used for data collection, coding and analysis. This systematic approach provided a degree of reliability to the study. To ensure further reliability of data coding and analysis a procedure for interrater reliability was undertaken. The investigator defined the sixteen categories identified in the study. Those

categories comprised the phases and the three elements of thoughts, feelings and actions for each phase. Four examples of illustrative data were chosen to represent each of the categories. A table of random numbers was used to determine which of the data would be selected for the reliability check. Of the sixty-four pieces of data, twenty-eight were chosen.

Two nurses with varied teaching, clinical and administrative experiences were selected as raters. Using the defined categories and the twenty-eight items of data the raters were asked to make two decisions. Firstly, they had to sort each item of data into one of the three phases. The second sort entailed coding each item of data into one of the three main elements comprising each category, thoughts, feelings or actions.

In the first sort the percentage of agreement was 85.7. The raters found that in most instances the phases were clearly described but there was some overlapping, particularly with the spouses' thoughts and feelings. The second sort resulted in a 82.1 and 85.7 percentage of agreement for the two raters. Again the greatest difficulty was in differentiating whether the item of data was describing a thought or a feeling. Considering the high level of agreement, however, it appeared that the categories guided the raters in coding the majority of the data correctly.

## CHAPTER 4

### FINDINGS OF THE STUDY

Based on the methodology described in Chapter III data were obtained from subjects who were spouses of myocardial infarction patients. Using an interview guide with open-ended questions the researcher asked spouses what their thoughts, feelings and actions were in response to their partners' heart attack. In addition to the verbal data obtained, the spouses' behaviours were observed during each interview.

Common verbal and observed spousal behaviours were identified during the six-week period of investigation. Three distinct phases of behaviour over the time of the study were found. Appendix E shows the relationship of the findings to the three phases of spousal reaction to loss.

#### PHASE I The Event and Initial Spousal Response

This phase covered the hospitalization period of the patient from the third to the seventeenth day post-myocardial infarction. The reactions that the spouses experienced were described or observed during the first and second interview. The interviews corresponded with the acute (coronary care unit) and convalescent (postcoronary care unit) hospitalization of the patient. The findings from both interviews were subsumed under one phase.

### PHASE I--Thoughts

Four categories were identified that described what the subjects were doing in a cognitive sense. They were termed reviewing, anticipating, comparing and redefining. The order of the categories as reported does not necessarily imply the subjects progressed with a sequence of thoughts. However, a degree of order is evidenced with some of the categories and is reported as such.

#### Reviewing

Of the twelve subjects, ten initiated the first interview with a spontaneous blow-by-blow description of "how it happened". They moved from a past to a present timeframe and were able to recall vividly their partners' symptoms and reactions and then detail their own reactions to the situations.

In recalling the incident, seven subjects discussed their surprise at such an unexpected event. Two expressed guilt feelings. They felt ignorant in not recognizing the symptoms of a heart attack and thought their passive role in the incident had in some way inhibited the seeking of medical attention.

#### Anticipating

Many of the subjects' thoughts focused on the anticipated loss of their partners. They questioned many things, the reason or cause of the illness - "why this happened" and issues related to complications, recurrence of the heart attack and the quality of adjustment. During



the first interview the subjects' greatest fear was that of another heart attack, because they perceived the intensive care period to be a critical and uncertain time. One woman summed up her fears:

Well my thoughts are pretty well everything  
how bad is it, how well will his recovery  
be--I mean anything can happen yet.

Fears of recurrence were commonly reported:

I am frightened of another occurrence, that  
part, that's one of the major concerns ...  
so I worry about when he gets home, and if  
he gets home even ... I would always be  
sort of frightened after you have him home,  
that it would occur again.

As the patients progressed in an uneventful recovery and were transferred to the convalescent ward, the subjects began to focus less on the fear of recurrence. The questions at this time centered more on how well their partners would adjust, both in the hospital and at home.

Many subjects anticipated their partners would not cooperate:

So I worry about how I am going to hold him  
back. Oh I can do it you know, but I don't  
want to get into any arguments. A lot  
goes through your mind and you think, well,  
will he be alright when he gets home?

I'm worried about (my husband). He's so  
stubborn. He said he was just waiting  
till the nurses weren't watching him so  
closely and then he was going to sneak a  
walk in the halls.

As the patient moved closer to discharge the majority of subjects began to discuss in detail the changes they anticipated in roles and responsibilities. These changes were perceived as affecting themselves and their relationship. The subjects anticipated that the illness would affect their own lives even more so than it did their partners.

A comment by one woman summed up this anticipation:

It has quite a bit of effect on me. I think more so than my husband. For me there are more important ways of doing things, than really for him. Because with him, if he takes it easy and doesn't do anything, well with me, I have to plan our social life differently and I have to learn to cook differently, and I have to compromise more to his way now.

Many subjects spoke about finances. Only two subjects expressed financial concerns. The majority felt financial matters would not pose a problem in their lives. Retirement seemed to play a significant factor in five of the subjects' responses. One woman stated:

I don't think our lifestyle will change that much. We are retired so we can come and go and do as we want. Maybe we don't have as much as some, but we have enough.

In the first interview one half of the sample asked general questions related to their information needs: "What I want to know is how do we approach this thing?" "How do I handle him?" As the patient moved closer to discharge ten subjects identified specific information needs.

All subjects wanted to know the medical plans "I want to know the do's and don'ts, otherwise he could be doing something and I don't know if it's right or wrong." "I want to know all about his heart so I can do the right thing for him and me."

In the second interview, ten subjects organized their plans for approaching the convalescent period. Their thoughts dealt with the physical and psychological plans for their partners. In anticipation of what was to come, the subjects redefined their roles to include the new responsibilities of controller and protector. One young subject saw the necessity of changing roles and responsibilities, yet realized the difficulty in carrying these tasks forever:

It's strange to me to see him like this (dependent). It makes me feel, well I don't mind. I was always treated like the weak one, but I can handle it perfectly well, but I wouldn't want it to go on forever. It would be too much.

### Comparing

In the first interview eleven subjects sought a frame of reference. They compared this loss with other losses they had experienced or that other people had experienced. In this way they seemed to make some sense of their loss, dealing with it in some familiar concrete reference.

I had quite an experience with this bad accident so this time I wasn't as confused about it all. He broke his femur in several places in a car accident four years ago. He was in the General about four months things don't seem as bad as they did back then.

Like I say I've been through so much, three sufferings deaths recently, so if he's going to go let him go quick. I don't know whether I've hardened because of this, but I'm prepared. I can cope, I can cope.

One woman seemed to search actively for a reference point:

I saw the specialist, and he said it was a slight attack, but there are people who have had even slighter ones than my husband, but then there are the people like the rest of his family who are very bad.

The need to discuss a frame of reference was less in the second interview in which only two of the subjects repeated their comments.

### Redefining

During this phase the subjects' thoughts reflected a time for redefinition of self, partner, marriage and philosophy of life. The topics were discussed briefly in the first meeting, and then described in more detail by the majority of subjects in the second interview.

The threatened loss of a partner precipitated many thoughts of marriage and relationships. Of the twelve subjects eight took stock of their marriage, reflecting on the strengths and limitations of their partnership:

Our life has been one that you know, there has been no need to feel guilty over any lack that either one of us may have done, or may not have done. (My wife) and I have been pretty close, well, since we have been about nine years old, it's like a part of yourself, -- pretty much what she feels I feel.

It was a revaluation time also to almost lose a loved one makes that person even more cherished. One man, voice choked with emotion explained it this way:

Like I guess everyone probably feels the same way about their spouse, like she is the only one. You know you don't realize how much one means to the other, until a crisis comes.

Another woman expressed similar thoughts:

It's a funny thing you know, while he's healthy you do get annoyed with each other and you think you might be able to do without each other, but you can't do without one another. I can't wait for him to come home!

Many of the subjects reflected on what they believed, and how they were approaching the situation. They were aware of the uncertainties but tried to accept and make the best of it:

It's kind of hard to tell right now what to do. I'm just taking it as it comes, and I'll judge it ... No I don't think you can ever feel confident nothing could happen, you just hope for the best if you know there is no solution you have to wait and see what happens.

A fatalistic approach to life was voiced by five of the subjects. One woman simply stated: "I'm not a cold person, but when your time is up, it's up". Another subject quoted an old saying: "You know there is an old Scottish saying, what's 'fore you won't go past you". This fatalism seemed to comfort the subjects in some way, as if this situation was no longer in their locus of control and so there was no point in worrying. One subject said: "Both (my husband) and I are fatalists, what's going to be is going to be, and there's sweet boo we can do about it." The heart attack precipitated a lot of thinking about life and death issues for one spouse: "(My wife) isn't worried now, nor am I, I think you realize now, well and truly, you are mortal."

The redefinition of self and partner was discussed by all twelve subjects. They described their partners' personality characteristics, and how they viewed their partners' reactions to the illness at this time. Many of the subjects saw their partners as very independent and energetic, and anticipated they would have difficulty accepting the restricted activity:

He's very active, he can't sit down and relax, he's got to be doing something, that's what bothers me, because it's going

to be very hard for him to slow down. He'll have to slow down, but will he be able to?

The majority of the subjects described their partners' early reactions as non-accepting, "I don't think it has really registered yet, what has happened, not yet". By the second interview the subjects felt their partners were more accepting and cooperative with the medical regime:

I think he's realizing that he'll have to take it easy, and there are lots of things he'll have to forget about. I think I realized more from the beginning than he did, he thought once he's out of the hospital he'd be right back to where he left off. Now he's beginning to realize that it just won't be that way anyhow.

Accompanying this increased realization, subjects reported partner reactions of confusion, depression, worry, fright and dependence. The subjects' thoughts turned inward as they reflected on their personalities and how they perceived themselves in this situation as a result of this loss. Some of the personality characteristics described were: "I'm not a relaxed person -- I am a loner", "I'm an optimist, I'm not a whining woman, I'm a positive thinker", "I can't take a lot, I'm weaker than my husband".

Generally, the working subjects saw themselves as more independent, while the women who did not work or were caring for children at home viewed themselves as financially or emotionally more dependent on their partners.

Several subjects worried about their vulnerability and realized how tenuous their emotional and financial positions were. One spouse

stated "I find I'm preoccupied with myself" and another reported feeling sorry for herself, but not showing it. The majority of spouses viewed this time as a gathering of strength and doing the best they could, for they recognized the need to be strong and independent.

One subject described how it felt to be strong at a time like this:

Well sometimes it's harder on the person at home. I'm sure in a lot of cases it could be very bad. You have to be awfully strong yourself even though you are the person that is well.

#### PHASE I--Feelings

During the interviews subjects were asked to describe their feelings in response to their partners' heart attack. Subjects described mood states and physical or health disturbances as feelings.

#### Mood

Statements of shock and disbelief were reported by eight of the subjects during the initial interview.

No matter how much you think you are prepared for things you are really not. I never thought about a heart attack.

It's taken me by surprise, when someone has never been sick before it hits you pretty hard, it just seems to happen, and it's there, it's hard.

Many of these comments were discussed in retrospect, for by the fourth or fifth day the surprise element had receded, and the heart

attack had become more of a reality. However, one subject still felt shocked over the situation:

It doesn't seem like it is really happening, once I relax this will hit me, I haven't had time yet.

It finally "hit" one woman the day of the first interview:

It was a shock. It didn't hit me until this morning. It's the funniest thing, it did allow me to get rid of tension and tears, I've had no tears up till now.

Another woman described the feeling of a delayed reaction:

People do tend to underestimate the seriousness of the problem (heart attack). It really was a revelation to me to realize how serious it was. It seems to come more with time. I didn't grab how serious it was at the beginning. It's just an osmosis thing.

The majority of subjects reported feeling upset, and found the time in the intensive care unit the most difficult. Although it was a stressful time, the subjects were able to describe their feelings clearly. Often they could not find the right word to describe their feeling state, yet their comments and nonverbal behaviours clearly pointed to the sorrow they felt. One woman, struggling to remain composed, expressed these feelings:

You do get upset, of yeah sure, ah, I don't think angry or depressed but you just ah, I don't know, it's really hard to say what you really feel, you know. You just feel sorry that things have to happen this way you know--it's a hard time.

Subjects also reported feelings of despair, depression, guilt, confusion, and anger. Three feelings were identified by one woman:



Despair more than anything. Anger that I hadn't been there when it happened, and gratitude that it had not happened on the way to work, during rush hour traffic.

The subjects, regardless of their sex, described the intensity of their feelings. One man commented:

I didn't think I could get emotional, but the first day I really broke down. You know it sort of gets automatic, the I love you, and honey, and all of that stuff, but then this was something else, walking out, after visiting hours, and I'd look back, and my God it's a hard thing to do, to walk away.

As the patients progressed in an uneventful recovery the majority of subjects reported feeling more positive and optimistic:

Well, I'd say I was 75 percent better than last week. Everything points to her recovery, so I've changed my mood too as far as that goes.

Well I feel calmer, the things you have to consider are more under your control, or at least I think so, and I suppose that's the important thing, but it's certainly a shaker at first.

The optimism, however, was guarded as they realized the situation was still precarious: "Well anything can happen yet." "I'm okay as long as it doesn't happen again." "As long as he watches it, everything will be alright."

### Physical Disturbances

Every subject reported health concerns. Interferences with sleep and appetite were most common. Subjects reported feeling general fatigue and irritability.

I have trouble sleeping at night. It gets hard then, everything seems to go through your mind and you know you can't sleep. I've gone off my food, if it weren't for (my son) I wouldn't even bother cooking, I have to cook for him.

Most of the subjects spent several hours, day and night at their partners' bedside. One woman maintained a five-day vigil in the intensive care unit. She described her feelings:

I didn't leave his side. I was afraid he was going to die. It's horrible watching the monitor through the night, It was horrible! I couldn't eat, I couldn't swallow anything, I couldn't sleep.

One young subject described her fatigue:

It's been a heavy, thinking week. I've been very, very tired. Short periods of tired, where I haven't been hardly able to keep my eyes open ... I'm eating one meal at night that's all.

By the second interview sleep and appetite disturbances had decreased but reports of increased fatigue and irritability were more common. Several subjects reported being "on edge" with friends or family. Subjects with children living at home seemed to experience more tension and irritability:

I get upset quite easily. Things have to be just so, or else I get upset. I'm more irritable, especially with the young one ... I can't be bothered with social contacts, they ask too many questions and get on my nerves.

Related to physical disturbances were comments of heightened concern for ones' own health. Four subjects' reflections on their own

health, and the necessity of keeping healthy for their partners' sake were voiced by four of the samples:

I often think now, when I get a pain it probably wouldn't be something serious, but it could happen ... I'm making sure nothing is happening to me because I should be keeping myself in good condition so I'll be able to look after her.

Yes, you have to look after your own health. You can't look after him then. He could lean on me a bit, he's not as fit as I am.

#### PHASE I--Actions

During the interviews subjects described their behaviour patterns since their partners' heart attack. The researcher also observed the subjects' actions at this time.

#### Verbalized Behaviours

Ten subjects reported different patterns of behaviours during the first week of hospitalization. Their activities were very patient focused, centering around hospital visits and communicating the critical situation to friends and family. The spouses coped as best they could, often by keeping busy and refusing to think of themselves or beyond the immediate situation. One woman explained her behaviours during this critical period:

You don't have time to break down in the early stage, you're too concerned, you're very intense and all your thoughts are trained to hoping he'll get better and behave himself and not be naughty. And

really, you don't think of anything else, and even if you've got the time, which I didn't, even in the car, I made sure I had the radio on, so I didn't think and at home you do the washing or clean the house, change the turtle bowl, feed the cat, talk to the kids and then you are so exhausted you go to bed and sleep and wake up in the morning and start again.

Another woman saw her behaviours as quite different now that her husband was ill. She reported:

I've been cleaning my house thoroughly. I have to keep busy. Normally when he is home I watch T.V. or read, but I work, I come to the hospital, and then there are a few phone calls at night and then I go to bed. I go to bed much earlier.

In the second week of hospitalization all twelve subjects reported their routines as becoming more hectic. Three-quarters of the subjects did not drive, so the continual commuting and travel arrangements, plus the added responsibilities, decision making and concerns seemed to result in greater fatigue with little time to self.

One woman with three teenage daughters described her day:

I'm up at 5:30, the twins have been a big help, so I like to make them a good breakfast, then I stay up to tidy the house, and we have a big garden so that's a lot of work ... I leave home at ten for the hospital (forty miles away) I try and eat at the hospital and I'm tired when I get home at night--I'm in bed at midnight but I don't sleep well.

The actual changes in daily routines, regardless of the quantity or quality were perceived stressful by the subjects. One man expressed his situation:

There's an inability to start anything you just do what you can to get by. You keep

the place clean, eat properly and get down to the hospital and that's a full-time job and you don't sleep that well.

Although routines were considered hectic, one half of the group reported loneliness: "I've become a little lonely at home in the evenings, it's pretty lonely and the evenings are the worst." "It's different now by myself--I never go anywhere, it's no fun going anywhere by yourself."

Despite the fact that the subjects grieved for their partners' presence, they were not interested in socializing with others. They seemed too fatigued and preoccupied with their own thoughts to initiate contacts, or listen to other people's conversations. The emotional and physical fatigue the spouses felt resulted in an apathetic approach to their normal routines. One man who described himself as a hockey addict reported:

Well, things went on the blink. I wasn't interested in the T.V. or the elections that were on. I could have cared less what was going on. I have no feeling to play crib or bridge or pool, which I like doing. Nothing interests me, I just want to be left alone. I come home at night and just sit down and stare into space.

The topic of helpful others was discussed by eleven subjects and five felt friends and family were not helpful during this time. "I would just as soon have quiet now, because you do have things to think about." "I can't be bothered with social contacts, they ask so many questions."

Often "helpful others" were misguided in their attempts to comfort:

My sister tries to minimize everything and this is not really a-- well she says it's going to be okay I know this person had this and that, and they are all okay, but well this is different if it hits yourself. People are phoning. I find it tiring if they talk very long. I'm not a telephone person. It's mostly the men who phone and they go on and on. They know every Tom, Dick and Harry that ever had a heart attack and the results of it and I'm not interested in it!

Generally speaking, friends and family were sought for solace, and the doctors and nurses were seen as helpful for information by six of the sample. Nurses met both of these needs for some subjects. One 45 year old woman expressed her views towards the nurses.

The nurses were wonderful. They were so calm, so you were calm. They were truthful and told you everything. You could ask them anything. They brought me coffee all the time, I have not gone home yet; I've slept in the chair since Monday (five days ago). They (nurses) tried to get me to go, but they never forced me.

For some spouses the investigator was the only support person they had. At the termination of the first interview a 56 year old man spoke appreciatively:

Thank you for letting me speak. It gave me a chance to let my feelings out and air my concerns, because you know, you can't do it in front of your partner, you try and keep positive and keep the homefront going.

Another subject confirmed the inability to confide in her loved one:

It's nice to talk to you, it gets it out and it's nice and informal here. You know even with my husband and children I still keep up a front and everyone is handling it (illness) in their own way.

Keeping up a front, no matter what the personal cost, was a behaviour seven subjects described. There seemed to be altered communications between husbands and wives, almost akin to a conspiracy of silence. For whatever the reason, sharing of feelings and concerns was not perceived as appropriate. One 34 year old woman described her communication patterns with her husband:

We will both be very careful right now of what we'll let the other person know. Like he asked me if I had eaten, and I say of course I've eaten because I don't want him to worry about me because it's not a priority right now.

### Observed Behaviours

The investigator recorded her observations of the subjects' behaviours during the interviews and compared these observations with the behaviours verbalized by the subjects.

As indicated earlier in the findings, the subjects viewed the first week as stressful and this perception was evidenced in their observed behaviours. Of the 12 subjects, five spouses acted as if they were under great stress. Two women openly wept during the first interview and the three others visibly fought for emotional control. These five subjects were all adequately groomed. Their hair, make-up and clothing were neat and tidy in appearance but their faces looked very drawn and pale with dark circles under their eyes. They talked with long pauses and sighs. Their voices lacked inflection and were soft or trembling at times. These spouses rarely smiled or used body gestures for emphasis. They gave the investigator occasional eye contact and were noted to glance frequently down at their hands or laps.

Another five spouses saw this time as stressful but they reported being upset more in retrospect for they felt the worst was over. Although these subjects looked fatigued and concerned they were able to discuss their reactions with less emotional difficulty than the former five. Sighs and long pauses were less frequent in their conversations. They smiled occasionally and gestured with their hands.

Of the 12 subjects, the remaining two spouses did not present the same behaviours. The behaviours reported and observed by these two women indicated calm and optimism. These subjects were responsive and eager to talk. They smiled often, used frequent eye contact and gestured appropriately with nods and active facial expressions. These subjects seemed very much in control of their emotions. The observable behaviours demonstrated by these two women were congruent with their reported behaviours but not congruent with the remaining ten subjects.

There are several factors that could contribute to the differences in the spouses' behaviours and this will be discussed in the next chapter but an interesting correlation was found between the time of the first interview and the type, frequency and intensity of behaviours. The subjects interviewed from day two to day four of the partners' illness perceived this time as very stressful and their behaviour reflected this perception. The time of the first interview for the remaining subjects varied from day three to day six and their reported stress was more in retrospect which concurred with the behaviours observed by the investigator.



At the time of the second interview all patients were convalescing in the post coronary unit and the subjects seemed to be less upset and more optimistic about the illness. Their reported hectic routines were reflected in increased symptoms of fatigue observed by the investigator. They smiled more frequently and their speech showed more inflection. Eye contact was frequent and directed at the investigator. Nods, hand gestures and leaning forward were common behaviours noted.

#### PHASE II Reaction to the Event

The second phase has been termed reaction to the event. This phase corresponded to the third interview with the subjects and covered the initial post discharge period of the patient. The time frame of this phase varied for each subject the range was from day six to day fourteen, the average being nine days post discharge.

#### PHASE II--Thoughts

Three thought categories have been identified in this phase and labelled assessing, implementing and redefining.

#### Assessing

At the time of the third interview, the study sample consisted of ten subjects. All ten assessed their partners' physical and emotional health in some detail. During the first week many of the spouses described this time as difficult or scary. It was termed by one spouse as "like walking on eggs for the first while". The

assessment, especially during the first few days at home, tended to occupy many of the subjects' thoughts:

I watch him too much, I watch his breathing, I ask 1000 times a day, are you alright? Well last week was the hardest, I was up a lot, I was up three, four or five times a night, going in and looking at him, I wasn't getting any sleep.

By the end of the first week and the beginning of the second week "things were starting to get back to normal". The subjects continued to assess their partners' physical and emotional state, yet in a more relaxed manner. During the hospitalization phase, the subjects were very concerned that their partners would not cooperate and would exceed their limitations. They anticipated the worst in terms of the adjustment. At the time of third interview however, the patients were in fact cooperating satisfactorily and the subjects felt encouraged. The majority spoke positively about their partners' recovery. In discussing their partners' adjustments several areas were examined:

Well, things are fine, they are getting back to normal (my husband) is adjusting well to his diet, he doesn't mind it--he is well on his way to normal activity ... He goes shopping every day, he walks around and does things around the house-- there has been an improvement.

Not all the subjects viewed their partners' recovery as positive. A husband's reaction was described by one woman in this manner:

Well it was so bad and you could see that it was a mental thing. To suggest anything wouldn't do any good; he never spoke, he was real quiet. It was all up here (points to her head). I suggested things but he wasn't keen on doing anything!

In an earlier interview, one young subject feared that her energetic "hyper" husband would soon become bored and irritable at home. Her fears were soon realized:

Well he's bored, not scared, just bored. I can see he's dying to drive. I enjoy having him here except he's cranky. I think he's getting stronger and as he gets stronger, he gets worse to handle.

In terms of assessing the changes in their lives one half of the subjects felt all those changes that were anticipated either did not occur or were not as bad as they had feared. One woman who had anticipated a lot of extra work with cooking and shopping was pleased to find out her concerns were not actualized:

I think things are going to work out fine. Things aren't that much different so there isn't that much of an upset. We have a few little changes from our routine but it's nothing drastic like I thought it would be.

One woman who called herself a "worrier" had feared many changes would occur as a result of her husband's illness. In discussing her thoughts one week after her partner's discharge, she no longer held these concerns and she explained her new thinking in this way:

Well you know when it happens you don't know what really to expect and of course you always think of the worst, but it's good to find out that it's not as bad--so there are not too many changes; not right now, not really--sure our social life will have to change to a certain extent but it doesn't really bother me that much.

In this early post discharge period, one half of the sample reported significant changes in their lives. Many of the changes

revolved around a shift in roles and responsibilities. With two teenagers at home one woman found her life had many changes:

Yeah, it's quite different because I can't do the things I use to do. I can't get the vacuum out or have an empty house, to dust furniture. I have to plan around everything. My lunches are different, my dinner and breakfasts are different. I have someone asking for coffee or tea every hour.

### Implementing

The mental planning and organizing done by the subjects during the hospitalization time expanded in this post discharge period to implementation. The approaches or roles the subjects had anticipated they would fulfill were now specifically defined and acted out. All subjects defined their roles in detail. Their comments revealed their perceptions of how they attempted to control the situation. In all areas the spouses acted very much like "watchdogs" they limited visitors, monitored their partner's physical activity, prepared the correct diet and refrained from engaging in any emotional issues. One man commented on his new role.

Well you wonder if a disagreement, minor or major, is something you have to watch and how careful am I going to have to be--yeah I watch in practical things, like you know, for people to come and visit, that's all right ... And I say to her don't forget your pills and you don't want to leave the house for too long, you scoot over to the store knowing that really nothing is going to happen, but you still parcel out your time.

Several subjects hovered around their partners during the first week, fearful of letting them out of their sight. As their partners recuperated, their own anxieties lessened and they slackened their protector role somewhat.

Fear of not fulfilling her new role and thus somehow harming her husband caused a good deal of guilt in one subject. Anxiously she expressed her concerns:

I will definitely do my part. I've got to organize visitors better so they don't come all at once. It's my fault completely if he has another one, I have to organize better ... I don't want to do anything to rouse him. I am concerned he could have another heart attack. We don't sleep together now, I am restless and I don't want to disturb him right now ... Well, if he gains weight it's my fault, if I don't give him the right foods low in cholesterol that will be my fault.

Although the subjects were concerned and wanted to do the right things, changes in roles and responsibilities were not priorities with all the group. Three of the sample were working women and their comments reflected the value placed on their role also: "At work I am very busy and I don't have much time to worry about him." One woman who took her holidays to be with her husband was delighted to return to work: "I'm not fussing and worrying as much now that I'm back at work." Another subject who had spent long hours in meal preparation for her husband's return home felt she would do anything for her husband, but she was not going to be a slave, and she was "paying the bills too!" She commented:

I think that's where the difference lies between one woman's reaction and another. If you are working all day you have to cope with everything, but if you're not working you sit home and fuss and mope and do all the little things for him you want to do.

### Redefining

At this time the majority of the subjects continued to redefine their philosophical beliefs in light of their losses. They seemed to attach meaning to more concrete signs that life was returning to normal. Their comments reflected a more positive and accepting attitude. In drawing an analogy from one's reactions to death a subject summed up these ideas:

Well you know this thing (heart attack) is like what happens when someone dies, there is so much confusion and change and you wonder, well, should I do this or will I now have to do that, and everything is kind of up in the air, but after a few weeks or months, things settle down and life goes on. It has to, whatever is going to happen will happen, there is no point worrying about all those things.

Only a couple of subjects spoke about the future in terms of anticipating what to expect or how to plan. The majority of the group thought from day to day and tried to be as positive as they could:

Well, I think there's no sense in planning the future because you never know. You don't know the score from one day to the next really. At first that upset me, but it doesn't now because I know you can't change it, so you just make the best of the day.

The subjects' thoughts revealed a more egocentric focus during this time. Many subjects continued to look at themselves in this situation and comment on how they were affected by the loss. The spouses saw themselves as "holding down the fort" and this responsibility resulted in some negative feelings. Some grieved for their own time and independence. A few felt that 24 hour responsibility for their husbands was too much and they wanted their own space. In an animated conversation one of the subjects described how "stir crazy" she felt:

The first week was terrible. I couldn't get out at all. My neighbour was my psychologist. I ran up there one day and said, have you got anything to do, jigsaws, anything. I'm going out of my mind!

In conjunction with a desire for more free time, four subjects reported feeling overwhelmed. The altered roles and extra responsibilities kept them very busy. These four worked hard without any significant recognition of their efforts. The resentment was now starting to surface:

Well having him around there's nothing worse than having him sitting around all day. Your routine is off--your're going back and forwards running errands. Men are not good patients. He won't do anything. I scurry around and do the housework; he watches T.V.

A real concern for one subject was the loss of a well-established routine at home whereby her husband would prepare the evening tea. The illness disrupted this special relaxing time for her. She reported:

Well of course when he was sick I started doing it (preparing evening tea). Well God I was nuts to start doing that again. He's a lot stronger now and he can do it but he's got that he'd just like to sit there and let me do it and this has got to me. Maybe it's cause I'm tired, it wouldn't really irritate that much but I haven't even had my shower yet!

## PHASE II--Feelings

### Mood

This time was characterized by a general mood of gratefulness. Of the ten subjects, seven reported feeling better. This optimistic mood apparently evolved from the definite signs of their partners' recovery. Because their partners had "made it"--were so cooperative and accepting of their restrictions--the subjects felt they indeed had something to be thankful for. One subject was delighted to find many of her fears were unfounded and her mood reflected the positive turn in events:

Well things are going better than I expected--I'm feeling pretty positive cause he's doing pretty good--I'm feeling more relaxed and things are starting to get back to normal ... So I can sleep now, and it helps that he's home, and he's taking it (heart attack) the way he is.

In commenting on their mood state, four women discussed their feelings of ambivalence. Three of the subjects reported this ambivalence had affected their mood in that they felt "lower or more irritable." The women were pleased and grateful for their husbands' recovery, yet at the same time they desired recognition and thanks for their efforts and more free time to themselves. The subjects felt



guilty about this need and they frequently berated or admonished themselves for being so selfish. These feelings are illustrated by this subjects' comments:

Well I feel exhausted, cranky and irritable at times. I'm up early I do all this and that and he doesn't seem to appreciate it. I get down sometimes. You know he seems so well you sometimes forget he is sick--it's just that somedays I think that I get left behind. Sometimes I wonder about my feelings I think, you are selfish, and I feel bad, but it's just that you have feelings and you have your own life too, but it's just that what I feel you can't take out on you husband so.

#### Physical Disturbances

A correlation was found between mood state and physical or health status. In the sample, six subjects reported feeling calmer and more positive as appetite and sleep patterns returned to normal. Four subjects reported feeling stressed, with complaints of sleep, appetite and stomach disturbances. One woman, who previously had appeared very positive and calm without any health disturbances, now experienced a "delayed reaction". She described how her feelings had affected her health:

I was really sick that first week when he came home. I had terrible headaches. I think the heart attack hit me stronger than I realized. My head was so bad I could hardly see and my neck, apparently the veins were all swollen up and it was really rotten. It started the day before he came home and I went to see the doctor and he put me on some medication. The doctor thought it was all the stress.

Increased fatigue was reported by the majority during this time. Though their mood and sleep patterns may have improved the changes in roles and responsibilities along with the ever present worries of relapse contributed to the growing fatigue.

## PHASE II--Actions

### Verbalized Behaviours

During the first week of their partner's discharge the majority of subjects reported behaviours which seemed to be assessment-oriented. They watched their partners constantly, checking to see if they were in any distress. Their new protector role, in conjunction with the extra domestic, social and financial responsibilities meant a very busy schedule. The freedom from hospital visits, however, allowed more time for some of the new routines at home. As the week progressed and recovery seemed more assured, many subjects reported things were now starting to get to normal. As one woman stated, "It's better to have him home than when he was in the hospital; before I had no time for anything else and now I can watch him better." Four of the subjects felt their roles and responsibilities were greatly altered, and they did not see their lives as returning to normal. These women grieved for their own time and independence, they felt their "24 hour duty" allowed for little private time.

Concerns regarding diet and activity and medication were voiced by the majority. The information guidelines provided by the hospital were perceived as helpful. Yet questions regarding these topics indicated a need for validation and reassurance rather than for

information. Two subjects did focus a good deal on diet as evidenced by their lengthy discussions. These women had researched low cholesterol diets in detail and had spent hours in meal planning and preparation.

The topic of helpful others was introduced again in this phase by seven subjects. Friends and family were usually seen as helpful: they offered encouragement and spelled off the boredom for the convalescing partners. One half of the group who had family contact spoke positively of the assistance they received. Family and close friends in particular were seen as helpful "as long as they don't overdue it" in terms of tiring the partners.

Two subjects mentioned their frustration with their well-meaning friends who insisted on imparting all their knowledge about heart attacks. One woman coped by leaving her phone off the hook.

A few subjects had contact with their general practitioners during their partners' check-up visits. These subjects stated the visits were helpful in terms of information offered and validation of their partner's progress in recovery. However, only one subject approached her doctor to discuss feelings or concerns.

The findings reflected a decrease in communication between seven of the couples. The topic of the heart attack was rarely discussed between the couples, especially after the first week at home. Often the impetus for discussion arose when friends and family visited. As one spouse stated, "It's only when visitors come that we talk about it, otherwise we never mention it."

Four of the subjects expressed concerns that their partners did not know or appreciate how tired and stressed they felt. These women felt in a quandary because they wanted appreciation and sympathy, yet they did not wish to draw attention to their needs and feelings for fear of causing another heart attack. One woman expressed her conflict:

Well (my husband) is not a talker, he keeps everything to himself-- I get down sometimes and he doesn't seem to realize! I don't know why. I'm just keeping my feelings inside. I'll never say anything to him. I just go and lock myself in the bathroom ... I find I'm eating too much. I'll have to stop, maybe it's a part of this stress, I don't know.

The communication patterns of the remaining three couples could be described as open in that they shared their feelings and concerns and seemed to be aware of each other's needs. Two of the subjects set down some "ground rules" with their husbands without fear of reprisals. Both women took a firm stance on refusing to buy cigarettes for their house-bound husbands. This was an area with potential conflict but they were able to resolve the issue by discussing it with their partners.

#### Observed Behaviours

The behaviours of the subjects as observed by the investigator during the third interview were found to be congruent with the reported behaviours. The overall mood of gratefulness and air of optimism were reflected in most of the subjects' actions. Their speech and hand gestures were animated, their faces were bright and they smiled

frequently. The subjects were well groomed while their posture was more relaxed. There was an absence of nervous tapping, fidgeting or tremors seen in the earlier interviews. Good eye contact was maintained throughout the interview.

During the third interview period, three of the subjects behaved similarly to the rest of the group although their actions were somewhat more subdued. These women were friendly and talkative, however, the tone of their speech was softer and lower with more frequent sighs. They looked fatigued, with lined and drawn faces while their body posture was slouched. Good eye contact was usually evident and occasional smiles were noted.

One change in behaviour from the previous interviews was the increase in the number of social overtures shown towards the investigator. These social gestures varied from offers of tea and coffee to tours of their homes and invitations extended to dinner or other social events. This social theme was also reflected in the increase in "social chatter" in the subjects' conversations. In comparison with previous visits, a greater proportion of the third interviews was comprised of discussions of family topics, social activities, hobbies and interests. For the first time, several of the subjects indicated interest in the investigator's situation beyond the interview setting by questioning her hobbies, career goals and family life.

### PHASE III Impact of the Event

The last interview covered the early convalescent period of the patient, varying from day 20 to day 38 post discharge, with an average of approximately 28 days. The findings of the fourth interview revealed two more distinct patterns in the thoughts, feelings and actions of the ten subjects. Up to this point the subjects had shared many of the same feelings and concerns as reflected in their reported and observed reactions.

The findings were separated into Group A and Group B to illustrate the differences in the subjects' responses. Group A comprised seven women, the majority of the sample. Group B were the remaining three subjects, one man and two women.

#### PHASE III--Thoughts (Group A Findings)

The thought categories identified in phase three were assessing and redefining.

#### Assessing

The subjects continued to assess their partners' physical and emotional health. Generally the subjects did not view the recovery as positively as in phase two. As the convalescence lengthened, many of the husbands were getting bored and frustrated with their inactivity. Some patients tended to overdo it and experienced subsequent pain. One subject was so frustrated with her partner because he never disclosed

how he was feeling. She feared he was overactive:

I think about him a lot; if he was honest with you and he'd tell you just how he feels then it would make it easier, and when they don't tell you, you have to guess and then it makes it harder, and sometimes he can hide it (pain) pretty good too.

The subject discussed concerns that loomed in the near future: fears of their partners' driving and returning to work. This discussion often led into the overall fear of recurrence, a worry that had not been strongly voiced since the early hospitalization period:

Well I don't think he should go back to work, it's too heavy--well not for a few months--but then if it means he'll be cut off his pension, then he'll have to. A pension is important, but he should take light jobs--but I wonder if he'll have another one, of course he's been careful and he hasn't had any more pains, he has been good all along.

I worry about another heart attack, especially when he goes back to work. I'm not really a worrier, but when he goes back to work with that company he always does more than his job--it's so hectic, a lot of deadlines and (my husband) flares up so easily in work situations.

Even if the patient's recovery was uneventful, the women did not view this time as positive for the stress of having their husbands "around all the time" as well as the extra demands placed on them added a lot of pressure. All seven subjects assessed the changes in their lives. The changes described a few weeks earlier had grown to occupy many of the subjects' thoughts.

### Redefining

Many of the subjects thoughts were egocentric in focus. The women viewed the loss from their perspective. They discussed how they saw themselves in this situation as a result of the loss. They continued to speak of their protector roles and extra responsibilities, but also began to verbalize how many of their thoughts were focused on themselves. The time had come for them to take a hard look at their lives and their future. One woman expressed these thoughts well:

Well, this last week I've become very very self-centered--I really became greedy--no not greedy, just over concerned, over compensating for myself--I was absolutely at the end of my rope, I couldn't take it. I've been thinking, I'm young and I've got a long future ahead of me and it's really something to think about. If I thought (my husband) would be incapacitated or unable to get back into the main stream it would really involve a lot, and the kids--and we have a lot of financial problems.

The disruption of a normal life meant extra worry and responsibility for many of the subjects:

It takes a lot more effort, you have to think more about every thing--you really have more to worry about, like before you didn't worry, you just knew everything would go by plan, and not it's all--well it's all stopped. It's like grand central station here--I'm buried with responsibilities, it's hard 'cause I've never had all these before. I don't mind because I know I can do it, but it gets to you--it adds up, all the responsibilities.

Several subjects mentioned that the changes in their routines were patterned after their husbands' wishes. They conceded to their



partners for fear of initiating an argument and possibly another heart attack:

He wants to do the things he can't do but then he doesn't want to do some of my work, even simple things, yet you don't want to have a row so.

My house today is so dirty, it looks like a hurricane hit it, yet I can't touch it. (My husband) wants to do the painting outside--and it's just not worth the argument to say, look I want to do the housework, but it's very important to me because I am a very fussy housekeeper.

### PHASE III--Feelings

#### Mood

The upward swing in mood found in the early post discharge period was no longer apparent in this group. A general slump in mood level was reported. The impact of the illness really seemed to have "hit home". Feelings of depression, resentment and guilt were most commonly reported. Several of the subjects discussed their depression openly.

One woman spoke quietly:

Well he is okay, no problems there but I think my mood is lower compared to how it used to be. I am quite normal, but I am nervous person though.

Although the alteration in mood was noticeable with all the group subjects the intensity of depression was most remarkable in the two youngest women. Both of them had adolescent children at home financial concerns and other responsibilities. One 34 old woman described her mood since our last visit:

Well the last couple of weeks really turned around. I became very deeply depressed. Small things kept bothering me, I got stuck with all the work, the house, the garden, everything. I have been really very teary--I become physically very ill. The doctor gave me some antidepressants, they are just starting to work ... Things are picking up a bit, they couldn't have got any worse.

This same woman had spent a great deal of time reflecting on her thoughts and feelings. She expressed her home and family responsibilities and her role in this situation:

I don't have time to be sick, you have no time to break down--you have to be the pivot point for everyone, so the more people involved the more difficult it becomes. The younger the family is, then it becomes even more important.

Many woman grieved for their own time and space. So many demands had been placed on them that they felt "buried". The extra demands combined with the lack of recognition for their efforts were reported as major concerns. One subject reported feeling "left behind", continuing she stated:

Well I don't begrudge doing anything for anyone, but I don't have any time. Anyway, maybe it's just the way I'm thinking, but I feel nobody cares that I don't have any time, and nobody knows how I feel.

The majority of the group spoke of their desire for time to themselves. This time was difficult to come by. Even if they "freed-up" their time and responsibilities they had their partners to contend with:

I am one of these people who likes time to myself, I don't know what I do with it, but I can't really get along without having

that time. Right now I can't go into town by myself--he'll say, oh I'll go with you, and I don't want him to!--and he won't understand that I don't want him to come.

The resentment reported in the early discharge period was pronounced a few weeks later. Four subjects verbalized resentment over the lack of free time. The extra responsibilities: cooking, cleaning, caring for husband, children, entertaining visitors, all compounded this feeling. One subject explained emotionally why she felt so angered and resentful:

I have had dozens and dozens of visitors in my home these last few weeks. I told them (the latest visitors) I can't take any more of this, no more people visiting. (My husband) is very surprised to hear me say this. Men can't really understand all of this because they really have no reality on the subject at all! They don't know what's involved in the cooking, cleaning, laundry, towels, bathrooms. Really! They think the magic fairy does it all, and when all your visitors are here you still have to do all the cooking, cleaning and keep doing things, keep people fed, keep them entertained.

Along with airing their resentment the subjects in the same breath, admonished themselves for being so selfish and unkind. They wanted to express their need for more free time and recognition and at the same time to acknowledge their gratitude for their husbands' health and their good marriage. This ambivalence surfaced with several expressions of guilt:

No really, I'm so grateful he's home and he didn't have a worse heart attack. I think how selfish I am that I think of these things when I should be so grateful he's here.

You feel that you are wanting all the attention, and there's nothing wrong with you really--it's just that I'm feeling short changed, and then I feel guilty, I could of lost him, which I never wanted to do--and he's the best of husbands and he provides and he's so good and he has spoiled me terribly--but just a nice kind word would be nice, and then you get to feeling bad because they (family) are not unkind.

The impact of the illness finally hit one subject, a woman who had previously denied any concerns and had consistently maintained a very light, cheery manner. She spoke of her experience:

I had a delayed reaction, it dawned on me exactly just what had happened--it dawned on me that it was July, my mind was a blank and things hit me all at once. I was really scared. It was horrifying, well, the thought that God he could have gone--and I thought of finances and what could I do?--an apartment--I could never look after this house, I mowed the lawn for the first time in my life this week because (my husband) used to do it--and all those things hit me just like that!

### Physical Disturbances

The general emotional slump felt by the subjects coincided with reports of increased fatigue and irritability. This fatigue ranged from "being tired" to feeling incapacitated. In retrospect one subject described her fatigue, "Gee it's really frightening, I just didn't realize how tired I was, I was so sleepy all the time!"

Three women were the most seriously distraught and reported the greatest number of physical symptoms:

I became physically very ill, it was just everything. It manifested itself in my

back and kidneys and stomach--At first I thought I had a kidney infection.

These headaches keep bothering me, they are right at the back of my neck. I don't really feel like eating. I'm not sleeping much, I'm up every hour or so.

### PHASE III--Actions

#### Verbalized Behaviours

As the weeks progressed the subjects continued to fulfill the protector-controller role as they had done in the early phase. This role did not occupy as much of their time for their husbands were convalescing well. Along with this recuperation came boredom and frustration for the patients, and so they looked to their spouses and friends for entertainment.

The changes in roles and added responsibilities continued to keep many of the women very active. As the weeks passed by the continual energy required to cook, clean, organize family and watch over husband began to show its full impact. Organization of the partners' diet still occupied a lot of time for two subjects.

The topic of helpful others was discussed again during this period. Due to their general fatigue and slump in mood several subjects did not welcome visitors at this time. A few close friends and relatives were helpful in relieving the patient's boredom. Too many visitors, however, were perceived by the subjects as tiring for both patient and subject and therefore not welcomed.

Although the subjects confided freely with the investigator, they spoke of a general reluctance to discuss their feelings with their

partners, friends, family or physicians. Two women, both teary and depressed described this reluctance:

I need someone to talk to. I hate to go to my doctor, it makes me feel stupid, 'cause there's nothing really wrong, well (my husband) is better so--I hate talking to a strange doctor--I'd just end up in tears, and I'd feel worse. I'm sure it wouldn't upset the doctor but it would upset me.

Well, you can't talk to your friends or relatives about this, even with your doctor you can't talk because he doesn't really understand. There's nothing that the doctor can say to the wives, naturally the doctor is more interested in the patient, but the effect it has on the family and the spouse is tremendous, and the younger the family the more traumatic because that means more people involved and more future to think about.

Many subjects described a hesitancy to disclose their thoughts and feelings with their partners. Several felt their husbands could not or would not understand.

Some men are like that--he has noticed I'm getting tired but he just doesn't do anything to help--he just doesn't think.

(My husband) can't relate to how I feel, he just doesn't see it. I don't know why. I cried, he is very sensitive to that, but he still doesn't understand.

### Observed Behaviours

The changes in the group's mood were well reflected in the subjects non-verbal behaviours. The subjects appeared quieter than in the previous interview. The overall reports of fatigue and depression were evident in their tone of voice and slouched body posture. These

subjects sighed a lot and rarely smiled. Active hand movements, tapping, clasping and unclasping of hands were noted with two subjects. These movements were absent in the previous interviews.

Three subjects who had looked fatigued two weeks earlier appeared more so at this time. Their faces were drawn with dark circles under their eyes. A subject, who reported being deeply depressed, spoke in a soft monotone voice and her posture was slouched. She looked drawn and wore no make-up. Her obvious depression was in stark contrast to her previous appearances as a well groomed, energetic, articulate woman.

The social theme evident in phase two was found to be subdued at this time. Many subjects made some type of social overture to the investigator but the gestures were not as effusive.

### PHASE III (Group B Findings)

The thoughts, feelings and actions of the remaining three subjects varied significantly from Group A. Group B subjects seemed better adjusted.

These subjects discussed their present situation at length but also moved beyond the present to a future orientation and spoke optimistically of the months and year to come.

This group comprised three subjects, two women and one man. The two women had full-time employment outside their homes. The man, although retired, supplemented his income through his art work. All three subjects had children but none of them had family members living at home.

### PHASE III--Thought

The main thought characteristics found in this group were assessing and planning.

#### Assessing

The assessment included the checking of their partner's physical and mental health and as the weeks progressed these thoughts occupied less of the subjects' time. The assessment varied from the Group A subjects in that it expanded to include more of an "us" or partnership orientation. The subjects examined, as a couple, the changes that had occurred and were still to come. They planned realistically, yet optimistically for the future. One subject discussed his thoughts about his wife's heart attack:

Well I suppose it's a veneer on almost everything. You think of everything in terms of is it too much, or are there too many visitors and so on--but I find as each day goes by (my wife's) situation takes a little less of my thoughts, so now I can think more in terms of what I am going to find over at the store, rather than I must be away only twenty minutes. The time has sped by and she is just so much better.

Time dimmed the memory of the heart attack, and life began to return to normal for these subjects. The determination to live a normal life and "push" the heart attack from their lives was felt by all subjects. One woman explained this feeling:

I think life is getting back to normal. The longer it gets--like today it's been six weeks since the heart attack and every week it gets a little bit better and we are pushing it away. Because, for one thing, you don't see anything, if somebody would



really look down or bad then you would have that in front of your eyes all the time, but this way is different. So we just do things and life goes on.

The heart attack brought many changes to the lives of these subjects. Whatever the new limitations, the group seemed able to cope well; the changes were accepted matter-of-factly. These subjects looked on the bright side of the changes in their lives:

Well I don't know, but I think that everything goes for the better! He has changed completely he has been more talkative. Now he says if something hurts or whatever, and he does things around the house. Well sometimes a change can bring a good reaction too. I go for walks a lot more than I used to. He chases me out for walks. It's good for both of us.--I'm happy, I think we both did pretty good!

### Planning

Subjects planned realistically yet optimistically for the future. A heart attack can act as a catalyst in a couple's lives, bringing welcomed change. One couple finally decided to sell their home--something they had been "sitting on" for years. This same spouse was delighted with the changes involved with the heart attack such as fresh air, exercise and extra time spent with his wife. He explained his new situation:

Gosh I don't know how to say this--but ah--a heart attack can have a lot of benefits too! (laughter)--it forces you to go out and do the things you've always wanted to do!

All three subjects took stock of their situations. They reflected but did not dwell on their losses; they viewed their life and their

relationship optimistically. Realizing that their time together was tenuous they seemed to look forward to the future, determined to make the best of it. One woman portrayed this frame of mind with these words:

Some people think about it (heart attack) all the time, and well you can create more trouble for yourself. Sure everything looked so grey and dreary at first but now it's starting to look better--you have to say well it's happened, now let's try and make the best of it. Well I know it's hard to plan for the future, but we are going with a good frame of mind for our vacation--and our daughter is coming to visit in October so ... .

For one man, the heart attack precipitated a reflection on his own mortality:

Well I think it (heart attack) certainly makes you realize that you are mortal. You know, you don't go on thinking you never reach the end. So (my wife's) heart attack has caused me to think a lot--but ah, maybe that's a normal way to go and that's how acceptance builds.

Acceptance is described in another subject's thoughts. She seemed to size up the past, present and future realistically, yet with an air of optimism:

Well we are both intelligent enough to realize that we are very lucky, and we have a lot going for us. We have nothing to complain about; after all I'm fifty-seven and (my husband) is sixty and we've had lots of good times in our lives. It's not like we are thirty. And yet we have a lot of good times ahead, as long as we do the things that we should, and maybe do a few differently. And (my husband) loves to paint, and really wants to get back painting so I told him to get his easel up and get busy!

One subject compared his situation to other heart attack victims.

His comments spoke to a frame of reference:

Well we were walking this morning, and you can see the fast walkers, and you can spot them and can say well he's one of the club! (Heart attack victim.) You know what I mean, very muscular men in their fifties and walking to beat hell, and you think well they've been there too. And you see them hustling around, and that makes you feel more comfortable with the future.

### PHASE III--Feelings

#### Mood

In contrast to the often depressed mood of Group A subjects this group reported feeling calm, thankful and in good spirits. These feelings were reflected in their conversations:

Well I'm about 99 percent back to normal, I'm feeling good. Sure everything looked so grey and dreary at first, but now it's starting to look better.

Well I'm feeling easier, every day is another mark on the wall--I'm feeling pretty well myself now. There's no concern at leaving the house where as at first you get scared really to go out and then you kind of run back every five minutes to see if she is still alive; not now, now I'm more at ease.

One woman, in earlier interviews, had expressed a lot of resentment and anger towards her husband. She felt he had precipitated his own heart attack. He had ignored her pleas to change his behaviour and subsequently had a heart attack. Her comments in this last interview seemed more insightful. In examining her behaviour she had worked hard at a new approach, one she felt yielded a healthy compromise:

I guess maybe I still have that bit of resentment, if I allow it to be, but if it get busy and do something to occupy my time then I'm fine. You know it can well up inside of you and it does. I couldn't possibly survive if I didn't say something. I'm not going to be a mickey mouse with him just cause he had a heart attack but at the same time I'm far better than I used to be, simply because I don't want him to have another heart attack. And if that means that for me, not saying a lot will help, then okay, and it seems to be working out fine.

### Physical Disturbances

The reported improved mood and general feeling of calm and optimism were also reflected in a improved state of physical health. All three subjects reported feeling well, their sleep and appetite patterns were "back to normal." The fatigue and irritability described by Group B were not reported by these subjects.

### PHASE III--Actions

#### Verbalized Behaviours

The changes in roles and responsibilities in this group were shared by both partners. Two subjects, both working women, found their husbands assumed more of the domestic roles during their convalescence. This had a dual benefit: it alleviated the husbands' boredom and lessened the subjects' responsibilities after work hours. One subject spoke of the changes in her husband's attitude towards the housework:

Well when I get home from work I'm tired  
and I fall asleep for awhile. Well he has

changed completely, he does things around the house. So he is active, and he says why did you do that, just leave it for me, so he keeps busy--I don't mind him doing the dishes, it's not like before, there was just one person, and that was me, you know.

One energetic spouse had been moving furniture and cleaning carpets the day prior to the interview. She spoke sympathetically of her husband's feelings:

Well (my husband) feels so badly that he can't do anything for me. I said don't feel bad about the carpets, there are other things you can do. So he's been cleaning the silver and fixing the meals and it really helps.

Switching roles came easily to one of the subjects. He explained how the couple's experiences had helped them cope with their present changes:

Well it's been pretty easy. We don't really have a lot of defined roles--and we have been through this in a kind of mini-series before you know. Like if (my wife) was laid up with anything, or if I was laid up with anything it was the same as it is now. We'd just switch roles, so there hasn't had to be any accommodation to another role.

No concerns were voiced by this group in regards to diet, medication or activity. The subjects were pleased with the convalescence and they did not feel their partners were "overdoing it". One patient had already returned to work part-time. This activity was welcomed by both patient and subject with no difficulties reported. Returning to work was a concern for one 53 year old subject. She felt her husband, a labourer, would no longer be able to handle the shift work and physical responsibilities. Her attitude, however, was positive:

Well it might not be so easy for (my husband) but we'll just have to see how it works out. It's not the end of the world anyhow--I'm working so it helps some.

All three subjects reported a fairly quiet social life. An occasional visit from friend or relative was welcomed but there was a general tendency not to reach out and initiate a lot of social contact. Both parties seemed to agree on the amount of socializing to be done and were able to arrange an appropriate schedule.

Two subjects expressed positive feelings about their family doctors. They found them helpful, particularly in offering information and validating their partners' positive recovery.

One subject mentioned how he found other heart attack patients helpful and comforting.

Yeah, there's an amazing number of people that have been through it (heart attack) and you meet them and you realize it's not all that bad, it's scary, but see, they are still going strong, so ... .

The communication between the subjects and their partners was reported to be "good" and in some cases had improved since the heart attack. The illness had drawn these couples together; they seemed able to share their thoughts and concerns freely. This time was used to reflect on their relationship and their current situation. Many of their thoughts, feelings and actions had a team orientation:

Well the heart attack is in our conversations, but we don't dwell on it. This has been a serious situation and it brings you closer together. I suppose closer in the way that there is a complete dependence on one another. Well (my wife's) attitude has been great. She knows exactly how much she can take, so it's been pretty well a 50/50.

decision. We haven't consciously said well what do you think, it just happens.

One subject complained that her husband used to work midnight shift and this had strained their relationship. Since the heart attack she had noticed changes in their relationship and she spoke positively of this time:

Well he has changed completely. He has been more talkative. Before he would hardly say anything, and now he talks about his heart attack and what he has been doing. Now it's better, because when I come home he's awake, and we talk. Before the heart attack, I only saw him sleeping from the shift work, so now it's better.

### Observed Behaviours

The behaviours of the subjects during this last interview were congruent with their reported reactions. They seemed to enjoy the interview. They were alert and responsive, devoid of many of the anxieties and tension noted in the earlier group. The faces and body posture of the spouses appeared calm and relaxed. This contentment was also reflected in their eye contact and voice inflection. The subjects used their hands to gesture appropriately or else they held them in their laps.

One man, sitting nestled in his favourite chair, leaned back occasionally with his hands behind his head. He seemed delighted to have the opportunity to talk. In fact none of the subjects were in a hurry to terminate the conversation. The friendliness and comfortable atmosphere were also reflected in the number of social overtures made

to the investigator. This group was very social and initiated offers of tea, lunch and discussions of family and other interests.

### Summary

The findings from these three phases revealed a common pattern of behaviours which spouses of myocardial infarction patients experienced in response to loss. The pattern of behaviours comprised the thoughts, feelings and actions of the subjects from the initial impact of illness to six weeks post myocardial infarction. The data described the process spouses experienced from the initial perception of the loss to the subsequent impact of the event.



## CHAPTER 5

### DISCUSSION

This study focused on the reactions that spouses of myocardial infarction patients experienced in response to loss. The subjects' thoughts, feelings and actions were described in Chapter IV. The findings indicated that the spouses experienced behaviours in response to loss that were common and formed a pattern through time. Three distinct phases were identified: the event and initial spousal response, reaction to the event, and impact of the event.

In order to understand the ongoing process of loss experienced by the spouses, the findings were interpreted in light of the three constructs elucidated in the literature review: the reactions to loss, the elements of loss, and the meaning of loss. The purpose of this chapter was to integrate the findings with the loss literature and thus to develop an understanding of the phenomenon of loss for spouses of myocardial infarction patients. An overview of the interpretation of the findings is presented in Appendix F.

#### Phase I The Event and Initial Spousal Response

##### Reactions to loss

The thoughts, feelings and actions of the subjects in this study had a close resemblance to the characteristics of anticipatory grief as identified by Lindemann (1944). Lindemann described acute grief as a definite syndrome with psychological and somatic symptoms. He suggested that individuals who experienced anticipatory grief moved

through the same process of grief work as those who had experienced grief after an actual loss. Lindemann described grief work as a heightened preoccupation with the departed, a review of all forms of death which might befall one, and an anticipation of the modes of readjustment which might be necessitated.

The period of "heightened preoccupation" was a "very heavy thinking time" for the subjects and several thoughts occupied their minds. They often questioned why the loss had occurred and attempted to apportion blame somewhere. Not only did they search for a cause, or reason, but they also looked for some frame of reference, a concrete comparison to help them understand and accept their loss. The subjects' cognition extended to include thoughts of their marriage and their lives together. In taking stock of their lives they often reflected on how much they loved and needed their partner. This "heightened preoccupation with the departed" was also described by Parkes (1971) in his London widow study where he termed the behaviour "searching".

Lindemann also noted that the wives of soldiers who had departed for war reviewed the forms of death that might befall their loved ones. Bereaved persons often have a need to review the events leading up to and surrounding the death of a loved one. Fulton and Fulton (1972) concluded that families faced with the terminal illness of one of their members will rehearse the death before it occurs. This rehearsal may include thoughts about when, as well as how, the patient may die.

Rehearsal of death is an ominous phrase, yet one that aptly described the subjects' thought processes of reviewing and anticipating during this critical time. A common behaviour noted in this study was

the "blow-by-blow description" or "how it happened". This behaviour termed reviewing, seemed to allow the subjects time to reflect and contemplate the extent of their experiences and integrate the past events and feelings, with the present. Working through the past memories may have assisted the subjects in accepting the reality of the present and the threat of future loss. The majority of subjects viewed death of the spouse as close. Their greatest fears during the first week were of complications and of recurrence of another heart attack for their partner. They perceived this time as critical and uncertain and thus would lie awake at night, rehearsing or anticipating the worst that might befall their partners.

The subjects' behaviours of anticipating can be interpreted in light of Lindemann's third characteristic termed "anticipating the modes of readjustment". Initially, the subjects questioned whether their lives would change in the future, and they acknowledged the changes that had occurred in their daily routines within the last few days. As the patient moved closer to discharge, the subjects anticipated the changes that would occur in their lives and the readjustment that these changes necessitated. All of the subjects agreed that their partners would have to change their lives with regard to work, social activity and diet. Three quarters of the subjects feared and prepared themselves for the worst in terms of their partners' physical and psychological adjustment. Of the twelve subjects, nine spoke specifically about the anticipated changes that would affect them. Over one half of these subjects feared the worst. The thoughts of the modes of readjustment related to the illness, not to the death of their

partners. The spouses feared the worst in terms of changes and upset in their normal routines but they did not discuss readjustment that might be necessitated by the partner's death. Although fear of death was certainly on their minds it may have been too painful to entertain for any length of time. When the thought of death was discussed it was in relation to feelings of helplessness, loneliness and depression.

The reported mood states and somatic disturbances described in this acute phase approximated several of the anticipatory grief actions described by Lindemann. In addition to corroborating Lindemann's findings, the reactions of the subjects during this critical period of the partner's illness are similar to the reactions described by other writers who have focused specifically on the stages or phases that follow a major anticipated or actual loss (Bowlby, 1961; Engel, 1962; Fink, 1967; Kubler-Ross, 1969; Parkes, 1972; Shontz, 1975). The subjects' initial responses to loss in this study mirrored the reactions described during the initial phase or stage of a major loss.

Grief reactions were well described by many authors (Parkes, 1971; Royle, 1973; Skelton and Dominian, 1973; Larter, 1976; Mayou, Foster and Williamson, 1978). Their description of loss resembled the initial reactions described by the subjects of this study.

The findings reported by Skelton and Dominian (1973) and Mayou, Foster and Williamson (1978) were of particular relevance. These writers studied a representative sample of wives of myocardial infarction patients during the acute hospitalization period. Common reactions noted by both researchers were sleep and appetite disturbances, anxiety and tension. Skelton and Dominian (1973) reported

feelings of loss and depression as well as other psychosomatic illness related to the patient's heart attack.

The study reported spouses having many different feelings, however, depression was not commonly described by the subjects in Phase I. This finding was interesting, for it differed from Skelton and Dominian's study, where reported and observable behaviours of depression were noted. Mayou, Foster and Williamsons' (1978) findings, on the other hand, noted depression as a later reaction evident in the interviews two months after hospital discharge. The findings of this study concurred with this view.

In terms of actions verbalized by the subjects, a noteworthy difference was found between the investigator's data and the findings of Mayou, et al. These researchers noted the subjects had a tendency to cling to other people. None of the subjects in the present study described what could be reported as clinging behaviour. Six subjects felt family and friends were helpful without apparent dependency on this assistance. Five of the sample preferred to be alone and did not appreciate contact at this time as it was a busy thinking time and they desired solitude. There seemed to be a variation in the degree to which friends, family, doctors and nurses were reported as helpful by the spouses. Further, the spouses rarely sought information from the investigator. Although the majority of subjects indicated a need for information, it appeared that the structured cardiac teaching program met their needs during this early phase.

The period of reacting to the event was described as a lonely time. The subjects only wanted to be with their partners and often no

one else could substitute. As one spouse stated, "If I can't be with (my wife) then I'd just rather be by myself." This behaviour is similar to that described by Marris (1968) in his study of the effect of bereavement on London widows. He found the bereaved often tend to devalue all relationships except the one which has been lost, so that instead of turning to children, family or friends the widow may become almost indifferent to them.

Although the myocardial infarction spouses in this study seemed uninterested in social contact they did, in fact, yearn for attention and support as evidenced by their eager willingness to talk to the investigator. One woman described the researcher as a "caring outsider". Although the researcher was concerned about being intrusive at a time of grief, these individuals reported that the research was very helpful. The subjects had a great need for ventilation. This need is well documented in the literature (Lindemann, 1944; Glaser and Strauss, 1965; Parkes, 1971; Hampe, 1975).

Dracup and Breu found a similar reaction in interviewing spouses of critically ill cardiovascular patients. They found the spouses expressed gratitude for having the opportunity to share their feelings with an objective, empathic person--a person outside the family unit--in which all of the members were sharing their anguish. The researchers believed the benefits of additional support and an opportunity to ventilate their reactions outweighed the risk of psychological trauma. Parkes (1971) found a similar reaction when he undertook a longitudinal study of the reactions of London widows. Although the widows often withdrew from social contact, they welcomed

the investigator's study. Initially Parkes had some misgivings about the study, for he did not wish to intrude upon the widow's grief and cause her unnecessary pain. He found, however, the opposite:

On the contract, the majority seemed grateful for the opportunity to talk freely about the disturbing problems and feelings that preoccupied them ... she seemed to find the interview therapeutic ... I had no sense of intrusion after the first few minutes of the initial contact. (Parkes, 1971, p. 35.)

### The Elements of Loss

Both the literature and this study found that an analysis of the loss process produced some common elements or characteristics. From the comments and observed behaviours of the spouses it was evident that the elements of loss were related to the perception of the event in time.

The loss was a sudden, traumatic event since the heart attack was unexpected. The heart attack had occurred but was described by the spouses in three separate time frames. They reviewed what had happened, discussed the loss in terms of the present consequences and anticipated loss for the future. In particular, the event had a strong future and anticipatory quality. The subjects focused more on the threatened or anticipated loss of their partner. It was a critical time for the subjects with the fear of their partner's death looming as a formidable loss in an uncertain future. The heart attack also precipitated the recall of other loss experienced in the past which seemed to offer a frame of reference for the spouses.

Loss was also conceived as two events occurring simultaneously. From the objective eye of the investigator the heart attack was viewed as an observable concrete event: an actual loss that had clearly altered the biological functioning of the heart. For the spouse experiencing the same event the loss was a very subjective one.

### The Meaning of Loss

The full reality of what had happened did not penetrate the consciousness of the subjects at first. The reality of any catastrophic loss producing grief is generally too overwhelming to perceive accurately and to integrate fully. That which had occurred was incongruent with the reality previously known to the subjects (Carlson, 1978). Most of the subjects described their feelings of shock and disbelief while their reactions revealed a gradual development of awareness as they began to understand and attach some meaning to the loss.

Although persons commonly go through the same stages or phases following a major loss, there are several differences that can occur in this passage. For example, an individual's "timing" may be different: one may move slowly or rapidly through phases, bypass a phase, or perhaps vacillate between phases (Carlson, 1978; Roberts, 1978). Carlson developed this point by saying that generalizations about personal experience and behaviour are useful only when one maintains a commitment to the understanding and acceptance of individual variations (Carlson, 1978, p. 88).



Most of the spouses reported similar behaviours during the initial impact of the illness; however, two subjects did not "fit" the described behaviours of the group. Two women denied feeling any shock or numbness and reported feeling "pretty good and well". Their behaviours, as observed by the investigator, were congruent with their reported feeling states: they smiled frequently, demonstrated good eye contact, and gestured appropriately with nods and active facial gestures. They seemed responsive and eager to talk and displayed a mood of calm and optimism.

One interpretation of these reactions is that the spouses were actively denying their loss. For whatever reason, the loss was too painful to encounter so the subjects used denial mechanisms to remove themselves emotionally from the loss. This interpretation bears some validity, because in the third and fourth interview, the subjects did report the impact of the heart attack as "hitting them later" and "harder" than they thought. The vivid descriptions of their reactions at this time resembled the reported reactions of the other subjects during phase one. The reasons for the denial, then rested on many factors. These two women had suffered recent major losses that could have affected their reactions, at this time, to their partner's heart attack. One woman had almost "lost" her husband in a serious car accident. Although it had been three years since the event, the woman constantly recalled the incident in detail and reassured herself that "this" (heart attack) was not as bad, and that she was prepared this time. Similar reassurance was echoed by the second woman, who had "been through a number of family deaths recently". This experience

caused her to minimize the present event. She stated, "I can cope, I can cope."

Although the subjects looked into the past and to the future, many of their thoughts focused on the present. Their philosophical beliefs reflected a here-and-now stance. It may have been too uncomfortable for the subjects to project into the future when it was such an uncertain and unpredictable time. Many of the subjects spoke about hope. Hope has been identified as a need related to the process of anticipatory grief. This need has been studied in relation to the threatened loss experienced by significant others of critical or terminally ill patients (Friedman, Choldoff and Hamburg, 1963; Futterman, Hoffman and Sabshin, 1972; Hampe, 1975; Dracup and Breu, 1978). To feel there is hope was found to be the most significant need identified by relatives of critically ill patients during the intensive care phase of hospitalization (Moulter and Captain, 1979). Korner (1970) discusses the coping value of hope. She says the more uncertain man is, the more he needs a cushion of defense against his fears and anxieties.

Not all the subjects were hopeful. Some of them took what could be described as a fatalistic approach during this critical time. This approach is difficult to interpret. Are the subjects preparing for the worst? Are they absolving themselves? Does fatalism have coping value? A fatalistic approach does tend to take the responsibility and perhaps fear out of the event. The loss is essentially out of one's locus of control. Two subjects indicated these beliefs were of long standing and this was how they approached life in general. An interesting finding was that three subjects who held fatalistic values could

not find a reason for their partner's heart attack. They could not affix blame, so to speak, on the patient, on risk factors, or on themselves. A conjecture, at this point, is that perhaps the subjects actively searched for some explanation and "found" a metaphysical or superordinate structure as responsible. Somehow it was just meant to be.

Not only were the spouses' perceptions important in regards to their thoughts and feelings but also significant with their actions. The need to seek out support, or information was contingent on a "critical timing factor". If the timing was not right for the subjects, he or she would not seek support or information and did not perceive it as helpful. One subject felt his family was helpful in the first few days, but once the initial impact had hit, he preferred to be by himself, as he had "a lot to think about".

In summary, the findings indicated the subjects responded to their own perceptions of the loss, not the overt reality as observed by an "outsider". Their thoughts, feelings and actions described a process they experienced as they attempted to understand and attach meaning to the loss.

## Phase II Reaction to the Event

### Reactions to loss

The findings in this phase described a shift in the subjects' descriptions of their reactions to the loss event. In brief, the heightened thought processes decreased while the subjects' actions increased.

This was a busy time for the subjects, yet it was also characterized as a more certain period, one in which the subjects had more control over their partners' lives. This control is well illustrated in Vachon's (1978) study of widows of men with chronic cardiovascular disease. Vachon found that the wives felt they played an active role in helping their husbands during the time of illness, she stated:

These women felt that if they fed their husbands right, helped them alleviate their stress, made them cut down activities, that they wouldn't die (Vachon, 1978, p. 56).

In contrast to the earlier phase, the majority of subjects appeared bright, responsive and voiced gratefulness and optimism for the future. Although four subjects complained of sleep and appetite disturbances with increased fatigue, their affect remained positive and they reported a calmer, more positive mood state. The uplift in mood can be interpreted in light of the fact that many subjects anticipated the worst while to their delight many of the changes did not occur or were not as traumatic as anticipated. The subjects' mood shift may also have reflected the mood of their partners. They had "made it" through the first week at home. Although this time was described as very stressful things were starting to improve.

This upswing in mood is not well reported in the loss literature. However, the euphoric "we have made it" feeling is similar to the euphoric response observed by Kimball (1969). In a study of the post operative behaviour of cardiac surgery patients a euphoric response was noted during the later convalescent period of hospitalization when the

critical stages of their surgery had passed. Kimball identified the behaviours as confident, bright, responsive and "glad to be alive".

The researcher has also noticed a similar behaviour in her nursing experience while caring for critically ill patients. Many individuals who have recovered from a life threatening event do reflect on how lucky they are to be alive. An inference was drawn that individuals who are threatened with the loss of their lives, or their loved ones, experience a response similar to that described by the subjects in this study.

The subjects reported this time to be very busy. Their "watchdog or protector" behaviours involved hectic schedules of organizing the household, family and visitors as well as monitoring their partners' diet, medications and activities. Many of the subjects had gained information about their partners' prescribed diet, medications and level of activity from the structured in-hospital cardiac teaching program. Two subjects however, seemed rather anxious about the diet planning. Cooking the right meals was perceived as very important and these women spent hours in reading about and preparing low cholesterol diets. One interpretation of this behaviour was that the spouses viewed diet preparation as a familiar role--one they had enacted for many years--they could perform it well. It enabled them to protect their partners in a concrete fashion. However, the two subjects received the same diet information as the rest of the group, and their husbands' diets were not different from those of the other patients. What could explain their preoccupation and anxiety over diet? In re-examining the data, the researcher found these subjects verbalized a

lot of guilt. They perceived themselves, in part, as responsible for the partner's heart attack. They had cooked "all the wrong things". Thus, these feelings of guilt might have played a significant role in contributing to their behaviour.

### The Elements of Loss

In phase one the loss event was viewed by the subjects with a future and anticipatory perspective. The time frame changed in the early discharge period to focus more on the present. The event now had a life of three weeks. It was no longer seen as sudden or unpredictable. As one subject reported: "Well, it's (the heart attack) now three weeks old you know". The subjects found that their anticipated fears of recurrence and poor partner adjustment had not materialized. Their partners were convalescing well and the present and future looked optimistic. The heart attack now seemed fairly predictable and within control.

Initially the illness or threatened loss of their partners had a concrete observable quality. The subjects began to view the loss within a wider context; the initial loss expanded to include secondary losses, many of which were abstract in nature. Subjects identified loss they had experienced in terms of their roles, relationships and self-esteem. The initial threatened loss of their partners' lives had not occurred, now other loss was being realized by the subjects.

### The Meaning of Loss

The subjects' perceptions of loss broadened in this phase and now encompassed three areas; the patient, the couple and the spouse.

Through the subjects' eyes, this phase can best be described as the closure of the critical time of their partners' illness. The subjects could now allow themselves time to "take a deep breath" and say "we have made it". In the same breath, the subjects began to focus more introspectively on their loss. Some women grieved for their own time and independence. The added roles and responsibilities, including a lack of recognition for their efforts, caused them great concern. Their own loss was only beginning to be felt. The euphoric spirit tended to counter or de-emphasize their concerns and they admonished themselves for being so selfish when they felt they should have been grateful for their partners' health. It was a difficult time for the subjects, a time of transition. The meaning of loss as experienced by the subjects in this early post discharge period is illustrated in Figure 1.

The meaning of loss cannot be comprehended by taking a narrow perspective and focusing on only one aspect or level of a loss. The meaning of loss as experienced by the subjects now encompassed three different levels. There is an evident need to view loss in this totality in order to conceptualize the phenomenon of loss.

### Phase III Impact of the Event (Group A)

#### Reactions to Loss

Many of the subjects' thoughts were egocentric in focus. These

## 1. Patient Focus

Closure of anticipated loss ...

"He is alive and well and hasn't had another heart attack". ...

"I'm watching him and looking after him".

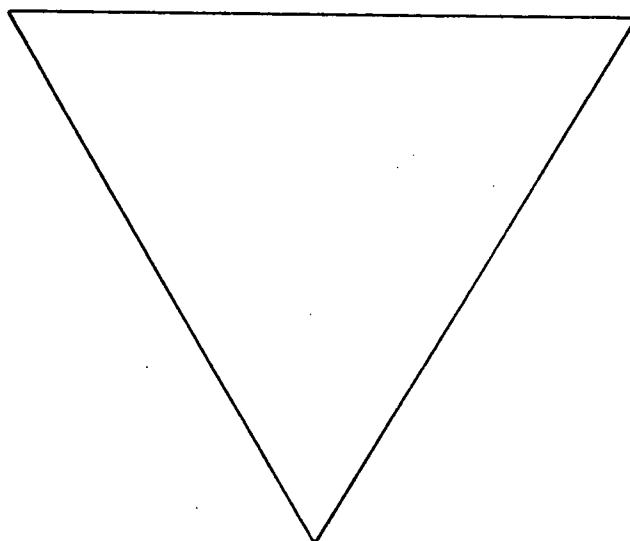
## 2. Couple Focus

Loss as it affects us ...

"We have made it ...

we're working together".

... "Yeah lots of changes for us".



## 3. Personal-self Focus

Beginning of actual loss

"I miss my own time" ...

"I do all the work and get

no thanks". ... "I have my own life too!".

Figure 1. The Meaning of Loss



women viewed the loss from their own perspective. They continued to speak of their protector roles and extra responsibilities but also began to verbalize how many of their thoughts were focused on themselves. The time had come for them to take a hard look at their lives and their future.

The subjects' feelings were heightened in this phase, similar to the intensity described in Phase I. In contrast to the shock, numbness, anxiety and tension reported initially the subjects described a range of emotions: anger, bitterness, resentment, guilt and self-reproach with depression the most commonly reported feeling. The multiplicity of feelings reported by the subjects in this study is well corroborated in the research findings (Adsett and Bruhn, 1968; Skelton and Dominian, 1973; Harding and Morefield, 1976; Larter, 1976; Mayou, Foster and Williamson, 1978).

In this phase ambivalence surfaced again but it was now more intense. The subjects were angry and resentful yet they admonished themselves for being so selfish and unkind. They could not come to terms with what they felt and what "others" expected them to feel. Anger and resentment were turned inward with resultant guilt and depression. The ambivalence experienced by the subjects was similar to the secondary emotional reactions identified by Peretz (1970). He described these ambivalent reactions as conflict between feelings that an individual anticipated and accepted with those he did not expect and could not accept.

The subjects had difficulty dealing with their resentment and anger. They resented the extra workload and demands placed on their

time yet they felt guilty if they expressed these feelings. Even if they felt abused they would not speak out for fear of upsetting their partners and perhaps precipitating another heart attack. Many wives felt it wasn't "right" to complain, after all, weren't they the healthy ones? As one woman stated: "It's catch-22, you are damned if you do, and damned if you don't."

Poor communication, and little evidence of sharing on a feeling level seemed to exist between the patients and their spouses. This finding was also reported in recent studies (Adsett and Bruhn, 1968; Harding and Morefield, 1976; Larter, 1976). The subjects had an obvious need to ventilate their feelings. Although this need was reported in the recent research (Hampe, 1975; Dracup and Breu, 1978; Moulter and Captain, 1979), it was not always met by health professionals. At a time when the subjects were most distraught, they felt they had no one to turn to other than a few close family or friends. The subjects perceived that "no one really understood".

Due to the limitations of the study it was difficult to conjecture why the subjects in such obvious need did not speak or reveal their feelings. There could be many reasons why the spouses grew apart from their partners. Several reported not speaking out for fear of precipitating a heart attack; others desired to "protect" their partners. Some subjects felt their feelings were socially unacceptable and it just wasn't right to discuss them. Another interpretation was that the prior communication patterns of the couples were non-sharing in nature.

### The Elements of Loss

The nature of the loss experienced by the spouses continued to broaden in this phase as the initial loss precipitated many secondary losses (e.g. loss of own time, independence, routines) and threatened future additional losses (fear of partners' driving and returning to work).

Many of the subjects reactions up to this point were in response to the threatened loss of their partner. This loss can be characterized as overt. It was concrete and easily recognizable, and as such, was more readily understood and accepted by the subjects experiencing the loss or to those outside viewing the loss. The loss described by the subjects in phase two and more in three, was a different character. It spoke more to the loss of personally significant needs and values. This loss was more covert in nature and was, therefore, not as easily identified or understood. Regardless of the covert nature of the loss, the grief reactions experienced by the spouses at this time were very heightened, similar to the intensity of feelings described in phase one.

### The Meaning of Loss

This phase was similar to the acknowledgement stage described in the literature (Bowlby, 1961; Engel, 1962; Kubler-Ross, 1969; Parkes, 1972). Glick, Weiss and Parkes (1974) described this time as the grieving phase. The individual was confronted with the daily realities of loss and the full impact of the loss was now truly felt. At this time the initial loss expanded to include numerous secondary losses.

While profound sadness and depression are dominant during this phase, the individual may experience numerous feelings and vacillate between these states.

There are many variables that could have influenced the spouses' perceptions at this time. Robinson (1974) stated that past experiences, successes, failures, relationships and standards can mold a person's perceptions and reactions to their loss. In this group all but one of the subjects were non-working women. The meaning of the loss varied significantly for these women compared to the working women. The non-working women seemed psychologically more dependent on their partners. Many of their values, beliefs, and sense of worth were apparently bound inextricably to their husbands. One could infer from these findings that the degree to which one's self concept was tied or mirrored to a loved one would have an affect on the loss experienced.

An interesting point is that the one working woman in the group had been coping well with her husband's illness until the last interview. She described herself at that time, as having a "setback", because of a very recent loss of a close family member. A factor that can influence an individual's capacity to adapt to a loss is a concurrent loss (Peretz, 1970; Schoenberg, 1970). This factor, then, could have influenced this subject's reactions at this time.

The subjects grieved for their sense of self, their integrity, worth and the normalcy of their lives. Depression was most commonly reported. Depression was felt most intensely by the two youngest subjects. Both women had adolescent children at home. Their responsibilities were endless: home, garden, pets, adolescents, visitors and

sick husbands. As one woman explained, "you have to be the pivot point for everyone, so the more people involved, the more difficult it becomes". When one considers the quality and quantity of change that the younger subjects experienced, it is not difficult to understand the severity of their grief reactions. Goldston (1962) confirmed this view, and stated that the greater the changes and shifts a family was forced to make as a result of a heart attack, the greater becomes the stress situation within the family. The relationship between age and severity of grief reactions found in this study was corroborated by Skelton et al. (1973). These researchers found that the severe grief reactions were more common among younger wives--less than 45 years of age--than among older wives.

One cannot examine the spouse in isolation. The reactions of the patient and the other family members are significant to consider. How the patient perceived the loss would indeed affect the subject. Because of the commonalities in the loss experience one could expect that the patient experienced similar thoughts and feelings. If the phenomenon of loss is viewed as a process, however, the couples may have been at different phases at different times. The meaning of loss for each person guided their own loss journey. It was possible that the loss experienced by both patient and spouse was so intense and egocentric that they were unable to look or feel beyond themselves. The data in this study corroborated the increased distance between the couples in terms of communication that may have limited sharing of their thoughts and feelings.

### PHASE III Impact of the Event (Group B)

#### Reactions to Loss

The reactions to loss of the remaining subjects, two women and one man, were different and have been described separately as Group B. These subjects in contrast to Group A were in good spirits, content with their partners and themselves. This contentment touched on all parts of their lives. They were pleased with their partners' adjustment and seemed grateful for what they had accomplished and how they managed together as a team. The subjects looked forward to the future with optimism.

Many of the reactions described by the subjects in this phase are similar to the acceptance and adaptation phase described in the literature when an individual copes successfully with loss (Bowlby, 1961; Engel, 1962; Kubler-Ross, 1969; Parkes, 1972; Shontz, 1975). This phase is characterized by a gradual move forward to organize one's life and integrate the realities of loss. Often the individual experiences a decrease in anxiety as hope takes the place of hopelessness. Instead of focusing on what has been lost, attention is redirected to the present and future.

The subjects in this group seemed more accepting of their loss. They viewed the brighter more positive side of the changes that had disrupted their lives. Their comments were honest and realistic. Life had been very difficult for them and they were aware of some hard and uncertain times ahead. Yet the overall feeling was one of "we have made it, as a couple", and it seemed these positive gains reinforced their adaptive behaviour. The life-threatening nature of the illness

also prompted a revaluation of the values and goals in their relationship. There was a realization for these couples that their time together was not unlimited.

Although it may appear fortuitous, this group was aware of the need for hard work. They also knew their lives would never return to what they had before the heart attack. This point was emphasized by Carlson (1978). She stated that acceptance and adaptation do not imply a 100 percent return to the pre-loss state. A person may never completely get over a major loss. Healthy adaptive behaviour may be, in fact, picking up the pieces and trying to make the best of the situation.

#### The Elements of Loss

Overtly the loss had similar characteristics to those described by the subjects in Group A. It was an event that had started as a biological loss and grown to include psychosocial loss for both the patient and spouse. In contrast with Group A subjects, the time frame of loss was different for Group B subjects. Group A subjects focused very much on the present, overwhelmed with the loss of normalcy in their lives and they feared future additional loss. For the Group B subjects the loss at this time was seen more in retrospect. Time had pushed the loss away. It was seen as a past event, an event that had changed their lives for the positive.

### The Meaning of Loss

These subjects did not appear to turn inward and view the loss from an egocentric focus, and they did not seem to grieve for loss of self. Many of their comments reflect an "us" or couple focus. There are several factors to consider that could shed some light on why these individuals reacted so differently to their loss. In contrast to the dependence evident in the subjects' relationships in Group A, the relationships of Group B could be described as interdependent. The latter leaned on each other: the balance between the dependence and independence was comfortable. They shared their fears and concerns and worked out the changes in roles and responsibilities. Their routines were disrupted but they did not perceive the changes as overwhelming. From an objective viewpoint, their lives were not disrupted as greatly as those of some of the Group A subjects. Another factor to consider was that these latter individuals were employed and were not home during the day to worry over their partners. Apparently they did not see themselves as dependent on their partners because validation of their values, worth and abilities was also gained from their work.

Larter (1976) found that the degree of marital accord was an important variable in examining the impact of illness on wives of myocardial infarction patients. Although it is difficult to infer from the present data, it seems Group B couples had open and sharing communication patterns. They felt that the heart attack had acted as a catalyst and had improved their communication patterns greatly.



Previous life experiences can assist an individual in dealing with a loss, by helping to develop a repertoire of coping mechanisms which can be used in future adjustments. The male subject in this group certainly agreed this was the case with his loss. He felt he had coped well with the event because of a previous "experience". He had been injured during the war; his long and recurring illness had caused him to be bed-bound for months at a time. He felt both he and his wife had experienced many changes in their lives, and had always managed to come through in the end. He approached this recent loss with a positive air and some workable ways of coping.

### Summary

The loss experienced by the spouses of myocardial infarction patients was described in this chapter within a phenomenological perspective. In each phase the nature of the loss experience was unique. The loss event, the perceptions of loss and the reactions to loss defined the process in which the subjects dealt with loss. The initial loss event expanded in depth and breadth to impact significantly on the spouse. The heart attack could now be viewed within the totality of the phenomenon of loss.

## CHAPTER 6

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

This study was designed to provide insight into understanding the event of a myocardial infarction within the context of the phenomenon of loss. An overview of the study is presented in this chapter followed by the articulation of a framework, based on the literature and the findings, which relates the concept of loss to the experience of spouses of myocardial infarction patients. In addition, implications and recommendations for nursing education, nursing practice and further research are delineated.

Overview of the Study

This exploratory study examined the phenomenon of loss as expressed by the spouses of myocardial infarction patients. The purpose of the study was to describe the thoughts, feelings, actions and observable behaviours of the spouses from the initial impact of illness to six weeks post myocardial infarction and to develop a framework, based on the literature, which related the concept of loss to the experience of spouses of M.I. patients.

The study was conducted with a convenience sample of 12 spouses, ten women and two men, whose partners had experienced their first myocardial infarction. Using a semi-structured interview guide with open-ended questions, the investigator interviewed each subject, four times, from day three to day 52 of the partner's heart attack. This period covered the time of the initial impact of illness to

approximately six weeks post myocardial infarction. The first interview was scheduled within 96 hours of the heart attack and the second interview followed during week two of the patient's hospitalization. The third and fourth interviews were scheduled for one and three weeks post discharge of the patient. The interviews ranged from 12 to 75 minutes, with an average time of 35 minutes. Each interview covered three content areas: the thoughts, feelings, actions of the spouses. Broad open-ended questions were used to elicit data on the spouses' thoughts, feelings and actions. During the interview the investigator observed the verbal (type, quality, characteristics of speech, focus of conversation) and non-verbal (activity, eye contact, body language, appearance) behaviours of the spouses.

An empirical inductive approach was used as the methodology for this study. Data coding and analysis were approached using the constant comparative method, an inductive method of discovering grounded theory developed by Glaser and Strauss (1967). The findings revealed that the spouses experienced behaviours in response to loss that were common and formed a pattern through time. Three distinct phases were identified: Phase 1 the event and initial spousal response; Phase 2 reaction to the event; Phase 3 impact of the event.

The phases were described further in light of the constructs formulated from the literature review: (1) the reactions to loss; (2) the elements of loss; (3) the meaning of loss.

Phase I covered the hospitalization period of the patient. This phase was characterized by heightened thought processes. Many of the spouses' thoughts were patient-oriented and focused on the anticipated

loss of their partner through complications or occurrence of another heart attack. The subjects perceived this time as critical and uncertain while the reality of the loss was beginning to penetrate into their awareness. Their reactions described the process of understanding and attaching meaning to the loss.

The second phase covered the early discharge period of the patient. This phase was characterized by decreased thinking and increased actions related to protector or controller activities. The present and future were viewed with more predictability and optimism. The subjects began to view the loss within a wider context as their perceptions of loss encompassed three areas; the patient, the couple and the spouse. Since the threatened loss of their partner's lives had not occurred, other loss was now being realized by the subjects in terms of roles, relationships and self-esteem.

Phase III described the impact of the event for the spouses. Two distinct patterns of behaviours were identified in this phase. Group A findings comprised one pattern of reactions for seven of the subjects. Different reactions were described by the remaining three subjects in the Group B findings. The nature of the loss for the Group A subjects continued to broaden to include many secondary losses for the spouses (e.g. loss of time, independence, normalcy of routines) and the threatened future additional losses (fear of partners driving and returning to work). The spouses viewed the loss from an egocentric focus. Ambivalent feelings were heightened in this phase. The subjects felt angry and resentful over their personal loss experiences yet expressed guilt and depression over their "selfish, unkind"

thoughts. In contrast, the Group B subjects did not seem to view the loss from an egocentric focus. They were in good spirits, content with their partners and themselves. Many of their reactions reflected an "us" or couple focus. The loss was viewed as a past event, an event that had changed their lives for the positive. They looked forward to the future with optimism.

### A Loss Framework

The findings in this study strongly support the use of a loss framework for assessing the reactions of spouses who are threatened with the death of their partner.

From the literature and the research findings of this study several constructs were identified that represented the major structures of a loss framework for spouses of myocardial infarction patients. The process of loss for the spouses began with the initial loss event--the heart attack. The illness was a stimulus which precipitated a series of events that became part of the phenomenon of loss. From the initial stimulus the spouses moved on to perceive and to attach meaning to the loss. The elements of loss described in this study shaped the nature of the loss experience. In addition, many individual variables can be considered as influencing the subjective meaning of loss for each spouse.

Loss was also described in terms of the the behavioural responses that followed the perception of the loss event. The thoughts, feelings and actions described by the spouses were the three main categories of behaviour corresponding to the psychological, emotional and

physiological disturbances found in the literature. Often the spouses exhibited a complex combination of all three categories of reactions to loss.

Another important construct described in the literature and in this study was the concept of phases of loss. In this study, the spouses' behaviours were similar to one another and formed a pattern through time. The pattern of behaviours comprised three distinct phases. Although the "labelling" of the phases in this study differed from that of the literature it was evident that the process or sequence of adaptation was apparently the same. The three phases described the process in which the spouses dealt with loss.

The loss literature was heavily laden with the word "process". Authors have not defined or described this process in identical terms. For analytical purposes, writers have taken apart the concept of loss and given it various labels, stages or phases but they have neglected to put it back together again. This "Humpty Dumpty" approach results in a fractured concept of loss, frozen in time, and neglectful of the actual experience of loss.

Loss is not a series of arrivals but rather a journey. It is a process that individuals become part of in an attempt to restructure life after a major disruption. Process implies continuity or movement. It is dynamic, purposeful and has an element of time.

Based on the findings from this study a framework of loss evolved based on a phenomenological perspective. Loss was seen as a process experienced from the initial event or stimulus to the successful or unsuccessful resolution of the loss. On one level loss was seen as the

initial event that precipitates the individual going through the perceiving and attaching of meaning to loss. On another level, loss was the sequence of grief reactions experienced in response to the loss event. These activities were viewed as interwoven or overlapping, like a matrix. The vertical threads described the reactions in response to loss while the horizontal threads represented the meaning of loss for the spouse. A process of loss paradigm was included to indicate the framework of loss for spouses of myocardial infarction patients (see Figure 2).

### Implications

#### Nursing Practice

Nurses are continually interacting with patients and spouses who have experienced major losses. The nurse can perform a critical role in preventing or lessening the impact of loss. The results of this study point strongly to the importance of assessing the actual and potential losses of the spouses in understanding the individual's perception of the loss. Armed with this knowledge, nurses are better able to provide the necessary guidance and support to the spouses with subsequent beneficial effect on the patients.

Although this study did not focus on relationships between variables, many factors emerged that must be considered in understanding the variance in the spouses' reactions to loss. Not only must the nurses be knowledgeable about loss but an understanding of the factors influencing the perception of loss and its severity is imperative if they are to perform their role effectively.

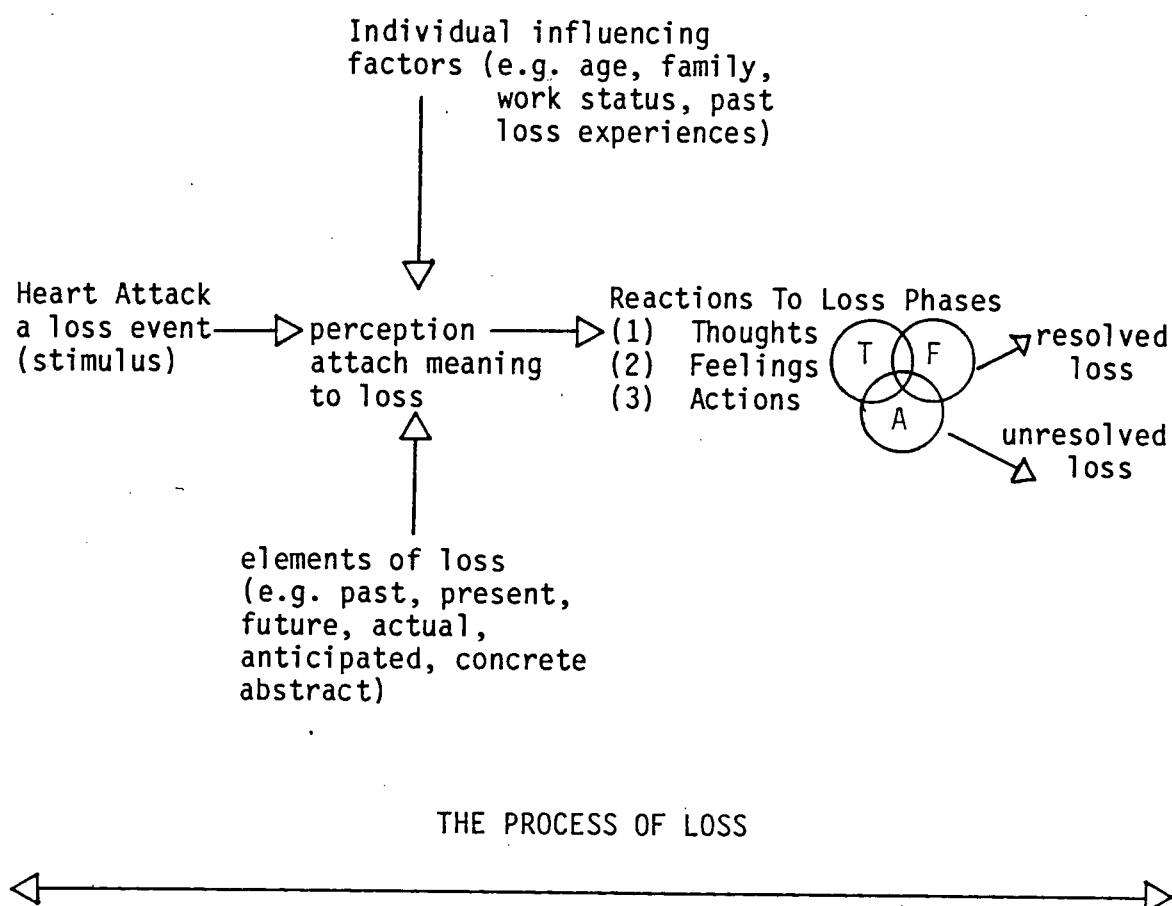


Figure 2. A loss framework for spouses of myocardial infarction patients.



This study suggested that spouses may experience anticipatory grief soon after the initial loss event. The reactions as described in phase one provide insight into the various ways individuals experienced and described this anticipatory grief reaction. The nurse who can recognize anticipatory grief can better assess the spouses' reactions and intervene to help these individuals cope with these feelings.

It has been suggested that talking about feelings that deal with such a critical area as a life threatening illness is difficult and intrusive for the individual experiencing the loss or threat of loss. The results of this study do not support this suggestion. All of the subjects in this sample were willing respondents, eager to talk about their concerns and touched that someone cared enough to ask. This finding had important implications for nurses because it indicated that spouses were approachable very early in their loss experience and they need comfort and support as well as information. Nurses must be available to patients and their families and must be able and willing to listen if the need arises. Spouses must be encouraged to discuss their concerns since they need validation that their responses are normal reactions to their loss.

The phases identified in this study described a common pattern of reactions that spouses of myocardial infarction patients experienced in response to loss. These phases can serve as organizing centers for approaching problems and working towards need satisfaction for spouses. The loss framework presented in this study offered direction for nursing practice. The reactions experienced by the spouses must be examined over a considerable length of time. It is not enough to

intervene once in the hospital or make one home visit. Nurses must meet regularly with patients and spouses throughout the course of recovery. The family members should be encouraged to ventilate their thoughts and feelings while the nurse must be available to listen.

The study revealed a pattern of divergence in the sharing of thoughts and feelings between some patients and their spouses. The nurse is in a position to facilitate interaction between the couple. Acting as a facilitator the nurse can assist both the patient's and the spouse's adjustment to their loss with resultant improved health for all family members.

#### Nursing Education

All levels of nursing education should include the appropriate knowledge and skills related to a family focus in health care. Nursing education must prepare the nurse to assess the spouses' reactions in response to loss and to help patients and spouses cope with their reactions.

All nursing programs should include the concept of loss in their core curricula. Included also should be content related to family dynamics, crisis and role theories, adaptation, change theory and interpersonal and communication theory. This knowledge and skill will provide the students with a general guide to assessing loss in individuals, in families and in their own experiences. As well as recognizing the commonalities of loss, the nurse must be taught to understand and accept the individuality of any loss experience and plan nursing interventions accordingly.

### Nursing Research

This study has provided further knowledge of the common patterns of reactions that spouses experience in response to loss. To what extent are these phases or common patterns of reactions present in the population of spouses of myocardial infarction patients? It is necessary for these reactions to be examined to a greater extent with a random selection of spouses from a variety of settings. Further study is also required to identify the commonalities and differences between the sexes.

This study was conducted during a six week time period, following the patient's diagnosis. A longitudinal study examining the reactions experienced by patients and spouses would provide greater insight into the loss experienced.

This study did not examine the patient's reactions in response to loss. Many questions are unanswered. Are the patients experiencing similar reactions to loss? Are their reactions concurrent with those of their spouses? What accounts for the convergence and divergence in the patient and spouse's relationship? How does this relate to the loss experienced?

Further research is needed to explore the loss-related variables. The variance in individuals' reactions in this study are evident and most remarkable.

While this study has added to the body of knowledge of loss that spouses of myocardial infarction patients experienced it has also raised many questions about the phenomenon. In addition, nurse researchers must begin to study the effects of selected planned

nursing interventions on patients and spouses experiencing loss. Such research should eventually lead to more efficient and effective nursing care.

### Recommendations

On the basis of the findings and implications of this study it is recommended that:

1. Nurse practitioners assess the reactions that spouses experience in response to loss and provide the immediate guidance and support required to facilitate the spouses' maximum adjustment to their loss. The patient with a family focus should be an integral part of nursing care in all settings.
2. Nurse educators provide the nursing student with the appropriate knowledge and skills required to assess the actual and potential losses of spouses and to understand the individual's need for meaning during the loss process. This knowledge should include an understanding of the many variables influencing the spouses' perceptions of loss as well as the elements or characteristics of loss.
3. Future studies with a large random sample of spouses from a variety of settings be conducted to increase the generalizability of the results concerning the phenomenon of loss.
4. Research be conducted to examine the differences between the Group A and B findings with particular attention to loss related variables.
5. Spouses' and patients' reactions to loss should be examined simultaneously in longitudinal studies.

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## Appendix A: Consent Form

## CONSENT FORM

Consent to participate in Research Study conducted by Patti Gauchie,  
R.N.

I, \_\_\_\_\_, agree to participate in the research study being conducted by Patti Gauchie. I understand that this study deals with examining the feelings and reactions that the spouse experiences when the partner has suffered a heart attack. I understand that my participation will involve four interviews of approximately one hour each and I have agreed to have these interviews tape recorded. I understand that I will remain anonymous and that the tapes of the interview will be available only to the investigator and the members of her thesis committee. I also understand that this tape will be erased when the investigator's thesis has been completed. I understand that I am free to withdraw from the study at any time, and that this action will not jeopardize the treatment of my spouse.

Signed: \_\_\_\_\_

Witnessed: \_\_\_\_\_

Date: \_\_\_\_\_

Appendix B: Information Related to  
Cardiac Research Study

## INFORMATION RELATED TO CARDIAC RESEARCH STUDY

As part of the data collection for my Master Thesis in Nursing, I am conducting informal interviews with spouses whose partners are heart attack patients being treated in the coronary care unit at St. Paul's Hospital. My thesis topic deals with examining the feelings and reactions that the spouse experiences when the partner has suffered a heart attack.

As a nurse, I have worked with heart attack patients and have been concerned with helping the spouses cope with the stress of the illness. In nursing we have not studied the spouse very thoroughly, so we have little information to guide us in providing the assistance spouses may require. I believe that my research is important in gathering this information.

I hope that you will consider participating in this study. I would like to conduct four informal interviews with you, two during the hospitalization period of your partner and the final two at one and three weeks after hospital discharge. The time and length of the interviews would be arranged at your convenience. All interviews will be confidential, your contributions will remain anonymous. You may withdraw from the study at any time. I will gladly share the results of this study upon completion of my research.

I will telephone you within the week to answer any further questions you may have in regard to the study and to discuss the possibility of your participation. I wish to stress that refusal to participate in this study will not jeopardize current or future treatment of your partner. I look forward to talking with you.

Thank you,  
Patti Gauchie, R.N.  
U.B.C. School of Nursing

## Appendix C: Data Collection Tool

## DATA COLLECTION TOOL

Demographic Data:

Date: \_\_\_\_\_

Name of Spouse (initials): \_\_\_\_\_

Spouse's age: \_\_\_\_\_ Patient's age: \_\_\_\_\_

Spouse's sex: \_\_\_\_\_ Number of days post M.I. \_\_\_\_\_

Interview Guide:

The interview will explore the degree, frequency, intensity and duration of specific psychological and somatic responses. Areas to be examined will be:

1. verbal (type, quality characteristics of speech, focus of conversation;
2. non-verbal (activity, eye contact, body language, appearance).

Questions (broad-open ended):

1. Can you tell me what your thoughts have been in relation to your spouse's heart attack since I last saw you?
2. When you think about your spouse's heart attack how do you feel?
3. Can you describe your behaviour since your spouse's heart attack?
4. Is there anything else that you feel is important to mention?

Appendix D: Sample of Data Coding  
and Analysis Procedure



# SAMPLE OF DATA CODING AND ANALYSIS PROCEDURE DISCRIMINATION

STEP: Data sorted and colour coded. Category identified and colour coded.

## Sample of Illustrative Data (coded with a red dot)

He is not a person who tells you  
he is hurt so when this happened  
....

He had pains in his arms so I was  
wondering ....

Well, how it happened was sort  
of a surprise ....

Well, we were up at Sechelt in our  
new motor home ....

Spouses give a blow-by-blow  
description of the heart attack.  
Investigator uses illustrative  
data to name the category.

HOW IT HAPPENED

## DEFINITION

STEP: Category defined and described. Category reworked until properties  
and concepts become clearer.

Characteristics or properties:

HOW IT HAPPENED

1. Initiated the first inter-  
view with a description of  
event;
2. moved from past to present  
time frame;
3. vividly recalled their  
partner's symptoms;
4. detailed their own reactions;
5. progressed from these  
thoughts to question the  
reason or cause of illness  
i.e. why it happened.

Interpretation  
in light of  
loss framework

category  
of  
REVIEWING

## CLASSIFICATION

STEP: Category compared and contrasted to other categories. Concepts and properties are  
threaded together. Larger abstract concepts evolve.

REVIEWING	Compared and contrasted with comparing redefining and anticipating	Main themes emerge (a) patient focus; (b) heightened thoughts (c) anticipated loss of partner	Phase I The Event and Initial Spousal Response
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## Appendix E: Overview of the Findings

## APPENDIX E

	PHASES	FINDINGS
T I M E	<p>Phase I - The Event and Initial Spousal Response</p> <ol style="list-style-type: none"> <li>1. Hospitalization period of patient.</li> <li>2. Subjects interviewed and observed twice (week one and two).</li> </ol>	<p><u>Thoughts:</u> (1) reviewing; (2) anticipating; (3) comparing; (4) redefining.</p> <p><u>Feelings:</u> (1) mood-shock/disbelief, upset with gradual control guarded optimism; (2) physical disturbances, loss of sleep and appetite, increased fatigue and irritability.</p> <p><u>Actions:</u> (1) verbalized-hectic schedules, loss of social contact; (2) observed crying, long sighs, decreased eye contact, slouched posture, fatigued faces, few smiles.</p>
	<p>Phase II - Reaction To The Event</p> <ol style="list-style-type: none"> <li>1. Early post discharge period of the patient.</li> <li>2. Subjects interviewed and observed once (week three to four).</li> </ol>	<p><u>Thoughts:</u> (1) assessing; (2) implementing; (3) redefining.</p> <p><u>Feelings:</u> (1) mood-gratefulness, optimism, beginning of guilt, resentment and ambivalence; (2) physical disturbances-improved appetite and sleep, increased fatigue.</p> <p><u>Actions:</u> (1) verbalized-watchdog, protector behaviours, altered roles and responsibilities; (2) observed animated speech, increased smiles increased eye contact, social overtures.</p>
	<p>Phase III - Impact Of The Event</p> <ol style="list-style-type: none"> <li>1. Later post discharge period of the patient.</li> <li>2. Subjects interviewed and observed once (week five to six).</li> <li>3. Two separate patterns of reactions - Group A findings Group B findings</li> </ol>	<p><u>Group A</u></p> <p><u>Thoughts:</u> (1) assessing; (2) redefining</p> <p><u>Feelings:</u> (1) mood - depression, guilt resentment; (2) physical disturbances increased fatigue, loss of sleep and appetite, headaches.</p> <p><u>Actions:</u> (1) verbalized - loss of own time, increased changes in roles and responsibilities, decreased communication with partner; (2) observed increased sighing, monotone voices, slouched posture, no make-up, decreased eye contact and social overtures.</p> <p><u>Group B</u></p> <p><u>Thoughts:</u> (1) assessing; (2) planning.</p> <p><u>Feelings:</u> (1) mood - calm, thankful, positive, accepting; (2) physical disturbances half back to normal.</p> <p><u>Actions:</u> (1) verbalized - shared roles and responsibilities, communication with partner; (2) observed - alert, responsive, calm, relaxed voice and body posture, increased eye contact and social overtures.</p>

**Appendix F: Overview of the Interpretation  
of the Findings**

## APPENDIX F

	Interpretation	Major Themes
<hr/>		
Phase I		
The Event and Initial Spousal Response	<ul style="list-style-type: none"> <li>- reactions similar to anticipatory grief reactions described by Lindemann;</li> <li>- loss is sudden and traumatic and experienced in 3 time frames, past, present and future;</li> <li>- full reality of loss has not penetrated, subjects beginning to perceive and attach meaning to loss.</li> </ul>	<ol style="list-style-type: none"> <li>1. heightened thought processes;</li> <li>2. patient focus;</li> <li>3. anticipated loss of partner.</li> </ol>
<hr/>		
Phase II		
Reaction to the Event	<ul style="list-style-type: none"> <li>- closure of anticipated loss, patient recovering well and subjects protecting and watching their partners;</li> <li>- couple focus - loss examined as it affects "us";</li> <li>- personal self focus - subjects express actual loss of self (e.g. time, independence, routines).</li> </ul>	<ol style="list-style-type: none"> <li>1. decreased thought processes;</li> <li>2. patient and spouse focus;</li> <li>3. euphoric feelings.</li> </ol>
<hr/>		
Phase III		
Impact to the Event	<p>Group A:</p> <ul style="list-style-type: none"> <li>- unresolved loss</li> <li>- loss expands to focus on loss of spouses needs, values, roles, more covert abstract loss experienced by subjects.</li> <li>- acknowledgement phase, the true impact of the loss now felt with numerous secondary losses.</li> </ul> <p>Group B:</p> <ul style="list-style-type: none"> <li>- resolved loss - acceptance and adaptation;</li> <li>- loss viewed from an us or couple focus not from egocentric perspective;</li> <li>- loss seen as a past event, an event that had changed their lives for the positive;</li> <li>- view future with optimism.</li> </ul>	<ol style="list-style-type: none"> <li>1. heightened thought processes;</li> <li>2. egocentric focus;</li> <li>3. heightened ambivalence and depression.</li> </ol> <ol style="list-style-type: none"> <li>1. acceptance and optimism;</li> <li>2. couple or us focus;</li> <li>3. future oriented.</li> </ol>