WOMEN'S PERCEPTIONS OF THEIR ILLNESS EXPERIENCE
WITH MYOCARDIAL INFARCTION

By
Penelope Claire Dunn
B.Sc.N., The University of Western Ontario, 1976

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

in
THE FACULTY OF GRADUATE STUDIES
The School of Nursing

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA
October, 1985
© Penelope Claire Dunn, 1985
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.
ABSTRACT

This study was designed to elicit women's perceptions of their illness experience with myocardial infarction for the purpose of exploring and describing the nature and meaning of this illness experience and its impact on everyday life. The phenomenological method, a type of qualitative research, was used to direct the study.

The data were compiled through a series of semi-structured intensive interviews with eight women. The women were 36 to 71 years of age. Six of the women were married and living with their husbands. The women had been at home following discharge from hospital for 2 to 14 weeks. Data collection and data analysis proceeded simultaneously and data collection ceased once consistent themes were identified and validated and the data collected were sufficiently rich and in-depth.

Women explain their illness experience with myocardial infarction as a loss phenomenon and the central and dominant loss within the heart attack experience for women is loss of predictability. Women's need for information following myocardial infarction is not met and lack of energy is a prominent feature in everyday life after a heart attack. Traditional sex role socialization sets the stage for potential problems in women's cardiac rehabilitation, especially in relation to support and role enactment. Physical rehabilitation is not a selected strategy to gain control over their loss experience for women with myocardial infarction.
The findings and conclusions of this study suggest a number of implications for nursing practice. There is clear direction for family-centered nursing care in the rehabilitation of women with myocardial infarction to address potential problems in relation to support and role enactment. This study reinforces the value of using the concepts of loss and grief to care for patients with myocardial infarction. Also, this study indicates that, in planning nursing care for women with myocardial infarction, nurses should focus on interventions to increase support, to meet patient and family educational needs, and to help women to anticipate normal physical and psychological responses to myocardial infarction. This study also has specific implications for the development of structured cardiac rehabilitation programmes addressing the special needs of women.

In relation to nursing education, nurses must be prepared to assess, teach, and counsel patients with myocardial infarction and their families. Most importantly, this study directs nursing educators to provide course work in women’s health issues to sensitize nurses to this field of study and to equip nurses with the understanding necessary to facilitate changes in women’s health care. Implications for future research include further exploration of information needs, support, and strategies for control in relation to women with myocardial infarction.
TABLE OF CONTENTS

ABSTRACT.............................................................................................................. ii

TABLE OF CONTENTS......................................................................................... iv

LIST OF FIGURES............................................................................................... vi

ACKNOWLEDGEMENTS....................................................................................... vii

CHAPTER 1  INTRODUCTION

Introduction to the Study..................................................................................... 1
Conceptual Framework......................................................................................... 6
Problem Statement............................................................................................... 7
Purpose of the Study............................................................................................. 8
Introduction to this Study's Methodology.......................................................... 8
Definition of Terms.............................................................................................. 10
Assumptions and Limitation................................................................................ 10
Summary............................................................................................................... 11

CHAPTER 2  REVIEW OF SELECTED LITERATURE

Introduction........................................................................................................ 13
Women With MI: Research Directly Studying Women........................................ 14
Women with MI: Studies Including Women........................................................ 18
MI and Patient Perceptions................................................................................ 21
Summary.............................................................................................................. 23

CHAPTER 3  METHODOLOGY

Introduction........................................................................................................ 24
Selection of Participants...................................................................................... 24
Criteria for Selection........................................................................................ 25
Selection Procedure............................................................................................ 25
Data Collection.................................................................................................... 26
Construction of Accounts................................................................................... 28
Data Analysis....................................................................................................... 29
Ethical Considerations......................................................................................... 30
Summary.............................................................................................................. 31

CHAPTER 4  PRESENTATION OF THE STUDY'S FINDINGS

Introduction........................................................................................................ 32
The Study's Analytic Framework........................................................................ 32
Characteristics of the Participants...................................................................... 35
The Women's Perceptions of Their Illness Experience....................................... 36
  Loss of Healthy State....................................................................................... 36
  Loss of Predictability...................................................................................... 40
  Lack of Energy................................................................................................. 47
  Lack of Anticipated Support.......................................................................... 51
  Change in Usual Role Enactment..................................................................... 61
  Strategies for Control....................................................................................... 67
Summary.............................................................................................................. 73
LIST OF FIGURES

Figure 1 The Study's Analytic Framework.
ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the eight women who so willingly and openly shared their illness experience with myocardial infarction to help other women.

For their kind support and scholarly counsel, I would like to thank my thesis committee members, Clarissa P. Green (chair) and Dr. Margaret Campbell.

I would also like to express my love and appreciation to my family, Bruce Dunn, Stephanie Dunn, and William Dunn for their contributions to this endeavour.

Finally, I would like to say a special thank you to Halina Streuser for her friendship in the writing of this thesis and to Angela Bovey for effort and commitment beyond request in the typing of this manuscript.
CHAPTER 1

Introduction

Background to the Study

Statistical evidence refutes the commonly believed myth that myocardial infarction (MI) is a potent health problem for men only, that women are invulnerable to MI. This myth obscures the reality and significance of this health problem for women. Although MI is much more common in men than in women, an examination of the mortality rates establishes MI as a major health problem for men and for women. Despite recent declines in death rates, ischemic heart disease remains the leading cause of death in Canada for both sexes and MI, in particular, accounts for the greatest number of these mortalities (Szklo, 1981; Patrick, Palesch, Feinleib, & Brody, 1982; Statistics Canada 84-206, 1982). The total number of deaths for 1982 due to MI was 19,552 male deaths and 10,858 female deaths (Statistics Canada 84-203, 1982, p.68). These numbers confirm the enormity of this health problem.

For older women, the magnitude of the problem is similar to that of older men. The number of deaths due to MI in women increases dramatically in the 65-69 year age group and continues to rise so that for the 75-79, 80-84, and 85+ age groups, the sex differences are minimal (Statistics Canada 84-203, 1982, p.69). The sex ratios decrease with age because of a decrease in the slope of the age increment in men, rather than an accelerated increase in mortality rate with age in women (Szklo,
Generally, these mortality statistics support the significance of this health problem of MI in women by documenting the magnitude of the number of lives lost and emphasizing that risk of death is a prominent feature of this illness experience. However, what is the relationship of this health problem of MI in women to women's other health problems? An examination of morbidity statistics for common health problems of women assists in putting MI in women into perspective among women's recognized health problems.

The reason to examine morbidity statistics is the paradoxical relationship between morbidity and mortality rates for men and women (Fogel & Woods, 1981). For women, mortality rates are lower, while men exhibit the reverse. Therefore, morbidity statistics give a more complete picture when discussing women's health.

Hospital morbidity statistics for health problems usually associated with women (Fogel & Woods, 1981) were reviewed. The impressive finding is that the numbers are closely parallel (Statistics Canada 82-206, 1978). For example, there were 16,811 women hospitalized with breast cancer and 14,379 women hospitalized with MI in 1978, the most recent available statistics. This further implies that MI is an important women's health problem. There are a substantial number of women who must cope with the process of rehabilitating from this cardiac event.

In addition to the mortality and morbidity statistics, the nature of the illness experience itself imparts an important
significance. The dramatic way MI presents, the period of extreme uncertainty that follows, and then, the living with the consequences of this life-threatening pathophysiological event contribute to this significance.

Typically, MI occurs suddenly, with little or no warning. The predominant symptom is one of excruciating and unrelenting chest pain. A feeling of impending doom, that something is very wrong, characteristically accompanies the chest pain. How the patient describes the MI pain episode is so characteristic of and integral to MI that it is a necessary component of the differential diagnosis (Hurst, King III, Walter, Friesinger & Edwards, 1982).

If an individual survives this initial phase of the illness experience, a period of intensive care follows. The rationale for this type of care is to monitor patients closely during this highly precarious time post-infarction when extension of the infarction, another infarction, and/or complications, especially fatal arrhythmias, threaten. Following this period of intensive care, the individual then is faced with the consequences of the heart attack: the physical and psychosocial impact of MI.

The aftermath of MI is widely viewed in the literature as a complex and difficult experience (Croog, Levine, & Lurie, 1968; Doehrman, 1977; Wilson-Barnett, 1979), encompassing profound physical and psychosocial effects. One reason for the psychosocial responses is the symbolic meaning attached to the heart. Because the heart is commonly symbolized as the "seat
of our emotions" and as the "fountain of life," when an MI, a life-threatening event, occurs, a compelling psychological dimension is added to the experience (Cassem & Hackett, 1977). This symbolization, coupled with the real threat of sudden death, contributes to the psychosocial responses to a heart attack. The nature of this response has been described in the literature as one in which feelings of anxiety and depression predominate (Cay, Vettner, & Philip, 1972; Cassem & Hackett, 1977). It is suggested that the threat of death plus the day-to-day living with this fearsome reality precipitate the feelings of anxiety. A heart attack frequently means lifestyle adjustment and this impact on lifestyle is linked to the feelings of depression. The illness experience following MI presents a challenge for health care professionals.

There is extensive research and writing on MI as it relates to men in the health sciences literature. To date, however, there has been limited work directly studying MI as it relates to women. Instead, generally, women are subsumed under research on men; there is a dearth of studies that explore women's illness experience. Because the needs and concerns of women cannot be assumed to be represented, using studies on men to direct the care of women may result in care that is not appropriate. There exists an identifiable need to study women's illness experience with MI.

The situation in the health sciences literature described above is an illustration of one of the reasons for dissatisfaction with women's health care voiced by women's health activists. The predominance of the male perspective to
the apparent exclusion of the perspective of women demonstrates a research bias. Marieskind (1980) remarks on the paucity of accurate data and the limited validity of what does exist concerning the health status of women in general. In the nursing literature, Stevenson (1979) points out that nursing research has paid little attention to women's health care needs as a separate entity.

Given the status of the literature studying MI in women, an appropriate way to begin to study this area is by exploring and describing the patients' views of their illness experience as perceived and expressed by the women themselves. This approach is congruent with a major thrust of the Women's Health Movement, with egalitarian rather than hierarchical health care (Marieskind, 1980; Ruzek, 1978). Focusing on the patient's understanding of the illness experience reduces the power differential between the patient and the professional and communicates to the patient a genuine respect for her views and a support for her involvement. For nurses, understanding women's experience with a heart attack is important for the direction provided in patient assessment and in the planning and provision of meaningful and effective rehabilitative care. Studying the patient's point of view is also highly compatible with the nursing profession's goal of patient-centered and holistic care (Swanson & Chenitz, 1982). Further, the nursing profession values the collaborative process in the planning and provision of nursing care.
Conceptual Framework

The conceptual framework that was selected to direct this study is Kleinman, Eisenberg, and Good's Explanatory Model (1978). These theorists identify three domains of health care in society, each having an explanatory model. Kleinman et al. emphasize the importance of eliciting the patient's explanatory model, so that negotiation of discrepancies between professional and patient models may occur and meaningful and effective care can be provided.

In this model, a sharp conceptual distinction is made between disease and illness. Kleinman et al. (1978) contend that "disease in the Western medical paradigm is malfunctioning or maladaptation of biologic and psychologic processes; whereas illness represents personal, interpersonal, and cultural reactions to disease or discomfort" (p.252). Simply put, diseases are treated and illnesses are experienced. Illness represents the human experience of sickness. Illness, therefore, is socially and/or culturally constructed. This social and/or cultural construction of the illness experience constitutes the patient's explanatory model of sickness. It follows, then, that variation in describing and coping with an illness experience may occur across cultural, social, and family boundaries.

The three structural domains of health care in society described by Kleinman et al. (1978) are as follows: 1) professional, 2) popular (family, social network, community), and 3) folk (nonprofessional healers). How an illness experience is perceived is dependent upon one's domain. Kleinman
et al. state that, for the patient and health care professional, "interactions are transactions between explanatory models..." (p.254), between the popular and the professional explanatory model.

It is not surprising that discrepancies in information as well as in values, expectations, and objectives of care often occur between these two explanatory models. Different perceptions and explanations affect patient care outcomes; negotiation between models is a prerequisite to relevant and competent care. Health care professionals are directed by this model to elicit their patients' explanatory models so that they may truly strive to understand their patients and provide care appropriate to the meaning of the illness experience for those individuals.

**Problem Statement**

The general problem this study addressed is the lack of empirical knowledge about women's illness experience with MI as perceived and expressed by women. The statistics together with the nature of the illness experience accentuate the significance of this health problem for women. The limited attention to this health problem for women in the health sciences literature is related to the popular view that heart attacks are for men only and to the more general problem of male-dominated health sciences research. It is consistent with both the goals of women's health activism and the goals of the nursing profession to focus on the perceptions of individuals; this focus
acknowledges their worth as individuals and also the value of their experience. Kleinman et al. (1978) provide a useful framework for conceptualizing this research problem. They emphasize the importance of eliciting the patient's view, the personal and social meanings of the illness experience. These data will equip nurses with a more valid basis for their practice. Nurses must develop their understanding of women's illness experience with MI in order to plan and provide appropriate, effective nursing care, nursing care which reflects the nature and meaning of the heart attack experience for women.

**Purpose of the Study**

The overall purpose of this study was to explore and describe women's perceptions of their illness experience with MI. The following specific questions were derived from this purpose:

1. What is the nature of the illness experience for women with MI?
2. What is the meaning of the illness experience to women following MI? What is the impact of this illness experience on everyday life? (activities of daily living, interpersonal relationships, work, leisure activities, feelings, emotions, and outlook on life).

**Introduction to This Study's Methodology**

The phenomenological method, a type of qualitative methodology, was selected for this study. This methodology is
consistent with the conceptual framework and the research questions of this study. Kleinman (1977) argues for the use of the phenomenological method to elucidate how sickness is socially constructed in everyday life. Further, Kleinman asserts that such studies would provide concrete contributions to patient care. Anderson (1981) identifies the social construction of illness as a topic "profitably studied within the phenomenological framework" (p.130).

The nature and purpose of the phenomenological method also support its use in this study. The phenomenological method requires the researcher to see the situation under study from the subject's perspective (Rist, 1979). This methodology considers all phenomena to be socially constructed and stresses "inner or subjective understandings of events, behaviours, and surroundings" or "how the world is experienced" (Rist, 1979, p.19). Omery (1983) defines the goal of this methodology as "an accurate description of the experience or phenomena under study" (p.61). Oiler (1981) states that the purpose of phenomenological inquiry is to "describe experience as it is lived" (p.178). Because the focus of this study was an explanation of women's illness experience with MI from the personal perspective of these women, it was appropriate to select this methodology.

Further, in contrast to traditional quantitative methods, a distinctive feature of this methodology is the sheer depth of study afforded. As Rist (1979) states, this research method "enables a comprehension of human behaviour in greater depth"
than is possible from the study of surface behaviour, from paper and pencil tests, and from standardized interviews" (p.20). Giorgi (1975a) identifies the value of the phenomenological method to be "the direct access it provides to meaning by interrogating its qualitative aspects" (p.101).

The phenomenological method fits well with the nursing profession's values and goals (Davis, 1978; Anderson, 1981; Oiler, 1982; Omery, 1984). The nursing profession's valuing of the individual and nurturant function parallel the reverence for the human experience central to this methodology.

**Definition of Terms**

In this study, the following definitions apply:

women: adult females in the Lower Mainland under the care of a physician, referred to this study by that physician, and who have been diagnosed with MI.

perceptions: the patient's view, the patient's understanding, the patient's perspective, the patient's explanation.

illness experience: as defined by Kleinman et al. (1978, p.252)

"...personal, interpersonal, and cultural reactions to disease or discomfort." The reactions of women to MI and to its impact on everyday life.

**Assumptions and Limitation**

The assumptions that guided this study were:

1. An understanding of the illness experience of women with MI can be determined by using the phenomenological method.
2. Women's perceptions of their illness experience with MI differ from those of men.

3. The illness experience with MI has meaning for women. MI affects everyday life.

The following study limitation was identified:

The richness of the data is limited by the time constraints of the researcher. These time constraints account for the number of women selected as participants and the number of interviews conducted.

**Summary**

MI is a significant health problem for women as evidenced by the mortality and morbidity statistics reviewed in this chapter and the overall devastating nature of a heart attack. It is increasingly recognized that the traditional research treatment of women's health problems is fraught with many difficulties, including the exclusive use of the male perspective, subsuming women under men, and not studying women. These difficulties apply here for women with MI.

This study proposed to explore and describe women's perceptions of their illness experience with MI and thus to address the lack of empirical knowledge concerning this health problem for women. Understanding health problems from the patient's perspective lays a sound foundation for nurses to understand the total phenomenon of the illness experience. From this basis, nurses are directed to plan and provide empathic and relevant nursing care. This means nursing care
which reflects the nature and meaning to women of their illness experience with MI. It is also nursing care which reinforces nursing's beliefs in the worth of individuals and nursing's unique nurturant function.
CHAPTER 2
Review of Selected Literature

Introduction

This chapter presents a review of the literature pertinent to this study's rationale and purpose. The intent of this review is to further substantiate the need to study women's experience with MI and to locate this study within the context of related professional literature.

The researcher recognizes that a literature review is usually woven into the description of the results when using the phenomenological method, so as to "bracket" explanations about the phenomenon under study (Oiler, 1981). However, women's experience with MI is not a phenomenon about which there is a body of knowledge. The literature review emphasizes this lack of attention by presenting the total works to date found by the researcher on women's experience with MI. The findings of these studies highlight the need for further investigations because of study limitations. These studies do not generate a mind set or presuppositions about the nature and meaning of the MI illness experience for women.

It must be noted that there is a small body of epidemiological literature concerning women and coronary or ischemic heart disease (see for example: Bengtsson, Hallstrom, & Tibblin, 1973; Szklo, Tonascia, & Gordis, 1976; Waldron, 1978; Haynes & Feinleib, 1980; Salonen, 1982; and Rosenberg et al., 1983). The research focus of this literature is an explanation of the sex differential in incidence rates for heart
disease. These works study the relative effects of risk factors in the development of heart disease in men and women. Additionally, the relationship of psychosocial variables to heart disease in women is investigated in an effort to determine the reasons for the marked differences between the sexes. The findings to date from these works are inconclusive. The differences between men and women are not thought to be associated with sex differences in risk factors (Szklo, 1980) and are, at present, not understood. Because the studies within this area are not designed to address any facets of women's illness experience with MI, but only pre-infarction events, these studies are not included in this literature review.

The review of the literature is organized into three sections. The first section is a summary of the studies that this writer found in the literature directly and specifically addressing women's experience with MI. The second section is a presentation of MI studies that included women in the samples and differentiated the analysis by sex. The final section is a discussion of the literature on patient perception and MI. This section speaks to the need to study the patient's point of view and provides a basis from which to view this research problem.

Women With MI: Research Directly Studying Women

Peter, Luxton, and Harper (1974) researched mortality in women with acute MI during a four year period in Australia.
The researchers were prompted to this investigation by figures which suggested that the prognosis of acute MI was different for women than for men. In this study, women were shown to have a significantly higher mortality rate one year post-infarction compared to the total one year post-infarction mortality rate. It is important to note that women comprised 17% of the total sample of 903 patients, or 154 women. This is a relatively small sample size. The strengths of this study are the investigation time period (four years) and the total sample size.

Papadopoulos, Beaumont, Shelley, and Larrimore (1983), in a more recent work, studied MI and the sexual activity of women patients. These researchers cited the paucity of data on this subject as the impetus for their investigation. Because a consideration of sexuality is well established as a critical component of the process of cardiac rehabilitation (McLane, Krop, & Mehta, 1980), this lack of research concerning women's sexuality after a heart attack is highly significant to note within the context of the research problem of this study.

Papadopoulos et al. interviewed 130 women patients and found that an MI had a negative impact on women's sexuality, and, further, that counselling on sexuality was not adequately provided. Data collection focused on resumption and frequency of sexual activity and reports of symptoms during sexual activity. The study did not explore how women post-infarction viewed their sexuality, their feelings and thoughts.

Johansson et al. (1984) researched sex differences in pre-infarction characteristics and long term survival. The study
spanned eleven years and the sample consisted of 262 women and 1,259 men. Their significant finding was that once a woman has had an MI, the risk of death is at least as high as that for men.

Griffo et al. (1983) conducted a comparative study of the effects of a physical rehabilitation programme in 179 men and 49 women post-MI. The study demonstrated that controlled physical training in women convalescing from an MI resulted in an improvement in work capacity similar to that achieved in men. However, this improvement was not maintained because of the women's poor compliance to the programme at home. The investigators conclude that these results do not support automatically excluding women from such physical rehabilitation programmes. This statement is an example of the inclination within the MI literature to fit women into the male perspective rather than to consider women's unique problems and needs.

In the most recent work that this writer found, Chirikos and Nickel (1984) researched work disability from coronary heart disease in women. These authors conclude from recent United States statistics that, despite the quite different incidence rates, work disability due to heart disease is the same in men and women. They infer that this is due to an increased likelihood of women responding to heart disease by changing work behaviour or dropping out of the labour force. Chirikos et al. assert that work disability is important to examine because return to work is frequently utilized as a measure of successful cardiac rehabilitation and because changes in work activity have
social and economic effects.

These authors speak emphatically to the dearth of research on women and heart disease in the face of an expanse of literature on behavioural adjustments to heart disease for men. To illustrate this point, Chirikos et al. (1984) report the results of their bibliographic search conducted on the topic of post-MI and post-coronary artery bypass work resumption from 1964-1982. Of the 33 studies found, only seven included women subjects and analyzed results by sex. They further noted the small sample sizes in these works to be a major limitation.

The goal of Chirikos et al.'s (1984) research was to determine the presence of sex differences in labour force withdrawal after a discrete and similar episode of heart disease; acute MI was selected. A secondary goal was to study factors affecting women's higher rates of work withdrawal.

Chirikos et al. (1984) did indeed find that a significantly larger percentage of previously employed working women were work-disabled subsequent to a heart attack compared with working men (work defined in this study as market work). Another important finding was that those persons who reported activity limitations in the early post-hospital period were found to be less likely to return to work. Interestingly, expected market earnings were not shown to influence the return to work behaviour of women as was the situation for the male counterparts in this study and for men in other studies as cited by Chirikos et al.

These authors conclude that significantly higher rates of work disability in women are not due to disease severity, but
to the behavioural response to the course of the illness experience. The results of this research highlight the need to explore the illness experience of women with MI. An understanding of the meaning to women of their heart attack experience may assist in putting these findings into perspective. This study was reviewed in detail because it is current and methodologically sound (sample size and empirical model design). This study powerfully supports the contention of this problem statement that MI is a highly significant health problem for women.

The research directly and specifically studying women's experience with MI is astonishingly limited — the five studies reviewed above comprise the total works this writer was able to locate in a health sciences literature search. These studies represent very diverse facets of women's experience with MI: 1) mortality, 2) sexual activity, 3) long term survival, 4) physical rehabilitation, and 5) work disability. It is important to note that all five studies yielded significant findings in relation to women's experience with MI. These results point to a post-infarction period that is difficult and different for women and emphasize the need to study women's experience.

**Women With MI: Studies Including Women**

There are a few reported studies on the aftermath of a heart attack which include women subjects in the samples and differentiate the research analysis by sex. These studies are
now briefly reviewed.

A Japanese study in 1970 (Hinohara, 1970) researched psychological aspects of cardiac rehabilitation. Women who had suffered a heart attack were found to be more type "A" (hard driving, competitive) than the control group of healthy women. This finding supported the earlier work of Friedman and Rosenman (1961), the originators of the type "A" and type "B" personality typologies. They had noted women with coronary heart disease (not MI specifically) to be more type "A" than their matched sample of healthy women. In an extensive longitudinal study conducted in Sweden (Bengtsson et al., 1973), women with MI were noted to differ from healthy women in their higher levels of stress, aggressive and neurotic self-assertion (type "A" behaviour).

Moss, De Camilla, and Davis (1976) researched prognostic factors in the early post-hospital phase following an MI. In their study, female sex was associated with a significantly increased mortality rate. This marks the second study reported in this literature review with this finding. It must be noted, however, that in both studies, there are relatively small sample sizes of women. The women in this study represented 18% of the total population of 518 patients, a limitation in generalizing the results.

Stern, Pascale, and Ackerman (1977), in their extensive study over a one year period of life adjustment post-infarction, also reported a significantly higher mortality for the women in their study. Again, their small sample size of women is problematic. The occurrence of this finding in yet another
study, however, is important to note.

Stern et al.'s (1977) study reported as a "new and challenging finding" (p.1684) the comparatively more difficult rehabilitation course experienced by the post-infarction women. They noted the women to be significantly depressed and anxious both in hospital and at the one year follow-up. Also, the women sampled took longer to return to work and to regain sexual functioning. Chirikos et al. (1984), as reviewed previously, substantiated the return to work finding and Papadopoulos et al.'s (1983) study of women's sexual activity post-infarction supports difficulties in resumption of sexual activity.

To account for their results, Stern et al. (1977) postulate that the poorer rehabilitation course for the women in their study is related to psychosocial aspects. The rationale for this assertion stems from the high degree of type "A" behaviour measured in the women, higher even than the men in the study. These results are more alarming than those discussed above. Previous studies found post-infarction women to be more type "A" in a comparison with other women. This study suggests that post-infarction women are more type "A" than a corresponding group of post-infarction men. These researchers acknowledge that further research is warranted to test these findings, both the type "A" findings and the seemingly poorer rehabilitation outcome for women. This writer assumes that this call for further research is stimulated both by the small sample size of women subjects and these important findings in relation to women.
In a study of convalescent discomfort following acute coronary events, Speegle, Bayer, and Greene (1979) quantified patients' expressions of discomfort. There was found to be a significant association between being female and higher discomfort scores. The researchers attributed this to women's greater acceptance in verbalizing discomfort compared with men in our society. This study is important as it is the only study of women with MI that researched some aspect of women's view of the illness experience.

This literature review of studies including women in samples and analyses suggests that women may be an at-risk group in terms of the course of rehabilitation post-infarction. Small sample sizes clearly limit generalization, but the findings reported here give definite evidence of the need to study women's experience with a heart attack.

**MI and Patient Perceptions**

There is a body of literature concerned with the variables affecting the course and outcome of MI. Croog et al. (1968), in a classic review of the literature on social and psychological factors in the recovery process of the heart patient, outlined directions for future research. These researchers noted the paucity of work on patient perception and possible relationships between perception and outcome of rehabilitation. These authors emphasized the need for empirical work focusing on how the patient views the illness experience. Their observations stimulated a number of studies on patient perception and outcome.
Garrity (1973) concluded that "health perception should perhaps be considered theoretically as a major intervening variable..." (p.715). Garrity found the patient's perception of health status to be more important than even clinical health status in relation to return to work post-infarction. Cay et al. (1973) identified that patients' own opinions of their physical status and extent of disability determined their return to work pattern. In a subsequent study, Garrity and others (Garrity, Somes, & Marx, 1978) replicated many earlier works in finding several correlates of this variable of patient perception. They proposed the development of a conceptual model of patient health perception. In a more recent study, Byrne (1982) found a strong relationship between illness behaviour and outcome at eight months post-infarction. In this study, the definition of illness behaviour is similar to patient perception. Chirikos et al.'s (1984) research, as reported in this literature review earlier, noted that return to work behaviour was associated with the participants' view of their physical limitations.

These literature findings support a relationship between patient perception and the course of the illness experience with MI. If perception is strongly linked with subsequent behaviour, it is clearly a priority to research the patient's point of view. Because a major component of cardiac rehabilitation is lifestyle adjustment, knowledge of how the patient sees the illness experience would assist nurses to provide meaningful help.
Summary

The importance of MI in relation to women cannot be underrated. MI is a significant health problem for women. However, women with MI have received limited attention in the professional literature. The findings of the few studies conducted of women's experience with MI intimate that women may well present a particular challenge in cardiac rehabilitation.

Kleinman et al.'s (1978) model asserts that socialization affects how individuals perceive their illness experiences. This model directs health professionals to elicit the patient's view so that social factors are considered in the planning and provision of care. Current concepts in cardiac rehabilitation are based upon an understanding of this process in men. An understanding of women's perceptions of their illness experience with MI would provide a more valid basis for nursing practice.

As described in Chapter 1, the phenomenological method of inquiry is the appropriate methodology for the conceptual framework and purpose of this study. Chapter 3 outlines the implementation of the selected methodology in this study.
CHAPTER 3
Methodology

Introduction
This chapter describes the application of the phenomenological method of inquiry in this study. The researcher's interpretation and implementation of the study's methodology are presented in relation to selection of participants, data collection, data analysis, and ethical considerations.

Selection of Participants
The phenomenological method directs the researcher to collect data from subjects who live the experience that is under investigation. Further, this research methodology considers the informant's natural setting or the home environment to be most conducive to the sharing of perceptions of life events (Oiler, 1982). Women who had returned home following hospitalization for MI were determined to be the appropriate data source.

Consistent with this methodology, a purposive or theoretical sampling technique was utilized to select the study's participants (Swartz & Jacobs, 1979). The participants were selected according to their ability to address the study's research questions. In this study, participant competency was determined by the meeting of five criteria.
Criteria for Selection

The selection of participants for this study was guided by the following five criteria:

1. Over 18 years of age,
2. Able to speak and read English,
3. Alert and oriented to time, person, and place,
4. Diagnosed with an MI,
and 5. Home following hospital discharge for approximately 2 to 16 weeks.

Selection Procedure

Initially, the researcher sought potential subjects through referral from the community practices of participating cardiologists in the Greater Vancouver area. Because subjects were not forthcoming, the sources for subjects were expanded to expedite the research process. Consequently, women were selected from one Homecare facility and from the census records in two acute care hospitals, all located within the Greater Vancouver area.

When the researcher received the name of a potential subject, suitability was determined as per the selection criteria and the professional opinion of the physician and/or nurse involved. Following this step, the researcher mailed out the Patient Information Letter (Appendix A). For some of the potential subjects, this letter was the initial contact. For others, their cardiologist and/or nurse provided an introductory explanation of the study and determined a general willingness to participate. Approximately one to two weeks later, the
researcher telephoned the potential subject to answer questions, assess a willingness to participate, and to set up a mutually convenient appointment time for the home interview. There was one departure from this procedure, the subject referred by Homecare. In this instance, the Homecare nurse hand-delivered the Patient Information Letter. Only two women were not recruited through participating cardiologists, the woman referred by Homecare and another woman from the census records in one of the acute care hospitals. In the case of these subjects, the researcher informed their cardiologists of their involvement in the study.

In total, eight women were approached for participation. All eight women readily agreed to be involved. The researcher's first contact by telephone was a positive encounter in all instances. The women seemed to ask questions easily about the study and what was expected of them. The Consent Form (Appendix B) was signed at the first interview. Prior to the signing, subjects were given an opportunity to again ask questions. The subject's role in the study was reiterated and ethical safeguards were outlined. The researcher read the consent aloud. The subject then reread the consent and signed it. The interview then commenced.

Data Collection

The data were compiled through a series of 11 intensive interviews over a three month time frame. There were eight first interviews and three second interviews. The length of
the interviews ranged from 45 to 90 minutes. The interviews were semi-structured. The researcher was guided by questions adapted from Kleinman et al.'s (1978) six questions (Appendix C). The adapted questions served only as a basis for beginning data collection. Questions were added or deleted as determined by the researcher during and/or following the first interview. This procedure is consistent with phenomenological methodology, where the researcher's role is one of active involvement in striving to see the subject's perspective as it unfolds. The researcher participates "in the constitution of the actual data" (Giorgi, 1975a, p.101). As Oiler (1983) points out, the researcher's involvement is "exploited" and "empathic and intuitive awareness" are integral to the research process in this methodology (p.179).

The women seemed comfortable and uninhibited with the audiotaping. Once the interview commenced, the taping seemed to be forgotten and the women often seemed surprised when the tape recorder clicked off to indicate a completed side. Although the option of refusing to answer any questions or to terminate the interview at any time was clearly communicated to the women, not one of the women made such a request. There were no apparent difficulties in establishing and maintaining rapport with the women. Before and following the taped portion of the interview, there was a time for social conversation. Most of the women expressed feeling pleased to be contributing to an understanding of women's experience with MI. Many also thanked the researcher for her time and indicated that the experience was in some way beneficial to them. After leaving
the participant's home, the researcher recorded field notes as an addendum to the taped interview. These field notes consisted of specific data related to the characteristics of the participants and general observations and impressions about the participant and the interview process. Also, any significant data interjected in the non-taped social conversation were noted. The field notes and the verbatim transcripts of the taped interviews comprised the data for this study.

Construction of Accounts

The researcher is intimately and actively involved in the research process in phenomenological research. Because the socially constructed nature of all phenomena is a basic tenet of the phenomenological method, this methodology acknowledges and accepts the intersubjectivity of researcher and subject. Meanings are not attached to phenomena in a vacuum. Both the researcher and the subject bring their own unique frame of reference to the research situation through which the situation is interpreted. The researcher explores "the meaning of that experience as it unfolds for the participant" (Omery, 1983, p.54). Rist (1979) regards the task of the researcher as "always one of learning how those involved interpreted and gave meaning to the experience" (p.20).

In this study, the researcher used the interview questions as a loose interview structure. Questions were posed in an open-ended way. The researcher responded to the participants using reflection and clarification and frequent suggestions to "tell me more." Through this interview style, the participants
guided the construction of the accounts. The researcher's major role was to assist the participants to explore the meaning to them of their illness experience. As data collection proceeded, the researcher was able to become submerged within the experience. The quality of the data increased with the researcher's enhanced understanding of the illness experience.

Data Analysis

To analyze the collected data, the researcher developed a procedure by synthesizing the writings of selected phenomenological researchers (Giorgi, 1975a, 1975b; Omery, 1983; Loflund & Loflund, 1984). Following each interview, the researcher listened to the tape to get a "sense of the whole" (Giorgi, 1975b). The tape was transcribed verbatim. The researcher then listened to the tape and read the transcript to immerse herself in the data. The next step was to consider each piece of data and to assign natural thinking units or meaning units or content categories. This step was carried out assuming an attitude of "maximum openness" (Giorgi, 1975b). Following this step, the researcher stated the theme that dominated each unit or category, using the same "maximum openness." At this point, the themes were considered in relation to the study's purposes and research questions. From this analysis, the researcher planned questions and topics for the second interview with the particular participant and also formulated guidelines for other subsequent interviews. The researcher decided to stop interviewing when it became evident that consistent themes were being identified and validated and
the data collected were sufficiently in-depth and rich. The study's analytic framework is the final product derived from this process of analyzing the study's data and refining that analysis over time.

**Ethical Considerations**

The rights of the subjects were protected as follows:

1. Written consent of the subject was obtained prior to interviewing.
2. The researcher made herself readily available for questions about the study.
3. The researcher clearly outlined what participation in the study involved.
4. The researcher reiterated to the subjects prior to each interview their right to choose not to answer any questions or to terminate the interview.
5. Subjects were informed that their decision at any time not to participate would not prejudice their health care.
6. The subjects were told that the study involved no anticipated risks to them. The potential benefit of understanding women's illness experience with MI to the nursing care of women heart attack victims in the future was articulated by the researcher.
7. The researcher informed subjects that safeguards would be utilized to ensure anonymity and confidentiality of the interview data. The tapes
would be coded and then erased upon completion of the study. Written materials would be shredded and discarded. The only individuals who would have access to these data would be the researcher and the researcher's thesis committee.

8. The researcher advised subjects that should the researcher assess the need for intervention by a health care professional, the subject would be referred back to the participating physician. The researcher and subject would discuss the situation prior to the referral step.

**Summary**

This chapter discussed the implementation of the selected methodology, the phenomenological method, to elicit women's perceptions of their illness experience with MI. Eight women participated in the study and 11 in-depth interviews were conducted over a three month time period.

The data, the transcribed tapes and field notes, were analysed to determine thinking units and themes. Data collection and data analysis were intertwined. The analysis from the beginning interviews shaped the data collected in the subsequent interviews. The researcher assumed the role of facilitator in the exploration of the meaning of this illness experience. The researcher and the participants contributed to the construction of the accounts. Chapter 4 describes the researcher's interpretation of these accounts.
CHAPTER 4

Presentation of the Study's Findings

Introduction

This chapter presents the findings of this study, the characteristics of the participants and the women's accounts of their illness experience with MI. Before discussing the data, the study's analytic framework is introduced and delineated. This analytic framework represents the researcher's interpretation and conceptualization of the data.

Explicating the researcher's framework is a critical criterion in the implementation of the phenomenological method. Giorgi (1975a, 1975b) asserts that the control in qualitative research comes from this communication of the researcher's perspective of the data. Adopting this same framework, another investigator should be able to also see what the researcher saw in the data.

The Study's Analytic Framework

The women's accounts describe the nature and meaning of their heart attack experience and the impact of this illness experience on their everyday lives. While the accounts of the participating women reflect unique illness experiences with MI, distinct themes run through the data that point to their common experience. These themes are the basis for the study's analytic framework (Figure 1 "The Study's Analytic Framework").
Figure 1. The Study's Analytic Framework

A Loss Framework

Loss of Healthy State

(leads to)

lack of energy

Loss of Predictability

lack of anticipated support

(leads to)

change in usual role enactment

Strategies for Control

The core theme that emerged from an analysis of the data was loss. There was a definite communication by the women of being without that which had meaning for them (a usual definition of loss). The women perceived their lives to be fraught with many significant changes since their MI and they constructed their accounts around these changes. It was this focus on change that directed the researcher to see the data from the perspective of the concept of loss. In sharing their perceptions through the context of change, the women were grieving the losses inherent in these changes. Given this, the study's analytic framework is basically a loss framework. The framework consists of six component parts: 1) loss of healthy state, 2) loss of predictability, 3) lack of energy, 4) lack of
anticipated support, 5) change in usual role enactment, and 6) strategies for control.

Within this analytic framework, loss of healthy state is operationally defined as a relinquishing of a former concept of one's self as a healthy person. This particular loss is a result of the real event of cardiac damage, the starting point, basis for, and/or impetus for the subsequent loss of predictability. It is the loss of their former healthy state that grounds the women's illness experience with MI.

The loss of healthy state that occurs with an MI experience leads to a loss of predictability. Loss of predictability refers to the women's perception of the precariousness of their illness experience. The women felt suspended, uncertain, and perplexed. It was as if they were adrift and floundering in an unfamiliar reality, this new and unpredictable reality of facing the impact of their MI in their everyday lives. Since perceptions reflecting a loss of predictability permeated and dominated the data, this loss characterizes and captures the essence of the women's illness experience with MI.

Loss of predictability was felt particularly in relation to energy, anticipated support, and role enactment. The subjects experienced a lack of energy, physical and psychological. They did not have the strength or endurance they used to have and they felt that their zest for living was missing from their lives. The women also felt a lack of anticipated support from their families, especially their husbands. They felt that they deserved full support because of the compelling nature of their illness experience and were disappointed that this support was
not entirely realized. There were also changes in performing usual roles that contributed to their sense of unpredictability. This illness experience influenced the enactment of the women's usual social and homemaker roles.

Strategies for control are defined as behaviours used by the women to gain control over experienced losses. Because of the profound sense of not knowing what to expect day-to-day, the women used a wide variety of strategies to engender feelings of control within their daily lives.

The women's accounts described both their losses and their strategies for control. The study's analytic framework, then, is the researcher's conceptualization of the women's explanatory model of their illness experience with MI.

**Characteristics of the Participants**

All eight participants were English speaking Canadians. Their ages at the time of the first interview ranged from 36 to 71 years. Six of the women were married and living with their husbands during the illness experience. Of the two remaining women, one was widowed and one divorced. Two of the women had children still living at home with them. Five of the women had grown children living away from them, some with families of their own. One woman did not have children. One woman had her mother living with her in a basement apartment.

Only two of the women were employed outside the home at the time of their heart attacks. The other six women had been homemakers for most of their lives. Of the spouses, three were working and three were retired.
All participants lived in the Greater Vancouver Area. Five women lived in single family dwellings, three women lived in apartments. From the researcher's very general observations of the physical setting, the women seemed to be homogeneously middle class in relation to socioeconomic status.

The timing of the first interview was from one to four months post-infarction, with three months being the usual case. This means that the women had been at home following discharge from hospital for 2 to 14 weeks. Only one woman was scheduled for bypass surgery; the remainder were being treated medically. None of the women was involved in a structured rehabilitation programme (e.g. The Y.M.C.A. Cardiac Exercise Programme). For five of the women, this was their first MI. The remaining women had experienced one to three MI's previously. Most of the women had additional illnesses. Two women reported being hypertensive; one women was diabetic; and one had surgery for cancer of the bowel in the previous year (1984). One woman disclosed an extensive history of past illnesses, including 29 surgeries. Two of the women were readmitted for angina during the interview period.

**The Women's Perceptions of Their Illness Experience**

**Loss of Healthy State**

The first aspect of the MI experience for these women was their perceived loss of healthy state. The women made sense of their heart attack experience by describing the shift in their lives from health to illness. This shift was marked by the
heart attack itself, the event that catalysed a series of subsequent changes.

Although data concerning the heart attack per se were not specifically sought, the women chose to tell about their heart attack pain experiences within their accounts. These descriptions were diverse. Each woman vividly remembered her pain experience and described the event in a truly unique way. They strived to accurately recount what had happened, and used various descriptions to isolate and identify what professionals tend to call "pain." The heart attack pain episode was distinctly individual in the way it was perceived and experienced, but it always marked the beginning of loss. The women's subsequent interface with the professional sector served to even more emphatically bring home their loss of healthy state.

For two of the women, their heart attack presented initially as "heartburn" or "indigestion." Although these women did not initially perceive their discomfort as heart related, they did perceive a need for medical assistance.

And it was just like a bad case of heartburn. That's all it was.
(See Appendix D for key to the presentation of the block quotations.)

You know, I thought nothing of it. I didn't know what it was, to tell you the truth. I thought it was indigestion and I was taking that anti-acid thing, you know. And I did let out a belch or so. Then it went away. Then it came back and it didn't go away and I said to my husband, well, this is an awful, you know, burning sensation. Maybe I'd better go. I started to perspire, you know, the back of my neck and that and I knew that it wasn't just anything, you know. So, I started getting ready to go to the hospital.
Two other women put forth graphic descriptions of their pain experiences that are a sharp contrast to the prior descriptions of gastrointestinal discomfort. Both of these women related scenarios that stand out for their colourful expression and unusualness.

I got this, sort of this tightness -- well, it was in the side here and also -- well, I'd had -- even when I was in the hospital, it was just like a piece of wet leather, like sort of a tightness right in here.

I was sitting in a chair and the whole room started spinning around. This is my experience. The whole front room spinning around and I called my husband and then I became nauseated.

The remaining women described symptoms that are most familiar to the professional domain. They described their pain using terminology such as crushing, choking, pressure, heaviness, radiating, and/or excruciating. The experience included symptoms such as nausea, perspiration, and shortness of breath. The following two women serve as examples of such descriptions.

Yeah, well, it happened about 2:00 o'clock in the morning and I was -- I broke out in perspiration all over. I got real wet on my chest, on my neck and my head and a little later on I got that heavy feeling and kind of a little pain with it, you know.

It isn't really, you know, a pain. It's a -- it's a choking feeling -- not a choking. It's as though somebody is pushing. It's pressure, you know.

I had such a pain in my heart that I was in tears all the way to the hospital and it just felt like my heart was tearing in two.

Well, the pain was right into my arm, right down to my wrist and I just felt like someone was sitting on my chest and the pain inside was really -- it was really tearing.
You know, it just felt terrible. Terrible pain.

These early experiences, it seems, represent the end of healthy state and the beginning of the illness experience. The women did not relate prior experiences that warned them or helped them anticipate this event. It was the actual heart attack episode plus the subsequent interaction with the professional sector that marked the transition from health to illness. That their healthy state had undergone redefinition was further entrenched by the advice given to the women by the professional sector.

Well, they just said do nothing, you know. Don't do anything but maybe walk half a block and then come back.

... 

Well, as they warn you, don't overdo anything. Don't overwork. Don't over eat. Don't over walk, I suppose and all that.

The nature of this advice, this prescription for regaining wellness, accentuates a special feature of this illness experience. The women were told to carefully monitor their activity during the early phases of cardiac rehabilitation. This is distinctly different from many other illness experiences. In many illness experiences, "doing too much" may result in feelings of exhaustion, but, for the MI patient, "doing too much" could well mean pain, re-infarction or possible death. The prescription for wellness clearly reinforced the loss of healthy state. For the women, then, their illness experience with MI was characterized by abrupt and important changes in the way they lived their lives.
Loss of Predictability

This section describes the central loss in the study’s analytic framework -- loss of predictability. Loss of predictability stems from the shift from health to illness identified in this framework as loss of healthy state.

The women related feeling an overwhelming sense of not knowing, not knowing what to think, feel, or do. It was as if their heart attack had catapulted them into a different and unfamiliar reality. Because the shift from health to illness was sudden and unexpected, the women felt suspended and bewildered as they tried to carry on in their everyday lives.

Yes, it is quite upsetting emotionally. You know, you just wonder what sort of life am I going to have, you know, from here on in, you know.

... ... ... ... ...

It kind of leaves you hanging in mid-air, sort of. You know, if you feel like -- I'd like to feel I still have a future and this way you don't know that. You're just sort of living every day for itself. Perhaps that's the way to do it, you know. I don't really know.

... ... ... ... ...

You're just sort of in limbo for a while until you can pick up where you left off, which would be sort of a gradual process I imagine. You sort of wonder to a degree, where to go from here. But I don't know. You're just in limbo waiting to carry on.

"Hanging in mid-air" and "in limbo waiting to carry on" conjure vivid images of being in a foreign and unpredictable reality. Loss of predictability extended even to the cues the women had previously relied on as barometers about their state of health. After the MI, these changed in meaning, yielding a new confusion. Now, the women felt that they didn't even know what they're bodies were saying to them.
I think you've had a heart attack and you come home and you know, you can convalesce for four months and you don't know -- you're a little apprehensive because -- say you get a pain in the chest or a pain somewhere, an ache or whatever it is, now, conceivably, I had those pains or those aches always before and you really thought nothing about them because we always have aches and pains in our body. But I think after a heart attack, you sort of think, is that related to a heart attack? Is that angina? What is that? And whatever it is, you don't ever get the answers really, you know. I say you don't get the answers probably because like the net result of it isn't serious enough. I mean, I guess if you had another heart attack, then you'd know.

So, -- then the other thing that I'm struggling with perhaps in my mind perhaps is I have to believe that I'm either entering or going through, whatever, the menopause and knowing as little -- it's my own fault because I haven't got a book and read anything about it -- I think there's probably aspects of the menopause I'm going through that I'm also confusing myself as to whether that has got something to do with my heart.

Q. Can you give me an example of something?
A. Yeah, because I get quite warm, for example, now, I don't know whether that is a hot flush or flash or if it has something -- it's also a symptom of the heart, that I've come to find out. I get quite light-headed at times. That again is a symptom of heart. It can be a symptom of many other things. So, I don't know what it is. But I do know that I was, you know, getting my menstrual periods essentially up until September, October -- October, I think, before my heart attack and I have not had one since. So -- and I'm fifty. So, I think that something in my physical and mental make-up is the menopause but I'm also not fooling myself that there is a post heart attack that I'm coping with as well.

This loss of predictability profoundly affected the women in their decision making and in their perceptions of reality in their everyday lives. This following account dramatically relates the feeling of being totally "unhinged" by this illness experience. This woman expressed the need for her husband to be at her side at her doctor's appointment to help her to sort out the interaction with the physician. Note this woman's
description of her mind as "a little bit mushed." The loss of familiarity has resulted in a loss of confidence in her ability to process information, to think!

Now, when I went to my general practitioner each week or every two weeks or however often I went, for the most part, I asked my husband to go with me. And I -- yes, and he did go and I wanted that specifically because you're going to go in; you're going to ask the doctor questions or he can volunteer information or whatever and you come out and your mind is a little bit mushed. You're not sure whether they've answered your question. In many cases they haven't but you also may get an impression of what they've said and it may not necessarily be what they've said or what they meant. So, that's why I wanted my husband to go because I thought if I got off base or track on what it was, he could say no, B., that isn't what the doctor was telling.

Because of the loss of predictability, the women needed specific, concrete information about their condition. They wanted straight, definite answers about their home management of their MI. To not get these answers reinforced the uncertainty and dilemma in their everyday lives.

You know, another thing, I -- that has confused me, perhaps, or I've been apprehensive about, is I don't really understand or know what I can do physically and nobody has answered that. Like I've asked it really of, not so much the cardiologist as I have of my general practitioner, and he has said well, just do things slowly like just do them, just do them slowly. Well, what is doing them slowly. Like, do you know what I'm saying? Like if you vacuum, what is vacuuming slowly. Either you vacuum or you don't vacuum. Cleaning windows, reaching say to clean windows or be it cutting a lawn or whatever, you know, like I just don't know and I think to myself, I don't want to do something that, you know, is wrong and you're going to jeopardize yourself for doing it and yet on the other hand, you don't want to, you know, coddle yourself to the point you think, well, I can't do. And you don't really get the answers for that. You know, so, as a result, you know, it can get a little bit depressing.

And I walk but I don't do any other exercises because I haven't yet been told by my doctor or the cardiologist that I can exercise beyond walking. They say, well, take it
easy. Well, I don’t know what easy is.

Although there was a need for specific information about their illness experience, it was not met to their satisfaction. The consequences of living with unanswered questions were an even deeper feeling of loss of predictability which affected their perceived ability to cope.

And I’m feeling very uneducated about it. And a typical example was I take a medicine — only one medicine fortunately. And it’s corgard© and it’s a beta blocker. Okay, when I was told this was a beta blocker, I said to my doctor, what is a beta blocker and he said, B. — well, he said, well, it’s a drug, of course, that’s taken for a heart condition and he said it does a lot of things. Well, I looked at him and I thought, now, I declare. Now, that wasn’t any kind of an answer to the question I was asking, to me. Possibly it was to him. And I never did get an answer.

Like I didn’t feel equipped at all, to come home from the hospital and cope with having had a heart attack.

Accompanying the profound and pervasive emotions that characterized loss of predictability were particular concerns felt by the women. These included the possibility of a repeat MI, the possibility of sudden death, and the potential for returning to normal. These concerns clearly reflect the women’s perceived loss of predictability. Even minor discomforts stimulated fears of an impending attack.

At times you get, you know, not really a pain but you just sort of get that — like a funny feeling and almost like a stitch or something like that, you know, and I think — it kind of makes me stop now and think, you know, oh, is it going to happen again?

Despite a recognition that things were proceeding without incident, the nagging dread of another attack persisted.

But I’ve had no problems so I just keep my fingers crossed hoping that’s the way it’ll stay. But then I went two months and never had any pain and then all of a sudden I’ve got it again, you know, so I never know when I’m going to
The poignant memories of the heart attack itself contributed to the fear of another attack. For the women who had experienced more than one cardiac event, these fears were particularly heightened.

My concerns are that I'd be very frightened to have another one. That's one thing I'm concerned about. I've had two very bad ones, one a year ago last October and then October and then when my heart lost it's rhythm, that was quite an experience in itself. I'd do anything to stay away from it. It's so dreadful. It's really a dreadful experience. Nobody knows until they experience just how dreadful it is. You just feel like your heart is shredding.

The fear of dying suddenly was shared. The following woman realized that her reluctance to go out was linked to this fear and to a friend's sudden death. The uncertainty that characterizes the loss of predictability is strikingly clear in this excerpt.

A. It has cut down on my activities that I would like to do, you know, and I can’t do. That’s a problem. And the other is that it leaves you with a -- at least it does me, it leaves me with a certain fear. Just a fear.

Q. Tell me more about that.

A. Well, I guess you feel like you’re going to slip away and you’re not ready to go, you know and -- but on the other hand, I feel that I shouldn’t feel that way because the Good Lord knows what he’s doing. You know, I should take that into consideration but it still doesn’t stop that fear of that happening to you. You go to bed at night and you think well, am I going to be here in the morning and I think that’s one of the reasons I fear going out. I’d hate to just drop somewhere because a good friend of mine just had gone down to the store and she was doing fine and she made it in her driveway and practically to her front door and the neighbours saw her lying out on the pavement and she was gone. Mrs. L. So, you know, it was a terrible thing to happen to an old buddy, if she knew. I hope I don’t know when it comes but it leaves you with that feeling. So -- it’s kind of a scary business but that’s about all I can tell you about it.
It's just that you think, you had one; now you really don't know how strict you have to do these things or how long it takes. I think in the back of a person's mind, they think they've had one; now, just how long is it before they have another one and how many do you have before that's sort of the end of whatever life be it.

Concern about the potential for returning to normal was voiced by several of the women. In essence, they seemed to be grieving for their old healthy self and their former familiar reality.

I really wonder about that, whether I'll ever get back to where I can do just anything. Or want to do it. Or be able to do it. You know. There's a difference right now of wanting to do it and being able to do it.

I would just like to be the way that I was before but I'm not. I know that. I'm not to the point that -- I haven't got the strength to do things. I still want to do everything. I still would like to do everything.

Well, there's always the unanswered questions, how long until I'll be normal again. My concern is that it doesn't happen again.

Well, I think of, you know, getting this all healed and getting back to, you know, normal. I don't know when — if I'll have to take medications all the time or what. I don't know. But I'm just thinking about getting back to normal activities. You know, I love to go to the -- to the horse races. I love gambling. I love to go to Reno. I probably couldn't pull that slot machine too many times yet but no, I -- I just think of getting myself all better again.

Part of this concern about the potential for returning to normal was a comparison of self with others. The women seemed to use data about others in similar situations as a means to measure their own progress. This appeared to give them
a reference point in their world of unknowns from which to evaluate their own cardiac rehabilitation.

It was a very scary experience and it's something that you hope will never happen to you again and still you -- we have had different friends and you think, well, gee whiz, they -- they seemed to be on the mend and all at once, they were gone like that and I've had quite a number of them. They seem to -- and still, you shouldn't feel that way.

So, but as I say, beyond that, I don't know how long and I suppose the time will come, it's kind of like a death perhaps, the time will come when you forget that you had one, providing things go along reasonably well. I mean, I have friends -- I have a very good friend -- he was our best man at our wedding. He had a massive heart attack ten years ago and like, he's never had anything since and he, you know. You know, as I say it's kind of like a death. I think for some time you do think about it whether you want to or not and hopefully as time goes on, you'll think less and less about it, and get back to doing things as you did them before.

But now, I don't know, you're not -- you're a little -- a little bit weaker and a little bit -- but I hope I can get back to my normal. I think heart patients do. I'm not so sure, but I'm trying to think of a person that had heart problems in my time. I know my aunt did. She had angina problems but she -- she continued pretty good. She was strong and she did things the way she normally did, you know.

In summary, loss of healthy state, the MI event itself, is the basis for the subsequent pervasive and compelling loss of predictability. Loss of predictability constitutes the essence of the women's loss experience following MI. In addition to involving a complex pattern of emotions and specific concerns, loss of predictability was felt in relation to energy, support, and role enactment.
Lack of Energy

The women's accounts identified changes in both their physical and psychological energy as a prominent feature in their everyday lives after discharge from hospital. These energy changes were tangible and potent indicators of the precariousness of their state of health.

Lack of energy was manifested in very dramatic ways. As the women explored their energy changes within their everyday lives, they described their lack of energy in terms of their body's response to exertion. Lack of energy, for example, altered their approach to and the pace and scope of their activities as well as patterns of sleeping. Further, lack of energy influenced their attitude towards daily life.

For the women, these changes in their energy were unexpectedly troublesome. The women described their lack of energy as a reaction and outlined it as a sequence of physical manifestations.

Yeah and I still get tired. I still get tired. My legs, the lower part of my legs, below my knees, gets quite weak at times and I've told my doctors about that. I have no idea what that is. Sometimes, you know, you just feel like your legs aren't going to hold you. And then it passes and then we're okay.

.......

I find that I want to do some things and I can't. Because it's amazing how weakening it is really because the other day, I was doing some ironing and I -- really I stayed at it a little longer and I noticed I was starting to get tired. I hadn't done an awful lot, just one or two things I wanted to do. But you know, my legs were actually rubbery. I could hardly get from there to here, in the house here. It was an odd feeling, you know, like, you feel like your legs are going to go out from under you.

The women realized that they could no longer push
themselves to get things done once they sensed they were tiring. This represented a new limitation for them to face in daily living.

Q. What happens -- how do you know when -- to gauge your activity? Tell me how you determine when you have to stop and when you can’t do something.

A. I just get feeling a little washed out. Maybe an hour and a half, an hour and whereas before, I would keep on going regardless, until what I wanted to do was done. Now, I think I’d better not. I feel I’m getting tired. I’d better sit down. Or I better lie down now. For a few minutes before I can go on. But you just sort of get a real drawn tired feeling. I’m going to have to sit down.

I find I get tired very easily, that I just run out of energy and I run out of it to an extent where I just can’t do another thing. I’m just absolutely flat until I go and lie down for about a half an hour or so.

You know, I never felt I ran out of energy. I might get tired but I could push myself and now I can’t even push myself to do a thing.

The women’s lack of energy affected the quickness of their activities. There was a definite feeling of being slower since the heart attack. The women were unable to keep pace and slowed down as a way of coping with the risk of overextending themselves.

I go grocery shopping now, providing he drives me. If the cart gets too full, naturally he has to take over the cart. I used to be a very fast walker. Now, I’m not. And I’m always trailing way behind him somewhere. This is what’s irritating. All of a sudden he realizes I’m not beside him and he’s walked away too fast.

I did things a lot quicker. You know, when I went to do something, it was just now and now, I just -- I think about it and I’m slower now, you know. If I turn around fast, I think I’d get dizzy. But I was very quick before. I was quick at everything. I didn’t walk, I ran.
I know that I operate slower, but I think that the reason again that I do it, as I said to you, at work, for example, which is where it comes maybe more, you get the adrenalin flowing and really, you know, get into it and do whatever it is that you’re doing. Now, it’s the same as at home, if I do that I can feel it physically. If I really, you know, get into doing something, I can feel it physically. So I -- you know, I discipline myself not to let that happen.

In addition to speed, their whole approach to activities was affected. Now, a thinking through process preceded everyday activities. The women pre-evaluated whether or not the activity would affect their heart and their rehabilitation.

You almost get to the point before you do something, you think, oh, boy, is this going to set something off again or is it okay to go ahead and do things, you know, like do some ironing or do a bit of cleaning.

... 

Yes, it is different because I -- well, [before] you don’t think about it. You just get down and do it.

Loss of energy also meant loss of one’s zest for living. The women reported feeling “less enthused about everything” and no longer “gung ho” to do things.

A. And then just gung ho and go ahead and do it all.
Q. Uh-hum.
A. I just -- I can’t do that any more.
Q. Uh-hum.
A. But now I find -- even just if I do this area and get it cleaned up then usually I have to sit down and have a rest for half an hour or so and then I’ll get up and go do something else.

-- and another thing, you know, sometimes you feel less enthused about everything. Your enthusiasm, like before, I had more enthusiasm. Like, I’m going to do this, I’m going to do that. And I went ahead and did it and now, you don’t have that. You know, you just got to think, well, gee, take one thing at a time; do this, do that.

Overall, the women described a general state of feeling
fatigued, exhausted, and zapped of energy. The changes in sleeping patterns were clear signals to the women of the extent of their energy losses.

I’ve been thinking about that and I’m not too sure what it means. It’s very frustrating because I like to -- I’ve been in hospital. I feel I should be well and I want to carry on with my living and I can’t. You try and do a little bit and you feel you have to sit down because you have to get more energy before you can go on again.

You know you get tired quicker though. You know, like some nights, if you think you’d like to go out and you think, well, I’d better not because you just feel a little bit tired, you know. I’ll go to bed at 8:00 o’clock or 8:30 or whatever.

Q. Tell me more. More about your diet and your sleeping.
A. Well, I used to go to bed at midnight, 1:00 a.m. I’m in bed at 7:30, 7:00.
Q. Why is that?
A. Just too exhausted.

It seems, then, that this illness experience meant a lack of both physical and psychological energy. The underlying loss of predictability was clearly apparent in the women’s accounts. The women were faced with getting to know and understand a new physical self. There was a constant comparison with the old physical self as this process ensued. The women shared their struggle to come to terms with these energy changes, a struggle because of the unknowns of their situation. This woman’s real quandary about her abilities speaks to this struggle.

You know, if I’m strong enough to do it then -- I don’t know. How strong are they after a heart attack? They say, you know, [you] get back to normal.

Loss of energy characterizes the pervasive loss of
Lack of Anticipated Support

Lack of anticipated support represents a second aspect of the central loss of predictability. The women had thought that they could count on their husbands to wholly support them at this critical time in their lives. Instead, the women experienced varying degrees of disappointment for which they were unprepared because this expected quality of support did not materialize.

This lack became a reality when the women returned home from hospital. A conflict situation developed between the competing demands of their home and family lives and their own health status. Fueling this struggle within the women was the recognition that the support they expected was not forthcoming. The women also sensed that the situation would be different if the roles were reversed, if their husbands had had the heart attack. Further, underlying this difficulty was the perception that the MI illness experience was a less valid and significant one for a woman. Lastly, the lack of anticipated support influenced the women’s cardiac rehabilitation at home in a number of ways.

The time at home following hospital discharge was a significant period in the women’s illness experience. The women recalled their illness experience in hospital as a time when they accepted what was happening to them. They described their feeling state as relatively free of emotions.

I think probably it’s the fact -- sometimes -- how should I
put this. While I was in the hospital, I didn't really have that many feelings about it. I just felt something had happened, you know, to there being a heart attack. I accepted the fact that it was a heart attack. It didn't upset me. It didn't -- I wasn't depressed. I didn't really have that many emotions about it.

The impact of their heart attack became much more fully realized when the women were discharged home from hospital. Re-entering their home and family lives brought into focus how this pathophysiological event would affect them. Coming home was a push into their new reality. For these women, being at home meant interfacing with their work environment. The problems inherent in rehabilitating from an MI in one's place of work were immediately evident. A very acute dilemma developed.

As one woman explained:

I suppose the first thing you notice is half an inch of dust on everything. The bathrooms no one has touched. You know. Newspapers stacked high. And you know that you won't even go ahead and do it [unless] you want to kill yourself and it's killing you to go look at it all the time. My husband realizes there's something wrong. Can't you at least get all these newspapers out? Must they lie there in a stack like that? You know, the dishwasher, everything, there's no reason why men can't think a little. I don't know what most women's attitude is. Not so much to having a heart attack. It's what happens after you come home. It's worse, I imagine, for those women who have small children at home and there are several women that I know of who still have children at home.

Even though the descriptions of the impact were not as striking and frustrating throughout the accounts, there was a definite sense that recuperating at home was not a smooth process. For the following woman, there was the awareness that, although she was not doing her usual work, she was still responsible for organizing to get it done. Furthermore, there was the realization that the support she had hoped for was waning and
trying to keep it going was not always worth the effort.

Yes. And then you try to organize everybody to sort of take over and that’s very difficult because they’re in and out. In fact, I think it’s one of the more difficult parts of raising children. It’s just when they reach that age to get them to realize that it’s sort of communal living and they all have to chip in. And they were well organized when I was away but when you come home, they sort of slack off a little bit.

Q. How do you feel about -- I guess what I want to say is do you feel your family understands the kind of difficulty you’re feeling?
A. No. No. They don’t.

Q. Tell me about that.
A. Well, I’ve never spoken to them about it for one thing. And like most young people when they see Mother starting to get well, they slack off a bit. No, they’re normal kids. They don’t really want to get up and start supper if their favourite T.V. programme is on. And I’d rather do it myself than hassle them to do it. And I think that’s normal too.

In addition to the sharp contrast to the prescribed therapeutic environment of rest and relaxation, there was the perception that things would be different for a man. The essential difference identified was the level of support and understanding. There was a belief that, if the roles were reversed, their husbands would have benefited from their wives’ utmost efforts to facilitate the process of cardiac rehabilitation.

One woman suggested that this difference was due to her traditional role within the home, but then quickly dismissed this as a possible explanation. Another woman implied that the support she had expected was more closely aligned with usual women’s roles. She felt that it did not fit with the male perspective where market work supercedes. Not only was it difficult for these husbands to provide the expected understanding and support, but, it seems, they continued within
their lives as if nothing had happened, without overtly acknowledging their wives’ illness experience. Clearly, these women wanted more and experienced a bitter disillusionment.

My feeling was, God forbid, but had it been my husband, I felt I would have coped with it differently. Like I would have been in a position, if you wish, or a condition to have really gone and educated myself as to how to handle this, for my husband, okay, to cook for him, to encourage him, to do whatever, but you come home as a wife who does the cooking and does the housework, etcetera and etcetera and you’re not feeling that good to start with and you’re not equipped at all as to handle it and you don’t feel, you know, just gung ho and full of whatever to do this.

Again, it might be just the individual but -- I mean all I’m speaking for is my own husband, okay. To my knowledge he has done -- like he has done nothing to find out anything about a heart attack, okay. I think he thinks to himself, well, she has done it. B’s done it. You know, B’s found out or she’s talked to the doctor or she phoned the Heart Foundation or she did this. But you know, he has to go to work and I’m sure, like if I said something to him, he’d say, well -- like he goes to work at twenty after seven and he gets home at 5:30 at night. Like what is it I want him to do. You know. So, if I was a career woman, and my husband had one, it might be different but no, I don’t think so. Because, I’m just in that era where that is the wife’s role, okay. So, some husbands may but I think for the most part [not] --

I don’t know. It’s different for a man. They worry about, what, you know, goes on at the office or whatever job they happen to be at. They’re totally dependent on their wife for moral support, physical comfort, everything. I don’t know. For some reason, men just don’t understand. When I come home from the hospital, he automatically sits and waits for dinner to be served. Finally it dawns on him, hey, wait a minute. But still, it never really, really reaches down deep inside, I don’t think. Look, she’s restricted in what she can do or at least what she’s told she can do. They never think that way. So, you ask a few times and then you finally just give up and forget about it. And every now and then they do think, well, you know -- they get the vacuum cleaner and vacuum or some such thing. I could have someone come in but by the time you get through showing them, telling them, explaining to them, why that’s equally as bad on you as it is to do it yourself, I think. I think when a woman has a heart attack, the man, the husband, and if there are any children, there should be some class, some something that
can really make them aware what has happened, what is expected of them. How it actually has to go.

Contributing to the women's perceptions of lack of anticipated support was the stated or unstated premise that a heart attack was a less significant event for a woman. As this woman shared:

Like the one thing my husband said, for example, he said, well, you're lucky -- if I'm using the words correctly, he said, well, you're lucky in comparison, he said. There's been men down at the mill for example, who had a heart attack. There was two that had them and they were off work for something like six months. So, he said, can you imagine, he said, the stress and the anxiety and etcetera, that they were under because they were the providers and they had to worry about their job and think about, like when am I going to get back to my job whereas, he said, you didn't have to worry about that.

Anyway, when he said that, I didn't say a word to him but I took rather offence of that. Because I didn't need to hear that. You know, it was sort of like, I got the feeling that, like you've had one but you really don't have anything to worry about so, like just get on with it and get better. Do you know what I'm saying? Because I didn't have to -- there didn't have to be stress or whatever about me going back to work. I didn't ever have to go back to work, if my health wouldn't allow me to, okay. But it happens to be the work that I -- because I work, it's something that I do because I want to do it. If it's a selfish thing, that's what it is. I certainly don't have to do it. Just for the monetary aspect of it. But that was just a typical remark and he didn't mean it unkindly. I know he didn't, but I guess when he said it, I wished that he hadn't and I just talked to a girlfriend of mine about it and I think, you know -- and I'm not being chauvinistic the other way around but I think it's rather -- in my feeling rather, typically male that -- and yet the tables would be quite turned if it was they who had the heart attack.

Because he said to me -- like these people that he supposedly knows that had a heart attack, they were off work and he said to me, you know, a man that has a heart attack, some of them don't know if they're job will be there when they go back; others do. Like what he was saying, I guess is say they're a plumber or a carpenter or that sort of thing that, you know, they don't necessarily have benefits. It would just be the stress they'd be under by being off work. I understand all that. But it was just the way I felt, I just felt I didn't need to hear
that. I guess -- I don't want sympathy so to speak because I'm not that type of a person. Perhaps just a little bit more understanding or an attempt of understanding what has happened. But he just had -- my husband happens to be the type of person that -- like naturally he wishes it didn't happen but he really doesn't want to talk about it. He doesn't really want to -- yeah, discuss it. He just wants me to get better and let's get on with the way things were. Like you should be able to be okay.

Within the above excerpt, women's illness experience with MI was poignantly minimized and dismissed. This incomplete validation of women's heart attack experience was an inherent component of lack of anticipated support. Consequently the women's rehabilitation process was negatively influenced. In addition to the considerable emotional wear and tear and possible physical over-exertion because of the lack of anticipated support, there was difficulty actualizing the lifestyle changes to effect a successful cardiac rehabilitation.

And see, my husband was also a smoker. Now, I'm not smoking and I hope that I'm not about to and he was good when I first come home from the hospital. Like he did not smoke in the home. And I thought, like he was cutting down and hopefully he would stop but we'll be sitting in the den and he does smoke in the den and I don't really like it, but I think to myself -- like, I get up and walk out of the den because once again, I just think to myself, like he knows and I've told him, you know, that it bothers me and I guess, ex-smokers are the worst. But it does bother me, plus I know that if I'm going to sit in that den at night and inhale the smoke of ten cigarettes, I might as well have five of my own. I mean, that's how much damage is being done. So -- but you know, I'm not going to say to him, you can't smoke. This is his home too. I guess if he wants to smoke, you know, I'm the one that has to make the choice.

Now, I think in my mind, if the tables were turned again, I wouldn't smoke in the home. If he wasn't smoking, I wouldn't do that to him. But I only think that. I mean, I don't know. I would hope I wouldn't. Because smoking is obviously such a big part of it.

Thus, not validating the experience seemed to extend as
well into a lack of support for those facets of daily living directly related to a positive recovery (lifestyle modifications). In addition to cessation of smoking, dietary changes were also problematic when the husband’s support was not felt. As this woman related, it was difficult because her husband was not following the diet prescribed for her. Planning and cooking two meals meant an increased energy output from her that she was unwilling to expend. It seemed that it was not easy to put herself first when her illness experience had been nullified.

But the cooking, I find the cooking very difficult. And I think it’s because it’s for myself. Because I’m cooking for myself and I would be cooking one way for myself and one way for my husband, if I really did what I was supposed to do. And I find that difficult. So, all I’m doing is -- as opposed to cooking for myself, I’m just cutting some things out that I cook for him. Because I don’t like cooking that much to start with. I’m a reasonably good cook but I don’t really like it and it’s just not in me. I haven’t got the interest to cook two dinners.

Q. Do you think that if it was reversed, you would change your eating habits.

A. Yeah. No question. Now, the -- yeah, because I would cook for him and I would eat what’s there because I know that what I’d be cooking for him is food that I should be eating myself anyway. But, you know, when I came home from the hospital, I said to him, you know, could we sit down and plan a menu, you know, something that would appeal to him, you know, that would be within this. Oh, yeah, he thought that was a good idea, but like it’s never happened. So, like I’m not going to push. I just think it’s wrong to push somebody else into something that even though it would be the best thing for them, if that isn’t what they want.

The women countered their felt disappointment in the lack of anticipated support by trying to understand their husbands’ responses to their illness experience. There was an almost universal opinion among the women that their husbands were impaired in their abilities to help. Both their husbands’
difficulties in coming to terms with their MI and their simply not knowing how to effectively help out, were thought to limit the quality of their husbands' support.

He’s, you know -- and as I say, he hasn’t -- there was a programme on, P., last Wednesday. It came on at 9:00 o’clock. I think it was on Channel 9 and it was this chap who’d had a heart attack. It was on for an hour. Okay, it was -- well, it was only that hour and of course, I -- my Mom had told me about it and I just made a point of watching it. Actually it was quite good. I mean I watch whatever I can and read whatever certainly I can and I told my husband it was coming on and this will just give you an example, when it first flashed on at 9:00 o’clock, he got up and I didn’t know where he was going or what he was doing but he went and ran the bathtub and had a bath. It was like he didn’t want to see; he didn’t want to know. So, you know, when a person -- when you get that feeling that a person is that way, it’s difficult because you don’t want -- like I don’t want to put something onto him that’s going to distress him. I mean, you know, I think you have to have it within yourself and we -- you know, we’ll have been married twenty-nine years this year. So, it’s not like we sort of don’t know each other or know each other’s moods and what have you, you know.

Willingness to help and reasonable effort were comforting, on some level, for the women. There was still a sense of not being wholly supported, because there was not a complete takeover of the responsibilities perceived to be theirs. This lack was almost always linked to their husbands’ gender-related expectations. As these women explained:

And he does the cooking and in fact, he was bragging, well, I won’t get kicked out of the kitchen any more now, he says. He loves to cook. And he does the vacuuming and he does the laundry but he draws the line at ironing, of course [underlining added].

.......

He’s not one of those men that will jump into the lady’s work and all that, you know, but he tries very hard to -- to oblige. Like he certainly doesn’t vacuum weekly. He did it once and then he did it again the other day. Ach, I don’t think he was very thorough but it doesn’t matter. He’s doing it. So, there it is. You know, what can you ask of him [underlining added].
There's things that I shouldn't be doing like maybe vacuuming off the chesterfield or doing extra vacuuming, that a woman does you know, he doesn't -- I just feel like I'm imposing on him an awful lot and -- It's just that I feel that I'm expecting too much of him. You know, of being a man and not used to that sort of thing. And I can't do it. I have found that out. One day I nearly knocked myself out. One day I thought well, I can at least vacuum the chesterfield. Well, I got the chair done but I folded up before I got to the chesterfield.

Clearly, then, it is evident that the less than total support had deleterious consequences, both physical and emotional. The women expended either emotional or physical energy to get things done to their satisfaction. They were not freed of their responsibilities so they could focus on rehabilitating from their MI.

Lack of anticipated support varied in terms of how strongly it was felt among the women. The variation seemed to be related to the women's family circumstances. For example, the two women not in partner relationships did not perceive the area of support to be an issue for them. The women with retired husbands felt some degree of disappointment with their husbands' input. Lack of anticipated support was most visible and profound in the accounts of the women with employed husbands. For these women, lack of support was developed extensively within their accounts and represented a fundamental and critical dimension of their MI illness experience. The following two excerpts illustrate the magnitude of the impact of this lack of anticipated support.

He finds that support difficult to give. Well, if he does, that's something that I either have to live with or
make a decision. You know. But this heart attack, I just get the feeling that he doesn’t know how to cope with it and maybe doesn’t know how to cope with it but doesn’t want to. He just sort of wants to -- he wants to avoid it as much as he can. I think, he’s just as glad as glad to get out of here at twenty after seven and go to work and come home and I make dinner. Like he isn’t one to help around. Like he never said, like, can I vacuum for you or can I do something for you, when he knows that these things are important to me because I’ve always been a fussy housekeeper.

He can’t understand or accept that jeepers, after two months, she should be able to do something. You know. Well anything. You should be able to wash windows. You should be able to do just about anything you ever did do. And he doesn’t seem to understand why. Well, Dr. L. tried to explain part of it the other day. Well, we used to be friends. Not only husband and wife, but friends. It’s a little different. It’s much different now. We used to make a big thing out of going grocery shopping. But up until -- I don’t know how it affects other couples. Everybody’s different, of course. He’s so used to coming home to a very tidy house. And he’s so used to having his laundry and his meals -- meals are always -- dinner to us was a ceremony. Now he’s doing most of the cooking. It’s -- I can see where this sort of situation, depending on the people of course [could] actually totally destroy a marriage.

The time period at home following hospital discharge is characterized by lack of anticipated support. The women recalled their illness experience in hospital as an interlude in terms of dealing with the impact of their heart attack on their day-to-day lives. Coming home marked a transition to a different reality. Home meant immediate immersion in a work setting. This contact meant experiencing the conflicting demands of the situation. Concomitantly, it seems, the women sensed that the situation would have been different if it had been the husband who had suffered the heart attack. Additionally, not validating the women’s illness experience was an inherent component of this lack of anticipated support.
Overall, the women’s cardiac rehabilitation was negatively affected. The women explained their husbands’ behaviour in terms of their difficulty facing their wives’ illness experience and their not knowing how to effectively help. The lack of anticipated support was felt in varying intensity across the participants. For some of the women, this aspect of loss of predictability formed a major portion of their explanatory models of their illness experience.

**Change in Usual Role Enactment**

Loss of predictability was also felt in relation to a change in usual role enactment. This section speaks to the change in performing usual social and homemaker roles. Within their accounts, the women focused on these two particular roles. The impact on the homemaker was developed most fully by the women as would be expected considering that all eight women were primarily homemakers.

The change in activity level because of the prescription for regaining wellness from the professional sector and the physical effects of the MI was very troublesome. The sudden change from a busy, activity-filled day was a difficult adjustment. Because of the prescribed activity restrictions, social roles were perceived to be adversely affected. The women experienced uncomfortable boredom.

The worst part I think is sitting around. You’re not allowed to do this; you’re not allowed to do that; you can’t go anywhere. You need to be able to get into your own car and drive to the grocery store. Do you have any idea what a privilege that is. It’s one of those things you take as -- before this, it was something that had to be done that you didn’t really care about, but you had to do
it because you had to have food in the house, etcetera. Now I consider it a privilege.

... ... ... ... ...

But the boredom. That's what -- that's really what gets me is just being bored, not being able to do anything.

Depression was also tied to a change in social roles.

Well, I get down a little, you know, because I can't go out and do the same as I used to. You know, you feel a little down but other than that, it doesn't bother me.

The tremendous overriding sense of not knowing which typifies loss of predictability generated feelings of fear in relation to usual social roles. Going out meant confronting their precarious health status.

No, I haven't been running around shopping like I usually do because I was really going strong before, you know.

Well, I think that, you know, you kind of feel if you want to go a long ways, you kind of hesitate. You either ask your husband or go with a friend or something. Because I wouldn't like to have it [another heart attack] happen in the car.

... ... ... ... ...

I couldn't go into a store by myself. I always had to be sure my husband was in the store. I might kind of take off and go and shop for something for myself, but that didn't -- I couldn't even do my Christmas shopping because I couldn't go into a store and that was after we got home.

The women's lack of energy influenced how they performed their usual social roles. There was a definite curtailment of even casual entertainment but it seems that this was not perceived as a negative outcome of their MI. This change was identified in a matter-of-fact way, without emotional overtones.

But I just don't -- like I don't feel, you know, that I have it in me enough to particularly want to do anything [entertaining] either.

... ... ... ... ...
About the same, yeah, but you don’t really -- you’re not the same. Say, if you want to call somebody for dinner and that, at least, I haven’t been able to say, well, gee, come on over for dinner, because I don’t really feel like cooking, you know, all that much.

The women’s response to a change in the usual enactment of their homemaker role was emotionally laden. The women felt guilty about their husbands stepping into their long-established role within the home.

I did at first, when I first came home I felt very guilty about letting him do that [housework], you know. I just -- I really felt that I should be doing that. You have a feeling you should be doing that because you’ve done it all those many years. I minded more not being able to do the things, you know, and I still do. I still mind it very much, you know, that things that I’d like to do and still I have to let it pass.

The guilt was also related to the perception of being a burden to their partners, an imposition on their husbands’ time and energies.

I felt very down because I just -- you know, you can feel that you’re going to be a burden to someone and I thought, well, poor S., he’s got so much to do and now, who knows whether I’m going to really be able to pull out of it or not, but I think I am now.

I just get down. I feel I ought to be doing more. You feel you’re a burden.

He’s learning to cook. So that he can share more, although he’s very busy himself. And it’s not too fair to work all day and have to come home and have to work at your meals, is it?

In this last excerpt, an underlying sense of ambivalence is communicated. Ambivalence about accepting or rejecting support is another dimension of the conflict situation between the competing demands of the household and their own cardiac rehabilitation described in the previous section. Although the
heart attack experience clearly and decisively established the priority need to take care of themselves, feelings of guilt and even selfishness surfaced. This woman shared feeling guilty about comparatively minor threats to her sons’ health, because of a change in her usual standards of housecleaning.

The dust is piling up. The boys are allergic to dust. You can keep the surface clean but you can’t get into the corners.

Putting themselves first was not an easy change to effect, despite the powerful reasons for this need.

And you realize you’re going to have to take time for yourself, which I haven’t done. And then you feel selfish. Because I have an eighty-four year old mother living with me.

In addition to feeling guilty, the women felt a loss of power and authority, because of the change in their homemaker role. Even though this change was a potentially positive one in the women’s lives, letting go engendered a sense of loss and required a definite effort from the women.

You have mixed feelings because I tended to do too much for them. And I’ve done too much for them. And it’s hard to sit back and really continue -- encourage them to continue what they started when I was in the hospital. You tend to sort of want to take over. Whereas it’s not good for them and it’s not good for me. So, we’re going to have to -- I’m going to have to back off and let them continue doing more of the chores and so on. There’s six people so there’s a fair amount.

Relinquishing their role meant power struggles about the best way to do routine household chores.

We run head on too sometimes. You know, I’ll say, well, this is the way I do it; that’s the way I want it done but he’ll say, oh, you’re getting better. You’re starting to complain.

The women described a new dependency arising from their relying on their husbands to do the housework. The incidental
details of day-to-day life repeatedly established how much control they had lost because of this change.

Well, I find that he’s taken quite a lot of my responsibility in the home. For one thing, he’s retired and he has no hobbies so it keeps him busy and he really enjoys it and loves to do it. He has done the shopping pretty well since he retired. I used to like to do it but you know, you do have to make changes when that time comes, as you’ll find out. But I find I get quite resentful about that, you know. I just feel well, I don’t think there’s anything wrong with me mentally that I shouldn’t have -- be able to make my decisions in the house, you know.

The other day he was telling me about something that should be done a certain way and I said, well, listen here, I did it for forty-eight years and everything was okay so why isn’t it now? Oh, I don’t mean that. I don’t mean that. But often our ways of thinking are different, of course; we’re two different people after all. But nothing very earth shaking. It’s just mostly about the way things are cooked and what we want to have. And you know, that kitchen part has been taken over by him. Well, I’m getting used to it and at first, I didn’t think very much of it, you know. I just felt like, I was being pushed out of the only thing I had any authority in and you kind of feel you lose your authority. You really do.

. . . . . . . . . . . . . .

I can’t even go into the garage and lift the door or get anything out of the freezer. I have to have my husband do that.

Part of the loss of power and authority was the adjustment to new standard of housekeeping.

A. You know, you have your -- you have your system daily and you think, well, you got to do this and you do it.
Q. Yes.
A. But now, you don’t. You know. It bothers you a little bit because you feel uncomfortable, that your floor isn’t vacuumed on time or something like that, you know. And I piled up a whole bunch of ironing.

. . . . . . . . . . . . . .

I accepted it because I thought it’s the only thing I can do. So, I just let him do his own thing. He did things differently, mind, and that, maybe I didn’t care about but then, that doesn’t matter, as long as it gets done. You know.
I don't do that much. Mainly because I think to myself, well, I can't wash walls and I can't clean windows, at least I think I can't. I can't vacuum. So, you know, I do my plants and I keep things tidy and do drawers and things because I've always -- like I've always been a good housekeeper and I like housekeeping but if I can't do it all or do it the way I want to do it then I just don't bother doing it. So, I've had somebody else come in. Like I had the [homemaking] service when I first got home from the hospital. I had them come in. Well, they were okay to a point, but didn't do things particularly the way I wanted. So, I don't have them but I have a young lady that comes in now every second week and I just overlook things that were that important before. I just think, well, I guess they're not so important, you know.

Feeling guilty and a sense of loss of power and authority over the relinquishing of their homemaker role overtly contradicts the findings previously presented about lack of anticipated support. The women felt disappointed because their husbands weren't supporting their cardiac rehabilitation by doing housework and yet, when their husbands did participate in the housework, the women felt uncomfortable and wondered themselves about the validity of their condition and whether it justified such assistance in their work. Added to this quandary was a loss of the one arena of power and authority that these women as homemakers owned and controlled. Therefore, although the women were disappointed because they did not get the support they expected, accepting support in terms of their husbands doing housework was also a difficulty. However, lack of anticipated support extended beyond doing housework. These findings then represent only one area of apparent contradiction. The women also grieved about their husbands' lack of understanding about their illness experience. Perhaps emotional
support in terms of trying to appreciate what this heart attack meant day-to-day would have been more readily accepted by the women.

The women experienced a change in their usual enactment of their social and homemaker roles. Feelings of boredom and depression were identified in relation to changes in social roles. While there were definite differences in social role enactment in terms of entertaining, these differences seemed not to be problematic for the women. The change in usual homemaker role enactment was characterized by guilt feelings and a sense of loss of power and authority. These changes reflect the study's central loss of predictability. Women's MI illness experience meant unforeseeable alterations in the women's daily living.

**Strategies for Control**

The women employed a wide range of strategies to gain control over their loss experience. These strategies for control were evident in the women's discussions of the cause and their projections of the outcome of their heart attack. Personal philosophies and life experiences were also sources for strategies for control. Additionally, the reactions of families served to deflect the impact of the heart attack experience away from the women and provide the women with feelings of control.

The women made sense of their illness experience by identifying what they thought caused their heart attack. It seemed that this causal attribution provided a degree of order
in this unpredictable illness experience.

And I still think to this day that had I been treated properly for high blood pressure, this wouldn't have happened.

Q. I'm wondering what you -- what you feel caused your heart attack?
A. My family. It's mostly hereditary. My sister died in her sleep. She was about forty-five. Another one not long ago, just a couple of years older than I. My dad. My brother.

I have read all the material. They gave me a little bit at the hospital and I got a bit more from the Heart Association on Broadway. The books say smoking, which I don't do. Diabetes. Well, there's latent diabetes in my mother's family, but I have been careful. We switched to vegetable margarines and so on. Tried to be careful. The only thing that I can think of is that perhaps I was raised on a farm and that was the cause, but also my father died at sixty-five. Heredity is a big item, I understand. He died at sixty-five of coronary thrombosis.

A second strategy for control was apparent in the women's perceptions of the outcome of their heart attack. The women voiced feelings of hope in the face of the many unknowns within their illness experience. When asked by the researcher to project the future implications of their MI, the women's responses were generally positive and optimistic. The hopeful tone of the replies was, however, tempered with feelings of uncertainty.

Q. How do you think then -- how do you think you'll be feeling say two months down the road?
A. Great. I think I'll feel better. I think if maybe I don't have the high blood pressure like I had, then I'll be feeling much better than I was.

I'm hoping that I'll get stronger and be what I was. I don't know whether it'll come to that, but I'm hoping it
does. I can feel that it’s taken a lot out of me, but I’m hoping that my strength will come back.

Q. I’m wondering now how you think you’ll be doing or feeling say two months from now. How do you see yourself?
A. Oh, stronger and healthier. Two months from now. That’s three months. I should be.

But to answer your question, I just hope that two months from now that -- you know, that I get on my little pony and get on with life the way it was before and that -- you know, it sort of isn’t, you know, I’ve had a heart attack or I’ve got to be careful in case -- I hope by that time that I know enough with the help of my doctors, reading and whatever, to feel comfortable about it and know in myself what I can do and what the consequences of something may or may not be if I do that.

Personal philosophies and life experiences also served as strategies for gaining control. In order to deal with the all-encompassing unknowns of their illness experience, the women used their basic attitudes towards life and past experiences as strategies for control.

Two of the women directly associated their past illness experiences with their ability to cope with this illness experience. They clearly viewed their past illness experiences as helpful in putting their heart attack experience into a manageable perspective.

It was just, oh, well -- you know, when you grow up knowing that you have a heart problem. I think your attitude is a lot different than if it’s all of a sudden, bang, you’ve got a heart problem. I don’t think it scares you as much. I wasn’t scared at all. It didn’t bother me.

So, to me, I didn’t think nothing of it. You know, I’ve had a lot of things wrong with me before, you know and I’ve had pain before. So, it just seemed to come as another sort of a thing with me. When I was a kid, I had osteomyelitis and you know, I was in the hospital for a
year with that, about. And then I had a cystic mass in my, you know, female organs and had an operation on that and it just, you know, all through my years, I had something wrong. But I have come out of it all right. And off I'd go again. But that's about it.

The women's perception that they were striving to do their utmost to promote their rehabilitation operated as an encouragement. This feeling of comfort in their efforts seemed to engender feelings of control.

But then it just goes whssss and I guess I -- I'm trying my -- I know that I'm trying myself to do everything that I can to prevent it. That -- and as long as I feel that I'm doing the best that I can, if it happens, it's going to happen.

. . . . . . . .

So, it's -- it's a pretty hard thing to talk about. I think that what I feel that I have to do is just live with it, not talk about it. Just live with it and do the best I can. That's the way I feel about it.

Religion played an important role for a few of the women in terms of how they coped. These women shared how their spiritual beliefs helped them to make sense of their illness experience.

I am basically a very religious person and I found that that was one thing that prayer got me through quite a bit in the hospital. When you're just lying there with your eyes closed, you do a lot of praying and which I did.

. . . . . . . .

I just figured, well, you know, you say a prayer and let God take care of the rest.

Specific strategies were employed to deal with their heart attack on a day-to-day basis. There was considerable effort expended to ensure that this heart attack experience did not "get the best" of them.

I think it -- I think it's me. It's just -- it's not going to get the best of me. I'm going to fight. It's
-- I'm not going to live the rest of my life just laying around doing nothing.

And I think you're a lot better off, if you're not sitting worrying about your heart attack. You know, if you're sitting stewing or worrying about whether you're going to take one, then I think that's a lot harder on you and -- mentally as well as physically. You know, I just don't think about it.

Like I've said, I've been bound and determined not to get on the soapbox and you know, go on about it.

Well, I -- I just tried to live as close -- as naturally as I possibly could, you know and not -- not to let myself pity myself. I didn't want -- you know, I think that you can pity yourself and make a wreck of yourself too. You know, you can be really sick if you let it get to you too much.

The women disclosed feeling fortunate in their illness experience with MI. The awareness that worse things could have befallen them seemed to serve as an additional strategy for gaining control. Further, the women weighed the advantages of a heart attack over other illnesses.

You know, apart from all that I've said, I guess -- my feeling is that something has happened to me that has happened to a lot of people. For whatever reason, it happened, I don't know. I just got finished saying to you what I think and I feel very fortunate from the point of view that I obviously didn't have a massive heart attack. I feel fortunate that I got in through the emergency door of the hospital and I came out the front door of the hospital and I'm home. For whatever reason different things affect different people, or causes them to have a heart attack -- like I've made the statement, for example, if -- you know, something has to happen to you -- something else could happen to me, not to say that it won't, but this heart attack, I said, you know I felt so grateful that that's all that it was.

I made that statement and when I went to the hospital, the thought occurred to me, what if they diagnosed I had cancer and I can truthfully say that went through my mind and so,
when I was told it was a heart attack and certainly and the result of the heart attack and where it was, etcetera, I just felt very fortunate and I thought, though I'm not a religious person, I thought, you know the Good Lord has done something here that has given me an opportunity to change my lifestyle a little bit that could conceivably give me quite a few years of a very healthy life that I wouldn't necessarily have had otherwise.

Anyway, so far -- you know, what can you say. I don't really know from hereon out, what life holds. But then -- and on the other hand, you feel, well, it could have been so much worse what happened. You know you could have had something that's going to give you a lot of pain and no relief from it, you know, but this way you feel -- . If you're going to be wiped out, it'll at least be fast.

I feel I was fortunate. But I sort of have accepted it all in my stride and I -- I don't feel -- you know, I don't -- you know, I feel fortunate.

The women described their families' and friends' reactions to their heart attack as more profound than their own. It seemed that the women used their families and friends as deflectors, directing the impact of their heart attack away from themselves. This deflection acted as yet another strategy for control.

Oh, they [family] were quite upset, you know. And were worried and one thing and another. In fact, they worried more than I did. You know.

This is the time of life where it's pretty hard to lose a partner. You know, it's not easy to make another life any more. So, we've always had a good marriage so, it's -- you know, you don't feel that it doesn't matter if one or the other goes, because it matters a lot. So, it's quite upsetting and I guess it was very upsetting for him -- for him, from what I hear from my family. So, for his sake too, I have to keep this thing on an even keel, you know. Not just for my own. So -- because he's a pretty good guy. So, I hope to see my grandchild grow up.
Yes, they've [family, friends] been quite concerned about me. You know, you can tell by the phoning and that. Friends, the same way. Some of them were really shocked. Like I say, I think everybody was more shocked than I was.

Strategies for control were used by the women to gain control in this "out of control" illness experience. The strategies for control outlined here seemed to give the women something to hold onto, something to help them make sense of this illness experience. Clarifying the illness experience conferred the perception of control. The specific strategies for control apparent in the women's accounts arose from the assigning of cause and the projection of illness outcome. Personal philosophies, life experiences, and the reactions of families and friends were also identified as specific strategies used by the women.

Summary

This chapter presented the study's analytic framework, a loss framework. The framework represents the researcher's interpretation and conceptualization of the women's accounts. The characteristics of the participants were then described. The women's accounts, their experience with MI, were discussed in relation to the study's analytic framework. For the women, their illness experience with MI meant fundamental and extensive alterations in their everyday lives. By exploring the meaning of their illness through the context of change, the women were grieving the losses inherent in these changes. As these women explained:

Yes, its -- its -- you have -- actually you almost have to
live a different way of life for a while.

Well, when you start to recuperate, you just wonder, you know, how you're going to -- well, I've always been a person that likes to work and I thought, well, am I going to be a vegetable from now on that the least little thing I do is going to upset the apple cart. But because you really don't know what you're going to be able to do and what you're not going to be able to do.

Loss of predictability represents the essence of the women's loss experience with MI, involving a pervasive and powerful set of emotions and specific concerns. Loss of predictability was felt particularly in relation to energy, support, and usual role enactment. To gain control, the women used a wide variety of coping strategies. Chapter 5 discusses these findings in relation to current related literature.
CHAPTER 5

Discussion of the Findings

Introduction

Chapter 5 discusses the findings of this study within the context of the current professional literature. The purpose of this discussion is to compare the findings of this study with the present understanding of the MI illness experience as recorded in the professional literature related to cardiac care. As concluded in Chapter 2, this present understanding is based upon an understanding of men's experience with MI because of the paucity of work addressing this health problem in relation to women. Therefore, in this discussion, a comparison of the findings of this study with the professional cardiac literature is really a comparison of women's experience with MI with men's experience with MI.

In Chapter 2, literature pertinent to the study's rationale and purpose was reviewed. The review located this study within the related professional literature and substantiated the need to study women's experience with MI. Some of this same literature is used in the discussion of the study's findings. Additional literature, both research and theoretical works, are also used in this discussion. Although some literature specific to women's experiences is also considered, the reviewed literature is limited primarily to cardiac literature, especially cardiac rehabilitation literature.

The purpose of this study was to explore and describe
women's perceptions of their illness experience with MI. The study's analytic framework represents the researcher's interpretation and conceptualization of the women's accounts of their MI experience. In this chapter, the study's analytic framework is used as an organizing structure for discussing the findings.

**MI As A Loss Phenomenon**

The data from this study indicated that the women were grieving the losses inherent in the many significant changes in their everyday lives since their MI. This finding is reflective of existing literature on MI where concepts of loss and grief are used repeatedly to understand the MI illness experience.

Cassem and Hackett (1977, 1982, 1984), for example, major theorists and researchers on the topic of the psychological aspects of cardiac rehabilitation, have repeatedly identified anxiety and depression as common psychological responses to MI. Most recently, these writers (1984) define depression as "a state of sadness due to a loss" (p.437), the loss of a valued part of oneself. Regarding depression as a normal response to MI, they advocate using the concept of grief as a model to identify pathological depression. The same intensity and time frame of mourning a loved one are applied to mourning the losses associated with the MI experience.

In the nursing literature, Scalzi and Burke (1982) outline a process of adaptation to MI based upon the concepts of loss and grief. They identify behavioural adaptation responses that
characterize each phase of loss. Delaney-Naumoff (1981) states that grief is "the dominant underlying emotion" (p.87) following MI. She conceptualizes the patient's loss experience with MI as "loss of heart" and describes the grief response to MI using the phases of crisis as a framework.

Thus, viewing women's experience with MI as a loss phenomenon is consistent with current theoretical perspectives within the professional literature. Although the concepts of loss and grief are operationalized somewhat differently in this study and in all three works described here, these concepts are the basic ingredients in each writer's understanding of the MI experience. This finding then represents a common and fundamental perspective towards the illness experience for both men and women.

**Loss of Healthy State**

In this study, the MI event itself, experienced as a pain episode, marked the transition from health to illness and was the impetus for the losses that followed. The pain episode was found to be diversely and uniquely perceived and experienced. Also, the women's subsequent interaction with the professional sector, especially the nature of the advice given prior to discharge, marked this transition by reinforcing the women's new perception of themselves as ill individuals.

This finding in relation to the MI pain episode was not surprising and is consistent with the literature. Hurst et al. (1982) clearly establish that individuality characterizes the MI
pain experience. To illustrate this point, they quote one patient's description of his heart attack pain as a "faint fuzzy feeling -- a softly spoken sternal word." Further, Hurst et al. urge clinicians to encourage patients to use their own words to describe their pain experience, stressing that patients with MI may present in many ways. It does, however, add support to the directive that professionals, in assessing MI pain, must attune themselves to how the patient describes her pain experience.

In this study, the advice given to the women by the professional sector contributed to the women's sense of loss of healthy state that had been triggered by the heart attack itself. The vague and proscriptive nature of this advice, which is discussed more fully in the next section, does not reflect the precise, detailed instructions advocated in the literature to promote cardiac rehabilitation (see, for example, Wenger, 1982). This finding does, however, concur with Mullen's (1978) findings that, after a heart attack, the patient's situation is marked by proscriptions and that this emphasis separates MI from other illness experiences. Mullen coined the term "the harder dimension" (p.298) to describe the threat that exists because overextending activity limits for the MI patient could mean death. In this study, the women were similarly cautioned to carefully monitor their activity and experienced the ominous threat of "overdoing it."

Thus, both women's perceptions of their pain experience with MI and the impact of vague advice focused on "don'ts" rather than "do's" mark the loss of healthy state. Both these events concur with the literature. Unlike the precise, detailed
instructions so widely recommended in the cardiac rehabilitation literature, these women reported encountering vague and general admonitions.

**Loss of Predictability**

It was found in this study that the women experienced a pervasive and powerful loss of predictability in their everyday lives after their MI. This loss was felt, in particular, in relation to energy, anticipated support, and role enactment. Although there are slight variations in the descriptors used, the essence of this loss as set out in the women's accounts and defined in the study's framework is present in the literature. In a frequently quoted study, Wishnie, Hackett, and Cassem (1971) found that their subjects felt "altogether unprepared for the sense of foundering (sic) which resulted" (p.1293) at home post-MI. Mullen (1978) noted that her subjects experienced "the difficult task of resuming life in a new and ambiguous state under conditions of uncertainty" (p.298). Delaney-Naumoff (1981) identifies loss of control and loss of direction as part of the loss experience post-MI. Cassem and Hackett (1977) found that feelings of anxiety and depression predominated as ascertained by documenting psychiatric referrals following MI. In a recent work, these same authors (1984) define depression as "desolation, sadness, or resentment in the weeks after infarction" (p.438). They also describe feeling vulnerable as a difficulty during early convalescence. The feelings described within all of these works echo the sentiments
of the women in this study.

One aspect of the women’s loss of predictability was the difficulty interpreting bodily cues after MI which generated feelings of confusion and anxiety and an increased awareness of the precariousness of their health status. This finding is documented in the literature. Mullen (1978) noted a process of being "self-consciously aware of bodily sensations" (p.301) after MI. She identified the problem as a difficulty in "interpreting vague indicators" (p.301). Newton and Sivarajan (1982) speak about patients’ new attention to each and every ache and pain for a possible connection to their heart condition. The literature suggests that this difficulty is not an unusual response for men and women post-MI. However, it seems appropriate to surmise if patients are equipped with precise and detailed instructions, sorting out various bodily sensations would become less difficult and less anxiety provoking.

As discussed in the previous section, the women’s perceptions of their loss of healthy state were influenced by the vague and proscriptive nature of the advice they were given prior to leaving hospital. Once home, the women perceived a need for specific, concrete information about their heart condition and their cardiac rehabilitation. It was the women’s perception that this need was not met and that this lack contributed to their feelings of loss of predictability. These findings stand in sharp contrast to the recommendations in the cardiac rehabilitation literature. This literature frequently and strongly urges practitioners to provide their post-MI
patients with specific, detailed, written instructions particularly concerning physical activity at home (Delaney-Naumoff, 1981; Hackett & Cassem, 1984: Newton & Sivarajan, 1982; Sivarajan, 1982; Wenger, 1982). The development of "the concept of individualized prescriptive exercise in rehabilitation" (Wenger, 1982, p.1153) has made this a workable goal because the activity is prescribed in the same manner as a medication; the frequency, duration, and intensity are precisely stated based upon the patient's abilities, needs, and interests. Further, a stress exercise test prior to or soon after discharge enables the health care professional to teach the patient how to assess his or her responses to activity, using concrete guidelines (Sivarajan, 1982). However, Mullen (1978) found that, once home, patients were, for the most part, on their own to work through "the vague and ominous warning, 'take it easy'" (p.298). Sivarajan (1982) agrees and asserts that this early time period at home between hospitalization and enrollment in a structured rehabilitation programme is characterized by insufficient information and represents an identifiable gap in health care services. Newton and Sivarajan (1982) state that information is a major need in the early discharge phase. They also remark that patients are often told to "relax" without the necessary guidelines to enable them to follow through. This study offers support for the findings concerning lack of information in the early convalescence phase at home. It seems that the widely advocated goal to provide patients with specific, detailed, written instructions so that they are well equipped to
cope effectively with their MI illness experience is not consistently achieved in practice.

One can only speculate as to why the women in this study felt dissatisfied with the information they received from the professional sector. In Hackett and Cassem's study of blue versus white-collar workers with MI (1984), they found that blue-collar workers asked fewer questions and were less knowledgeable than the white-collar patients. The blue-collar patients consequently felt anxious and uncertain and helpless, ultimately resulting in a poorer rehabilitation outcome. Could this chain of events be applied to the women in this study? Is there a parallel between blue-collar workers and women? Blue-collar workers may share with women a similar power relationship to the physician which could affect the exchange of information. Corea (1985) argues that differences in social class influence the quality of doctor-patient interactions as do commonly held sex role stereotypes. Corea contends that sexist beliefs about women not only affect physicians' perceptions about women's health problems but also "the willingness of physicians to give patients vital information" (p.81). Corea's work then suggests that there may well be a parallel between blue-collar workers with MI and women with MI vis a vis the information provided. There are certainly no clear cut answers and most probably many explanations for this finding in this and other studies. For example, women's perceptions could be altered by the illness experience. This finding could also be indicative of a gap in health care services for both women and men similar to the one referred to by Sivarajan (1982).
The women in this study identified three concerns related to loss of predictability: (a) the possibility of a repeat MI, (b) the possibility of sudden death, and (c) the potential for returning to normal, which involved comparing themselves with others in similar situations. These concerns are consistent with the literature. Wishnie et al. (1971) identified fear of re-infarction and fear of sudden death in their early study. Cay (1978) also names fear of death and re-infarction and adds concern about the loss of established living patterns. Mullen (1978) reported that her subjects asked questions concerning "how well he will live?" and "what can be salvaged from his former way of life?" (p.298).

The process of comparing oneself with others to measure progress towards returning to normal, as found in this study, was also noted in the literature. Mullen's (1978) subjects compared in order to predict how they would progress in their rehabilitation. She concluded that comparing oneself with others was used "normatively" (p.300). Cowie (1978) in his study of the patient's perception of his heart attack noted that his subjects compared themselves with others in a variety of ways in order to "typify" or "normalize" their MI. It seems, then, that both men and women use this comparison process to gauge their progress post-MI. In this study, comparing oneself with others was viewed by the researcher as indicative of the women's feelings of unpredictability. Cowie and Mullen see this process somewhat differently, identifying it as a coping strategy. This process fits equally well into either
conceptual category.

The description of loss of predictability in this study is consistent with men's experience with MI as recorded in the current professional literature. The need for information, however, is a somewhat surprising finding considering the extensive evidence that professionals can and do provide patients with precise and detailed instructions. If women receive less helpful information than men, as argued in this section, this difference could increase the intensity of the loss experience for women.

**Lack of Energy**

It was found in this study that lack of energy is a prominent feature in daily life after a heart attack. This lack of energy reinforced the women's sense of loss of predictability. These energy changes reminded the women of the precariousness of their health status. Also, as they attempted to learn their new activity limits, they felt they were living within an unfamiliar self.

Energy changes post-MI are well established in the literature. Both the deleterious effects of immobility and the sympathetic arousal due to the psychological stress of the illness experience are noted in the literature to operate in concert to effect this energy drain (Cassem & Hackett, 1977; Wenger, 1979; Wenger, 1982).

Wishnie et al.'s (1971) early research identified weakness as the most distressing complaint voiced by their subjects who interpreted this symptom as evidence of worsening of their heart
condition. The description of weakness in Wishnie et al.’s study is similar to the definition of lack of energy in this study. "Homecoming depression," a concept introduced by Cassem and Hackett (1977) to describe their subjects’ emotional response to returning home and facing the realities of day-to-day life following MI, is also analogous to lack of energy in this study. In subsequent papers, these researchers (Hackett & Cassem, 1982, 1984) define "homecoming depression" as a response, "the subjective sense of depletion along with weakness and early fatigue" (p.439) which is often perceived as cardiac decline. Newton and Sivarajan (1982) attribute the marked fatigue to the added psychological stress of home adjustment to the illness and the increased physical demands of performing activities of daily living. Cornett and Watson (1984) note that the fatigue is both unanticipated and troubling.

These descriptions coincide with the women’s perceptions in this study. One point of divergence is that the women in this study did not seem to view energy lack as an indicator of cardiac deterioration, but rather, accepted this symptom as part of the MI trajectory, albeit a somewhat unexpected and discouraging part. Also, the women’s accounts developed these energy changes more fully than is apparent in the literature. For example, the women explained how their lack of energy affected their approach to activities which now included a thinking through process to assess whether or not the activity could overextend their limits and adversely affect their heart.
Lack of Anticipated Support

The women in this study experienced a lack of anticipated support from their families, especially their husbands. This finding is congruent with the general thrust of the recent literature concerning women with MI. Women’s literature addressing the traditional socialization of men and women puts this finding into perspective.

One could assume from current cardiac rehabilitation literature that the responses of spouses of patients with MI are uniformly characterized by over-support, but this finding is based upon studies of female spouses. Delaney-Naumoff (1981) states that spouses either increase the MI patient’s dependency or effect a premature return to activity. This study and Boogaard’s (1984) recent comparative study of rehabilitation post-MI in men and women are evidence that support may be a function of whether the spouse is a husband or a wife. The literature extensively describes wives as “overprotective” and “oversolicitous” towards their husbands with MI (Cornett & Watson, 1984; Croog, 1984; Croog & Levine, 1982; Delaney-Naumoff, 1981; Wishnie, 1971). In Croog and Levine’s (1982) study, the wives provided support by helping their husbands to follow their medical regimen, to avoid stress situations in the home, and by assuming their husbands’ former duties around the house. In this study, the women were disappointed in the quality of support they received. In Boogaard’s (1984) study the men but not the women were “waited on.”
For the women in this study, a conflict situation existed between the opposing demands of their work as homemakers and their own cardiac rehabilitation. It is interesting and perhaps related that none of the women in this study was enrolled in a structured cardiac rehabilitation programme. These findings lend support to Newton and Sivarajan's (1982) contentions and Boogaard's (1984) findings. Newton and Sivarajan claim that limiting activities within the home to self-care during early convalescence may be problematic because the role demands do not cease during recuperation. In Boogaard's study, approximate METS (metabolic equivalents), the standard measurement of energy expenditure, were computed for activities performed during the initial period at home after MI, and women scored higher. Men and women differed in the types of physical activities performed: men spent their time resting, relaxing, and walking about the house, whereas women were engaged in light housework. Interestingly, the women did not perceive their housework as work or increased activity. Also, 50% of the men and 10% of the women subsequently attended a structured cardiac rehabilitation programme. Women's lack of participation in such programmes could be related to their difficulties with their work as homemakers after MI. If women are spending their time and expending their energy on housework, then they may not see themselves as having enough time and energy left for participation in physical rehabilitation.

These findings, women's conflict situation within the home and their lack of participation in structured cardiac rehabilitation programmes, make sense of Stern et al.'s (1977)
research that found that women with MI are even more "type A" than men with MI. In a later re-examination of this finding, Stern (1984) defines "type A" behaviour as "an action emotion complex" which includes "a chronic incessant struggle" (p.457). He refers to the women in his 1977 study as "super women." Stern's description fits with post-MI women's needs to maintain household activities to the apparent detriment of their cardiac rehabilitation.

Shaevitz's (1984) book, *The Superwoman Syndrome*, contributes to an understanding of this dilemma between home and health. Shaevitz's chart titled "How Traditional Men and Women 'Saw' The Home" (p.28-30), outlines the differences between men and women due to traditional sex role socialization. Some of these differences are particularly applicable to women with MI and are as follows:

1. Traditional women find it difficult to relax in their own homes, whereas traditional men see the home as a place of refuge from the stresses of the outside world.
2. Traditional women feel responsible for the household, whereas traditional men do not; if anything, they "help out."
3. Traditional women are now-and-detail oriented, seeing things that need to be done immediately, whereas traditional men are future and macro oriented.
4. Traditional women complete 95 per cent of household tasks, whereas traditional men complete 5 percent or less of the tasks to keep a household functioning.
Statistics on time spent on housework bear out these differences. For instance, Pogrebin (1983) concludes from an examination of several works that "on the average wives do 70 per cent of the housework while husbands and children do 15 per cent" (p.145). Studies on women working outside the home were included in this determination.

In this study, the women’s ages, their primary focus on the home, and their own assessment of themselves as traditional women indicate they were most likely traditionally socialized. In view of the differences in how traditionally socialized men and women see the home, it is quite understandable that women with MI, once home, experience a conflict situation between household demands and their own cardiac rehabilitation. The findings of this and Boogaard’s (1984) study suggest that women continue to feel responsible for the household no matter what happens to them. Also, given the statistics on usual time traditional men spend on housework, one wonders why support in terms of doing housework is even anticipated. It seems quite a difficult objective, then, to create a therapeutic environment of rest and relaxation at home for women with MI.

The women in this study asserted that the situation would have been reversed if their husbands, rather than they, were the MI patients. The women predicted that they would provide full support if their husbands had suffered a heart attack. It seems, then, that the women expected to be nurtured following their heart attack in the same way that they would nurture their husbands if they experienced a heart attack, but instead experienced a double standard. The cardiac literature
reviewed to this point in this discussion demonstrates and validates this prediction of full support. Women, as spouses of MI patients, tend to be over-supportive. In Croog and Levine's (1982) research, the wives clearly promoted their husbands' cardiac rehabilitation on emotional and physical levels. Croog (1984) later states that the family (meaning family with a wife) provides "emotional and social support, services, and material aid" (p.634).

The women's literature sheds some light on the reasons for this difference in nurturance between the sexes and women's emotional response to lack of nurturance. As the women in this study suggest, traditional socialization and men's resultant attitudes and lack of skills account for these differences.

Shaevitz (1984) notes that traditional men are only minimally aware of what needs to be done in the home and possess few homemaking skills. Further, she contends that men are "macro oriented" and this orientation creates a problem when men are asked to do housework which requires an eye for detail. The result is that women interpret men's less precise orientation as a reluctance to help out. Also, part of the male ideology is that "work" comes first and "work" does not happen in the home. Pogrebin (1983) points out that expectations as well as traditional socialization are involved. "Housework is the only activity at which men are allowed to be consistently inept..." (p.143). It seems that when traditional socialization has occurred lack of support is not surprising.

The emotional response to lack of anticipated support from
their husbands in this study was disappointment, disillusionment and frustration. Shaevitz (1984) points out that "men are less nurturing" and women respond by feeling "unfairly treated and upset because they don't get back what they give to them" (p.36). Shaevitz adds that men are not comfortable with dependency and often withdraw when their wives need them most because of an inability to deal with intense emotional situations. The result is that women feel "rejected, upset, and disappointed" (p.36). Eichenbaum and Orbach (1983) state that women's social role dictates that they must "defer to others" and "have emotional antennae" that lead to anticipating the needs of others. The result is "an imbalance in giving" (p.9). Loss of expected nurturance "causes tremendous pain, confusion, disappointment, rage and guilt..." (p.52). The women in this study certainly responded in accordance with these descriptions, and the men, their husbands, also behaved in an apparently characteristically non-nurturant pattern. Further, expecting support from a traditionally socialized man in terms of doing housework seems sadly unrealisitic, while a lack of support is more likely to occur.

Another explanation for lack of support may relate both to men's "macro orientation" and the invisibility of MI. Because men are not tuned into subtle nuances and details, their wives' MI illness experience may be difficult to discern and therefore easy to dismiss. Mullen (1978), Boogaard (1984) and Pinneo (1984) speak to this invisibility and its effect on support. Pinneo states that the MI "may not be readily accepted or it may be easily forgotten and old patterns of family interaction or
expectations of the patient resumed" (p.463-464). This attribute of the MI experience may combine with men's "macro orientation" to contribute to lack of support.

Another finding in relation to lack of support was the women's perception that their MI illness experience was viewed by their husbands as less valid and less significant because they are women. Given that housework is not valued in our society (Corea, 1977; Deckard, 1983; Wilson, 1982) and is not even considered "real work" (Pogrebin, 1983; Wilson, 1982), then it follows that these descriptors also apply to the homemaker. Traditionally socialized women get their identity from housework and housework is identified with them (Shaevitz, 1984). Further, theories of power relationships within traditional homes clearly locate the power with the breadwinner and powerlessness with the homemaker (Pogrebin, 1983). A logical extension of this is the invalidation of a woman's experience with MI and the belief that when a woman has an MI, her experience is less significant than it would be for a man.

For some of the women in this study, the lack of anticipated support negatively impacted on their marriages. Marital conflict is documented as a post-MI sequela in the literature. Wishnie et al. (1971) found that serious marital conflict was a definite potential problem. McLane et al. (1980) concluded from their literature review that marital conflict was a prevalent post-MI outcome. Both papers call for more research to clarify the nature of marital discord post-MI.

Although the family is widely and soundly cited in the
literature as a pivotal force in cardiac rehabilitation (Acker, 1978; Boogaard, 1984; Cay, 1978; Cornett & Watson, 1984; Croog, 1984; Delaney-Naumoff 1981), lack of anticipated support, especially from the women's husbands, was noted to adversely affect the women's cardiac rehabilitation. The women expended both physical and psychological energy that was not directed towards their rehabilitation. This lack of support and the resultant emotional and physical wear and tear may explain Stern et al.'s (1977) findings of increased anxiety and depression in post-MI women and Brown's and Rawlinson's (1975) finding that women tended to maintain the sick role longer following cardiac bypass surgery. Stern et al.'s (1977) and Chirikos' and Nickel's (1984) findings that women were less likely than men to return to market work can too be linked to lack of support for women as MI patients. An additional contributing factor affecting rehabilitation outcomes for women may be their lack of participation in structured rehabilitation programmes as was noted in this and Boogaard's (1984) study. Griffo et al. (1983) found that women's compliance to physical rehabilitation was a problem which affected the benefit derived. In an informal conversation with the director of a Lower Mainland cardiac rehabilitation programme, women's participation was discussed. The director stated that women give many reasons why they can't maintain their commitment to a programme, for example, children, husbands, meals. She noted further that women were later than men to search out programmes. This lack of participation in rehabilitation programmes, as discussed at the beginning of this section, may be related to the women's
conflict situation between the competing demands of the household and their own rehabilitation.

Lack of anticipated support fits with the current studies concerning women with MI. The women's literature provides insight into the reasons for this finding for women. Within the cardiac literature, the family is viewed as a pivotal force affecting rehabilitation and spousal over-support is the norm. This literature is largely based upon studies of women as spouses of MI patients. It is suggested that lack of support may account for the findings in the literature about women's participation in structured rehabilitation programmes and ultimately the poorer rehabilitation outcomes noted for women with MI.

Change in Usual Role Enactment

Changes in homemaker role enactment were upsetting for the women in this study. The women experienced feelings of guilt and a sense of loss of power and authority in relation to giving over their household roles to their husbands and families.

When women are traditionally socialized, they put the needs of others first and feel guilty if they don't (Shaevitz, 1984). Within the literature concerning women with MI, guilt is identified as an emotional concomitant to giving over usual household roles to husbands and families or to not meeting the needs of others (Boogaard, 1984; Newton & Sivarajan, 1982). Boogaard's (1984) women not only felt guilty, but also resisted help from their families. This guilt reaction helps to
explain the overtly contradictory stances of the women in this study. The women felt a lack of anticipated support and yet were not comfortable when their husbands took over.

Apparently, men do not experience guilt when their wives take on their former household roles (Croog & Levine, 1982). For men, the loss of breadwinner and sexual roles is identified as their major post-MI losses, and therefore most threatening to their self-concept (Wishnie et al., 1971; Cassem & Hackett, 1977). Changes in usual role enactment then appear to be firmly attached to sex role socialization, and therefore, different for women than for men post-MI (Wishnie et al., 1971; Cassem & Hackett, 1977).

Traditionally socialized women derive their identity from and feel responsible for the household. Further, the household functions as their prime source of power and control (Wilson, 1982; Shaevitz, 1984). Because of these perceptions, a change in this usual role enactment threatens women's self-esteem. The feelings of loss of power and authority expressed by the women in this study are thus explained.

**Strategies for Control**

In this study, the women used a wide range of strategies to gain control over their experienced losses. From the cardiac rehabilitation literature, one would expect exercise to be the predominant strategy selected and used by post-MI patients. Wenger (1982) states that, although there is no clear evidence that exercise alters the natural progression of the heart disease after MI, there are numerous benefits. Overall
patients feel better: more confident, less dependent, less depressed and anxious, and possess an increased self-esteem. Cassem and Hackett (1984) state that a structured cardiac rehabilitation programme is the best means to counteract post-MI depression. As this study, Boogaard's (1984) study, and Griffo et al.'s (1984) study found, women tend not to participate in physical rehabilitation programmes. The director of a local Lower Mainland programme, cited in the previous section, adds that lack of participation is related to perceived home responsibilities. Croog (1984) points out that these programmes are generally not being well utilized. This study offers support for this assertion. Also, given the benefits, women's lack of participation seems most unfortunate.

There is support in the literature for the finding of this study that assigning cause for MI patients is a strategy for control because it helps patients to make sense of their illness experience (Cowie, 1978; Mullen, 1978). Cassem and Hackett (1982) conceptualize denial as a means of minimizing the negative aspects and capitalizing on the positive aspects of the MI illness experience. In this way, denial may be interpreted as a strategy for control as defined in this study. The women in this study used similar tactics, both in using hope as a strategy and in using personal philosophies, such as not dwelling on their MI and feeling fortunate.

Similarities are noted between the strategies for control named in this study and the literature. However, physical rehabilitation, the major strategy advocated in the cardiac rehabilitation literature, was neither identified nor selected
as a strategy for control by the women in this study.

Summary

This chapter discussed the findings of this study within the context of the current professional literature. The intent was to compare the findings of this study with the present understanding of the MI illness experience, an understanding derived largely from studies of men post-MI. Similarities and dissimilarities within the MI experience were discussed. Women's literature was used to make sense of the divergent findings in women's experience with MI. The next chapter summarizes this study, draws conclusions from these findings, and outlines the implications for nursing practice, education, and research.
CHAPTER 6
Summary, Conclusions, and Implications for Nursing

Introduction

Chapter 6 summarizes this study and draws conclusions from the findings delineated and discussed in Chapter 5. Implications for nursing practice, nursing education, and nursing research are then outlined.

Summary of the Study

This study was designed to describe and explore women's perceptions of their illness experience with MI. Despite the statistical evidence establishing the significance of this health problem for women, there is a dearth of empirical knowledge about MI in relation to women. This lack of exploration of MI in relation to women is attributable to the popular myth that MI happens to men only and to the more fundamental problem of male-dominated medicine and health sciences research. It was argued by this researcher that using research on men with MI to guide women's cardiac rehabilitation could result in health care that failed to address the special needs of women.

Kleinman et al.'s Explanatory Model (1978) was used as the conceptual framework for this study. This model directs health care professionals to elicit the patient's point of view and to consider the total phenomenon of illness, or the illness experience, and not just the disease entity. This approach facilitates the planning and provision of health care, in this instance, nursing care, that is appropriate to and effective
The phenomenological method was selected as the research methodology for this study. It was determined to be suitable for investigating the meaning of the MI illness experience for women. The phenomenological method considers the individuals who are experiencing the phenomenon under study as the expert witnesses, the best sources for accurate and rich data. Using this methodology, the researcher was able to view the MI illness experience from the subjects' perspective and to help the women to accurately describe their perceptions. Both the study's conceptual framework and the selected methodology are congruent with the nursing profession's valuing of the individual and its unique nurturant function.

The literature review not only further substantiated the need for research on this topic of MI in relation to women, but also located this study within the body of current professional literature pertaining to MI, and led to the conclusion, from the few available studies, that women's post-MI experience may be both difficult and different than men's. Because current concepts in cardiac rehabilitation, as presented in the literature, are based largely upon an understanding of men's experience with MI, it was asserted that an understanding of women's experience with MI would provide a more valid basis for nursing practice.

The data were collected by means of 11 intensive interviews with 8 women over a 3 month period. The interviews were semi-structured, with loose guidance provided by Kleinman et al.'s (1978) six questions (Appendix C). The interviews were
audiotaped and then transcribed verbatim. Data collection and data analysis occurred simultaneously. The researcher's major role was to assist the women's exploration of the meaning to them of their MI illness experience. When consistent themes were being identified and validated and the data collected were determined to be sufficiently in-depth and rich, the interviews stopped. The study's analytic framework is the researcher's conceptualization and interpretation of the data and is derived from this process of analysing the study's data and refining that analysis over time.

The women's accounts describe the nature and meaning of their illness experience with MI and the impact of their MI on their everyday lives. The core theme that emerged from the data was loss. The women constructed their accounts around the many significant changes in their lives since the event of their MI. In so doing, they were grieving the losses inherent in these changes. Therefore, the study's analytic framework is essentially a loss framework (refer to Figure 1, p.33).

The first aspect of the women's MI illness experience was a loss of healthy state, which represented their shift from health to illness. The MI pain experience was a significant catalyst for this redefinition of themselves as ill individuals. This pain episode was found to be uniquely and diversely expressed and experienced by the women. The vague and proscriptive nature of the advice given to the women by the professional sector also contributed to the women's sense of loss of healthy state.

The central loss experienced by the women was a loss of predictability that was characterized by feelings of uncertainty
and an awareness of the precariousness of the recovery process from an MI. Aspects of the central loss of predictability were a difficulty interpreting bodily cues and a need for specific, concrete information and the perception that this need was not met. The pervasive and potent loss of predictability gave rise to three concerns: (a) the possibility of a repeat MI, (b) the possibility of sudden death, and (c) the potential for returning to normal. This last concern involved a process of comparing themselves with others. Loss of predictability was felt particularly in relation to energy, anticipated support from their husbands, and role enactment.

It was found that lack of energy was a prominent feature in daily life after MI for women. This lack reinforced the women's feelings of loss of predictability.

In addition to energy changes, the women also experienced a disappointing lack of support, especially from their husbands. The women reported a push-pull dynamic between the competing demands of their perceived household responsibilities and their own health needs related to their MI. This conflict situation might explain their lack of participation in structured cardiac rehabilitation programmes. Further, the women predicted and were upset to realize that if their husbands suffered a heart attack these men would receive more support than they were able to give. Additionally, the women felt that their MI illness experience was viewed as less valid and significant because they are women.

Changes in homemaker role enactment were described as uncomfortable by the women. The women experienced guilt as
well as a loss of power and authority when their homemaker tasks were assumed by their husbands and families.

Finally, in this study the women were found to use a wide range of strategies to gain control over their experienced losses. These strategies included assigning a cause for their MI, feeling hopeful, and relying on personal philosophies and past experience.

The findings of this study were discussed in relation to the current literature pertaining to MI. The purpose of this discussion was to compare women's experience with MI, as ascertained in this study, with the current understanding of the MI experience for men as recorded in the literature. This discussion concluded that there are commonalities but also significant differences between men's and women's experience with MI. Women's literature puts these unique findings into a clearer perspective.

Conclusions

The conclusions drawn from the findings of this study are as follows:

1. Women explain their MI illness experience in terms of experienced losses.

2. Women's need for information following MI is not met.

3. Lack of energy is a prominent feature of the MI illness experience for women.

4. Traditional sex role socialization sets the stage for potential problems in women's cardiac rehabilitation, especially in relation to support and role enactment.
5. Although the women were able to articulate a wide variety of strategies to gain control over their experienced losses, physical rehabilitation, the strategy most strongly recommended in the cardiac literature, was not even once identified. Therefore, physical rehabilitation is not a selected strategy for control over experienced losses for women with MI.

**Implications for Nursing Practice**

The findings and conclusions of this study suggest a number of implications for nurses involved in the assessment, planning, implementation, and evaluation of the nursing care of women with MI and are as follows:

1. Clearly, the nursing care of women with MI must be family-centered in order to address the findings and conclusion of this study concerning support and role enactment and, therefore, to provide effective and meaningful care for women with MI. As one women so strongly urged:

   I think when a woman has a heart attack, the man, the husband, and if there are any children, there should be some class, some something that can really make them aware what has happened, what is expected of them, how it actually has to go.

2. Because women explain their illness experience with MI as a loss phenomenon, it is important for nurses to assess women with MI using the concepts of loss and grief. For example, what is the nature of the loss experience? What specific losses are involved? The losses identified in this study provide nurses with a guide to the assessment of individual losses for women with MI.
3. The study's conclusion related to lack of information gives nurses a clear mandate to assess specific learning needs, especially once the patient is discharged home from hospital. What does this patient need to know about activity at home? Does she know what activities are permitted? Can she determine if she is overextending her limits?

4. The findings and conclusions about lack of energy post-MI direct nurses to assess energy changes prior to discharge and then again when the patient is adjusting to the home environment. Because of the physiological and psychological bases for energy depletion, the nurse should collect specific data about activity tolerance and potential stressors in the home environment in order to facilitate an easy transition from hospital to home.

5. Planning should include nursing interventions to increase support, to meet the patient's and family's educational needs, to develop the women's strategies for control over their experienced losses, especially physical rehabilitation, and to help women to anticipate normal physical and psychological responses to MI. Further, an approach emphasizing do's rather than don'ts, prescriptions rather than proscriptions, and specific, precise rather than vague advice is indicated.

6. In relation to implementing nursing care, nurses need to develop skill in teaching women and families, in problem solving with women and families, and in providing empathic, optimistic, and supportive nursing care.

7. This study directs nurses to evaluate the present cardiac rehabilitation programmes in relation to the special
needs of women. Nurses should seriously consider setting up structured cardiac rehabilitation programmes for women, tailored to meet women's needs. Such programmes could be designed to function as a combined support and physical rehabilitation group.

The findings and conclusions from this study provide a basis for nurses to develop a pivotal role in caring for women with MI that could significantly and positively impact upon women's cardiac rehabilitation.

**Implications for Nursing Education**

The following implications for nursing education are drawn from this study:

1. It is evident from this study that nurses must be prepared to teach patients with MI and their families as recommended in the literature concerning cardiac rehabilitation. This preparation should then include content in pathophysiology and psychology related to MI, as well as clinical practice in the application of the principles of teaching and learning.

2. Nurses must develop skill in interviewing and in the physical assessment of patients with MI. This skill is particularly essential for nurses in the community, in the identification of actual and potential problems and the adjustment of care plans.

3. Most importantly, this study directs nursing educators to provide course work in women's health issues to sensitize nurses to this field of study and to equip nurses with the understanding necessary to facilitate changes in women's health
Implications for Nursing Research

The findings and conclusions from this study point to a number of implications for further research in relation to women with MI. Selected implications for nursing research are:

1. The area of lack of information requires further investigation. Are there differences in information giving and receiving between men and women with MI? What variables are associated with effective information giving and receiving?

2. The findings and conclusions concerning lack of anticipated support suggest future research. How does support vary with family circumstances? What sources for support fit with women's needs post-MI?

3. Also, because the women identified such a wide range of strategies for control, it would be useful to investigate strategies per se in order to expand the professional sector's perspective and to isolate strategies that are particularly effective for women.

Summary

In conclusion, it is evident that MI in relation to women requires continued investigation. This study suggests that understanding women's experience with MI is necessary to augment and increase the validity of the current knowledge base for cardiac care. Eliciting women's perceptions of their MI illness experience makes use of the most valuable data source available to understand this illness phenomenon.
REFERENCE LIST


Cowie, B. (1976). The cardiac patient's perception of his heart attack. *Social Science and Medicine, 10*, 87-96.


Consent Form

I volunteer to participate in Penny Dunn's thesis study entitled "Women's Perceptions of Their Illness Experience With Myocardial Infarction".

I understand that the purpose of this study is to learn how women view their heart attack experience.

I have received the "Patient Information Letter" which outlines what my participation will involve and how confidentiality will be maintained.

Penny Dunn has answered my questions about her study.

I understand that my decision whether or not to participate or to withdraw at any time will have no effect whatsoever on my future health care.

____________________  ____________________
date                                  signature
APPENDIX C

Sample Questions for Initial Interview

1. What does it mean to you to have had a heart attack?

2. Tell me about your illness. What has it been like for you to have had a heart attack?

3. How has it affected your everyday life?
   - family relationships, relationships with friends, acquaintances
   - daily activities
   - feelings, outlook on life
   - leisure activities
   - work activities

4. How do you think you will be feeling one to two months from now?

5. What do you see yourself doing one to two months from now?

6. What are your concerns about your illness? about your recovery? about dealing with your illness?
APPENDIX D

Key: 1) A change in speaker is indicated by 10 dots.

2) The same women speaking at a different point in the interview process is presented by double spacing only (no dots) between the entries.