CHAPTER 1
INTRODUCTION: GENESIS AND RATIONALE

This chapter will firstly discuss how my interest in the study manifested itself. There will be an overview of the problems that arose in actually settling on this study. An exploration of the background of the research question and the aims and objectives of the study will then be described. This chapter then concludes with a brief overview of the chapters that follow.

1.1. Personal motivation for the study

As a nurse with approximately eighteen years of experience, and with the majority of those years in general medical nursing, I came to understand that women’s health and illness, particularly of women who have lived past their fifties, was rather ignored. They appeared to be the least interviewed and explored for their opinion and their experiences of health, illness and recovery. Also, as a woman, I felt that I had a duty to investigate within the women’s health area, as a matter of consciousness raising and to appease my feminist viewpoint, that women have a right to tell their stories concerning their experiences and to share these stories with others.

The development of the study was rather haphazard. The starting point was that I was interested in women’s health. This was explored with my supervisors, and when reading the literature on the health needs of women, I could see that there was a lack of studies on older women who had experienced heart attacks and who had attended cardiac rehabilitation. This area interested me because of the high incidence of morbidity and mortality that the population as a whole experiences because of cardiovascular
disease and because there seemed to be a paucity of research in the area of heart disease and womens’ needs.

Another motivation for me was that I am at that time in my life where I see my mother, and mother-in-law, in their late sixties, utilising the medical field for their health needs and talking to them about their quality of life and limitations that illness, or the thought of illness, could have on their health. Although they come from totally different backgrounds, they have in common their gender, age and perceptions of family and wanting to talk about their health limitations and changes that are occurring as they become older. Perhaps because I am a nurse, they feel comfortable talking to me about health matters that they do not talk about with others. I think that talking to them has made me more interested about women in that age bracket and the stories they have to tell concerning important events in their lives, concerning their friends and family. These women perhaps would never be able to tell their stories or reflect upon them.

My ideas developed after reviewing the literature on the topic of cardiac rehabilitation. The literature, mainly from the USA, suggested that more men than women attended cardiac rehabilitation. I then talked to Clinical Nurse Consultants and Nurse Unit Managers of cardiac rehabilitation centres and in their experience too, more men than women attend cardiac rehabilitation, more women than men drop out of cardiac rehabilitation, and cardiac disease was still one of the leading causes of death in women, particularly after menopause. I thought that a study talking to women who had been to rehabilitation and then deciding for whatever reason to drop out would be of interest to the staff involved in these rehabilitation centres and also to a broader audience of nurses.

However, my initial idea proved to be impractical. I involved the staff of one particular cardiac rehabilitation program and asked them to help identify
women who had dropped out of their program, and also women who did not attend in the first place. They were very helpful, sending out letters to the women so as to maintain confidentiality and asking the women to get in touch with me as the researcher. But, after three months and with follow-up requests, no one had answered my letters. It seemed that the women who did not want to participate in the cardiac rehabilitation did not want to talk to someone about their experiences of non participation.

After consultation with my supervisors, I decided I would talk to women who had participated in cardiac rehabilitation about their experiences and life after a cardiac event, in this case, a heart attack. Their experiences would give me an insight into their lives and events as women recovering from heart attacks, and some understanding as to why they participated in the first place.

The more I read about women and heart disease, the more interested I became. Research into womens’ health appears to be an area which is expanding as we are trying to redress the historical imbalance of the lack of research into womens’ health.

Throughout my years of nursing, I have developed conversational skills, such as interviewing skills, listening skills, and an understanding of communicating and conversing with others. This background helped to formulate my interest in qualitative research as a way of gaining information about women while maintaining a conversation, and allowing the expression of life experiences these women hold and perhaps have not told anyone else. I think that the women I interviewed were at ease with me interviewing them, perhaps as I was a women first, and a nurse as well.

Gibson (1993) suggested that there is a need to focus, not only on how women differ from men, but on what is unique about women and what they
can contribute and what they do well. Therefore, my study would focus on women, past menopause, who had recovered or were recovering from heart attacks and how they experienced this, the quality of their lives and how their stories are similar and how they varied.

1.2 The purpose and aims of the study

There have been major changes in world-wide population demographics with an increase in those over 65 years of age and recognition that the incidence of acute myocardial infarction increases with advancing age (Thompson, 1989). There has been a large number of studies on men and heart disease, while there have been many fewer on women.

The current research examines the lived experiences of older women, who were going through their recovery period after a heart attack and cardiac rehabilitation. The method of research was a phenomenological approach. Through doing this research I was not only concerned with the womens’ experiences, but also the application of the method itself.

This study has made me reflect on older women and their life history. It has given me a different perspective on womens' lives and how women cope with illness and recovery in similar and in different ways. I have now a broader appreciation of the innate strength that women draw upon when they are unwell and recovering from a major illness. I trust the reader, too, will gain an insight into older womens' lives and abilities and experiences of recovery.

The purpose of my study was to address the question, from the perspective of women, what are womens' experiences of recovery after having a heart attack and the womens' perceptions of cardiac rehabilitation?
The aims of this research included:

1. To describe themes and personal meanings of women who have experienced a heart attack and have participated in an outpatient cardiac rehabilitation program.

2. To examine women's understanding of having a heart attack and factors underlying their participation in rehabilitation (i.e., their decision-making process).

3. To clarify women's experiences of having a heart attack and the influences underlying participation in rehabilitation (i.e., their own knowledge and realities).

4. To investigate the meaning of recovery from heart attack and cardiac rehabilitation for women who participate in rehabilitation.

1.3 Overview of chapters

This thesis has been organised into six chapters.

Chapter one, as given, provides information on my personal motivation concerning the study, purpose of the study and why the study has taken place. An overview of the problems encountered prior to the study actually taking place has been provided. The overall aims of the study have also been presented.

Chapter two reviews current literature on heart attacks, with relevance to women and recovery. This chapter explores the impact of having a heart attack and recovery from a physical, psychological and psychosocial perspective. Firstly, the concepts of stress and anxiety and how they affect
education and rehabilitation are discussed. Then the decision making process incorporating personal control, motivation, self efficacy and locus of control is examined. A focus on women and illness and recovery processes, including coping, preservation of self and self definition is reviewed next, concluding with an overview of women and older age.

Chapter three discusses the phenomenological methodology underpinning the study. This begins with a brief overview of the origins of phenomenology as a qualitative research method. Nursing and phenomenology is then explored, followed by various types of methods used in phenomenological inquiry, concluding with an overview of the limitations and strengths of phenomenology.

The way in which phenomenology was applied in the current study is examined in Chapter four. This chapter starts with an introduction to my study and the methodology used in practice. A brief overview of the participants and how the data were managed is then given. The chapter concludes with the data analysis method used and ethical considerations.

Chapter five is the data analysis and interpretation chapter, which involves the womens' own stories and conversations. An overview of each woman is given, followed by an overview of significant statements, sub-themes and major themes which emerged from the data. The focus of the chapter is the exploration of how each theme is supported by the womens' experiences. The major themes which emerged from the data were loss of autonomy; coping; role changes and expectations; and changed relationships.

Chapter six is the summary and conclusion chapter, which is a reflection on the whole project. Personal meanings of, understandings of, making decisions about, and clarification of experiencing a heart attack have been discussed in this study. The relationship to previous literature and research is
explored, and implications and limitations from the study are discussed. Future research directions and conclusion complete the chapter.
CHAPTER 2
REVIEW OF THE LITERATURE

2.1 Introduction

Cardiovascular disease is one of the leading causes of death in both men and women in Australia. According to the Australian Bureau of Statistics (1997), 23.7% of all adult deaths were attributed to ischaemic heart disease. In 1995, 45% of all deaths attributed to ischaemic heart disease occurred in women. As a consequence of ischaemic heart disease, acute myocardial infarction may occur. The incidence of ischaemic heart disease in women increases with age, exceeding that of men, which can have implications for recovery and rehabilitation as preexisting comorbidities can limit participation in rehabilitation programs (Rankin, 1995). As our elderly population increases, ischaemic heart disease in women will become more of a serious and widespread problem (Wingate, 1991).

In consideration of the above, there has been little research into cardiovascular disease in women. Treatment and cardiac rehabilitation programs have mainly been focused towards men and their needs. The lack of information concerning women who have experienced a cardiac event, and their rehabilitation needs has required a shift in research priorities, from being generally male focused to now including research on women and cardiac recovery (Boogard, 1984; Parchert & Creason, 1989; Rankin, 1995; Young & Kahana, 1993).
The following literature review examines recovery issues and the impact of having a heart attack\(^1\) on the individual. An overview of the physical and the psychological concepts of anxiety and stress and how this may effect women and recovery is discussed. Women and their recovery process, including the notions of coping, preservation of oneself and self definition, will be considered. The impact of having a heart attack on women, particularly post menopausal women, will then be explored. Recovery and the decision making process which incorporates personal control, motivation, self efficacy and locus of control issues will be examined. A summary will then conclude the chapter.

2.2 Physical and psychological aspects of heart attack

Acute myocardial infarction (AMI) occurs as a result of ischaemic heart disease, an illness that increases with age. As a consequence of the development of drugs which help in coronary re-perfusion and the arrival of coronary angioplasty and by pass surgery, an increase of survival from a myocardial infarction is occurring (Wenger, 1991). Because of this, cardiac rehabilitation programs are developing and needing to be revised, especially due to the fact that older women attend these programs.

AMI occurs from a reduction of blood supply to the heart myocardium. In the majority of cases, thrombus formation precipitates coronary occlusion. This occlusion leads to myocardial ischaemia, and metabolic and cellular abnormalities occur from this ischaemia. The blood flow to the already ischaemic area is reduced, thereby decreasing the ability of the myocardium to contract (Thompson, 1989).

\(^1\) The term myocardial infarction is a medical term, the participants in my study talked about having "heart attacks", so both terms are used in this chapter. In the interpretation chapter (Chapter 5), the term "heart attack" is used.
In the early stages of infarction, a reduction in activity is seen as essential for healing of the myocardium to occur (Ekstrand, 1991). After this stage, early graded activity management and mobilisation has been considered to be of benefit for a patient recovering from an AMI (Gawlinski, 1989; Runions, 1985; Walling, Guy, Tremblay, Jobin, Charest, Delage, Leblanc, Tessier, & Ignacio, 1988). Further studies have led to the formation of ambulation programs in Australia, looking at energy expenditure and physical responses to different activities (Braun & Holms, 1989). The National Heart Foundation of Australia has also published guidelines for rehabilitation of clients, which includes ambulation programs (National Heart Foundation of Australia, 1990).

Note - Further discussion of the disease process, particularly in relation to women, is given in section 2.4.

2.2.1 Anxiety, stress and recovery

The nursing care of a patient after a cardiac event should take into consideration that a patient's apparent denial or lack of recognition of having had an AMI depends on variability of symptom presentation (Scherck, 1992). The client's readiness to receive information concerning his or her illness, needs to be taken into account prior to undertaking any form of rehabilitation.

Having a heart attack can be seen as a crisis situation, both psychologically as well as physically. Lawrence & Lawrence (1988) suggested that this is because the heart is "perceived to be the seat of human emotions and the source of life".
There is substantial research to suggest that a person is psychologically affected after surviving a heart attack and that this psychological impact can impede their progress (Bennett, 1992; Crowe, Runions, Ebbesen, Oldridge, & Streiner, 1996; Johnson & Morse, 1990; Scherck, 1992; Thompson, 1989).

Stress and anxiety were some of the areas explored in the above studies. The majority of the studies involved men as participants, or a comparison between men and women, and were concerned with the acute phase of the illness (i.e., their hospitalisation), not the longer term recovery process.

There have been a number of studies that suggest anxiety is experienced by patients post myocardial infarction (Gawlinski, 1989; Rankin, 1992; Scherck, 1992; Thompson, 1989). One study (Thompson, 1989), involved patients who had experienced their first myocardial infarction, whose anxiety levels were particularly high. The anxiety the patients experienced could have been as a result of lack of understanding and knowledge deficit concerning the event, and concern about daily activities and lifestyle changes needing to be undertaken because of their myocardial infarction (Thompson, 1989).

Lack of confidence, anxiety, fear of sudden death and further heart attack and depression, together with loss of motivation, are the most frequently reported psychological responses reported after experiencing a myocardial infarction (Scherck, 1992). A reduction in recovery potential can result from these psychological responses, particularly if experienced early in the illness. Moreover, studies reviewed by Low (1993) suggested that women suffer more psychological symptoms, including anxiety and depression than men.

Rakel (1992) also found that anxiety experienced by an individual will impact on the recovery process, affecting their learning capacity and rehabilitation, particularly in the early stage of recovery from an infarction. Lawrence and Lawrence’s study (1988), determined that cardiac teaching, to be an effective
nursing intervention, needs to be given when the client is receptive to education, and when the individual undergoes behavioural changes in an attempt to cope with stress.

Education has been shown to reduce the level of anxiety felt by patients post infarction, bringing about an increase in knowledge about their illness and decreasing the hospital stay (Rakel, 1992; Thompson, 1989). Although a study by Murray (1989) suggested that rehabilitation information and education given to patients was general in nature rather than specific or relevant to their own needs, and therefore questioned the effectiveness of such education in their recovery process.

The meaning of recovery for women will now be explored in a number of different dimensions. At first, women and their sense of self and how relationships and support influence women in their recovery process will be discussed. The inner strength and power that women exhibit throughout their recovery and women and older age will then conclude this chapter.

2.3 Women and recovery

Patients' perceptions of their recoveries have not been examined in any detail (Johnson & Morse, 1990). There appears to be even less information on women and their recovery process (Boogard, 1984; Parchert & Creason, 1989; Young & Kahana, 1993). In this section, older women will be concentrated on, particularly in regard to preservation of self and self definition. Womens' relationships will then be discussed, concluding with an overview of strength and power utilised in the decision making process.
2.3.1 Sense of self / self – definition

A women's sense of self has been examined in a number of publications, focusing on what women actually "do" (i.e. their role in life) (Parchert & Creason, 1989; Sharpe, Clark, & Janz, 1991; Varvaro, 1991). There is also literature that supports the idea that a woman's sense of self is entwined in her relationships with others and this can influence the recovery process (Belenky, Clinchy, Goldberger & Tarule, 1986; Doress-Worters & Siegal, 1994, King & Jenson, 1994; Moore, 1996; Oldridge, 1991; Peck, 1986).

King and Jenson, (1994) support other current feminist literature that sees women's sense of self as not only related to her role, but related to connections and relationships she has to others. Although King and Jenson's study involved women and recovery after cardiac surgery, the findings are concerned with preservation of self, which meant for these women "struggling with role-related behaviours and interpersonal relationships" (p.100). This preservation of self can also be extrapolated to women going through other forms of cardiac recovery.

Another researcher who supports the arguments of King and Jenson above, developed a model that addresses the impact of relationships and events on women's adult life experiences affecting their self-definition. A woman's relationships can foster or impede development of self-knowledge, affecting life style changes, and attitudes towards health and wellness (Peck, 1986). This women's self-definition model is an:

ongoing process of self-awareness and knowledge
gained primarily through relationships to other people
and the degree of satisfaction and sense of competence
one receives from productive efforts. It involves an
internal knowledge of oneself-in-the-world, ...gained
through connectedness, not through separateness

As suggested by Parchert and Creason (1989), the patient's roles and relationships are changed after a cardiac event, impacting on women's self-definition. Peck also suggested that self-knowledge is best assessed through extensive interviews, instead of a structured instrument, as the instrument might predetermine categories of self-knowledge and "superimpose a conceptual framework upon the women's self-understanding" (Peck, 1986, p. 283). McBride and McBride (cited in Parchert and Creason, 1989) also suggested that nursing research in women's health issues should identify the "lived experience" of the woman.

Peck's model pays considerable attention to flexibility and elasticity in relationships. Those relationships either cultivated or prevented clearness and certainty within which self-knowledge developed. This emphasis on the elasticity and flexibility in relationships is considered to be important, as is the need for a sensitive approach to self-definition, where many women try to remove themselves from total dependence upon their relationships while trying not to hurt other people whom they care about in the process. The importance of relationships and the support of significant others in the recovery process is examined next.

2.3.2 Support / Relationships

There has been some analysis of the effects of relationships on recovery. The role of the family, spouses and significant others need to be assessed and catered for after a woman undergoes a cardiac event. This should start whilst the woman is in hospital and then when attending cardiac rehabilitation (Gortner, Gilliss, Shinn, Sparacino, Rankin, Leavitt, Price & Hudes, 1988;
Parchet & Creason, 1989; Runions, 1985). Gilding (1997) also recognises the importance of the family and states that “Kinship is still crucially important in most people’s lives” (p. 257).

The wife’s involvement and perspective on the recovery of their spouses, post MI has also been examined. The relationships within a family and with friends are consistently considered to be fundamental to recovery (Newens, Bond and McColl, 1995; Theobald, 1996; and Thompson, Ersser, and Webster, 1995).

Riegel and Dracup (1992) reported on how over-protection on the part of family and friends can help prevent cardiac invalidism and may facilitate psychosocial adjustment in early months after AMI. Keller (1991), also concluded in her study that social support was significant in women’s recovery after cardiac surgery, recommending that the inclusion of close family and friends post illness in planning and implementing care is necessary.

The significance of social support is also defended by Moore (1996) and Oldridge (1991). In these studies, social support from family and friends have been shown to be of importance for women who undergo cardiac rehabilitation and exercise participation.

Following on from this, though, there appears to be a paucity of literature examining patients’ and their partners’ experiences during the first few weeks after a heart attack (Thompson, Ersser & Webster, 1995). This area would appear to be important to gain an insight into this relationship and how they might affect each other and the recovery period.
2.3.3 Inner strength / Power

For a person to have strength, the ability to cope and to accept their situation are seen as essential. Coping is seen as something desirable and necessary in our day to day lives. It has also been seen as “practical reasoning about present situations in terms of concrete past experiences,” (Benner, Janson - Bjerklie, Ferkeetich & Becker, 1994, p. 227).

Acceptance can be described as “a coming to terms” process involving comprehending that a heart attack has taken place, apprehending why that has occurred and what significance this event has for the future (Johnson & Morse, 1990, p. 129). Acceptance is not a form of resignation or giving in to an illness but can be seen as a positive movement towards coming to terms with living with an illness (Benner, et al., 1994). Rose (1990) suggested that acceptance was experienced by learning who one’s true self was and listening to and respecting that true self, believing and trusting and then acting according to what the true self needed and wanted.

Women have a shared recognition that personal strength, and development were possible within the process of recovery. This was seen in a study by Fleury, Kimbrell and Kruszewski (1995). Individual recovery after a cardiac event is a process that incorporates struggle through personal loss, re-patterning of valued activities, and discovery of personal strength. Women tried to heal themselves by focusing on alternatives and possibilities, re-evaluation of life goals, re-assessment of priorities and personal investment and appreciation of impermanence of life situations (Fleury et al, 1995).
Inner strength of women has also been studied by Rose (1990) in relation to the "healthy functioning of women", concerning women's lived experience of inner strength. Rose suggested that many studies reflect misinterpretations and misunderstandings of theories because they have only been based on male subjects and extrapolated to have some meaning for women (eg. concepts of self-esteem, self-identity, anger and power). Feminist theories have examined the concepts of strength and power and Miller (cited in Rose, 1990, p. 59) defined power as "the capacity to move or to produce change" and suggests that women are most comfortable using power "if it is in the service of others".

Broom (1991), suggested that traditional theories of power were linked to ideas that were devised by men; for example, virility, dominance and violence. Women have tried to re-conceptualise the term through ideas of empowerment, capacity and agency of change (Hartsock, 1983 cited in Broom, 1991). In the case of health, knowledge is one element of power and lack of knowledge about women's bodies, both physical and psycho-social, has contributed to their powerlessness (Broom, 1991).

One goal that feminists seem to have in common is the empowerment of women (Hunt, 1991). Empowerment can be defined as "the creation of a just society in which people may become self-directed through the creation of opportunities to choose between realistic alternatives " (Hunt, 1991, p. 390). In the case of the women's health movement, Hunt suggested that the goal was a just system of health for women as it can create an equitable social system compared to the rest of our capitalist system.
2.3.4 Women and older age

Women may face multifaceted problems as they become older, for example, financial problems, being more isolated, rethinking their independence, being considered as a carer, dealing with health problems and being placed in a sex role stereotype (Young & Kahana, 1993; King & Jenson, 1994). As the world population is getting older, this age group needs to be better understood.

Most people tend to think of an “older person” as being “older than us” (Colless, 1994). Others link the onset of “old age” with retirement. However, because of better health and longevity and the end of compulsory retirement, there have been distinctions made between the “young old” (ie. people aged between 65 to 74) who have retained their mental and physical vigour; the “medium old” (ie. aged 75 years to 85 years of age), who are less able to function independently and the “old-old” (ie. people aged 85 and over) who may have become frail (Belsky, 1984; Kingson, Hirshorn, & Cornman, 1986 both cited in Naiden , 1989).

Hagestad and Neugarten (1985), believed that both men and women perceive women as being ‘old’ at an earlier age than men. This was seen among many cultural groups, for example, Americans, Swedes and African Nyakusa. Naiden (1989) suggested that concepts of ‘oldness’ often ignore individual differences among older people.

Colless (1994) suggested that the belief that older people lose competence in sensory and motor tasks leads to stereotypical images of older people. Although there is some evidence to suggest that for most people, vision, hearing, smell and balance decline significantly with age, there has been
insufficient evidence to determine whether our other senses show the same levels of decline, for example, touch and taste.

The following section deals specifically with heart disease and how this affects women through their recovery process.

2.4 Women and heart disease

The leading cause of death for women aged 65 years and over in 1991 was diseases of the circulatory system (Australian Bureau of Statistics, 1997). In the National Health Survey 1989 - 90, almost 70 % of females who reported heart disease were aged 65 and over. Women also have a longer life expectancy than men, therefore married women over 65 years of age tend to outlive their husbands and to live alone. (Australian Bureau of Statistics, 1997). In general, illness has more after effects for women, (Hagestad & Neugarten 1985), including less chance of surviving a myocardial infarction, a more complicated recovery process (Rankin, 1995; Young & Kahana, 1993) and greater mental distress and sexual dysfunction than men (Wenger, 1991).

Women generally have fewer cardiac risk factors than men earlier in life, as pre-menopausal women have higher levels of high density lipoproteins (HDL) than men (Boogaard, 1984). This is associated with protection against cardiovascular disease. Low density lipoproteins rise after menopause, as HDLs decrease, correlating with the increased incidence of cardiovascular disease in post-menopausal women (Boogaard, 1984). However, this evidence is not conclusive, as cardiovascular disease in women rises more rapidly as women enter their sixties, quite a number of years after their menopausal state (Keresztes & Dan, 1992).
Coronary Artery Disease (CAD) in women tends to be later in life than in men, but CAD is still the leading cause of death in women over 40 years of age (Mastroianni, Faden & Federman, 1994; Rankin, 1990; Wenger, 1991). Although many women survive AMIs, there appears to be little research that describes their responses to this experience (Hamilton & Seidman, 1993). Hamilton and Seidman looked at a comparison between the recovery period for women and men after AMI, and they identified the need to investigate further the recovery period for women as this area had been neglected.

Flavell (1994) also examined the gender differences in anatomy and physiology and discussed interventions and diagnostic techniques in women, which traditionally had been focussed on men.

Another study used focus groups to explore women’s attitudes and experiences to cardiac rehabilitation (Moore, 1996). Moore found that several cardiac rehabilitation programs, in their design and operation, were perceived by women as not meeting their needs.

The risk of heart disease increases with age in women, but research tends to be focused on the middle-aged, male population (Healy, 1991). Physicians tend to believe that angina symptoms are more benign in women than in men (Wenger, 1991). This may be one of the reasons why women have been treated less seriously than men even when a myocardial infarction has been diagnosed (Pittman & Kirkpatrick, 1994).

Medical literature has indicated heart problems may be more serious for women. For example, Young and Kahana (1993) indicated that social, medical and demographic factors are implicated in a greater risk than men of death and reinfarction shown by women. Hamilton and Seidman (1993) and Cochrane (1992) also found that morbidity from AMI is higher in women than
in men, particularly in the areas of reinfarction, heart failure, valve complications and stroke. Hamilton and Seidman also queried the level of care that women receive, in this instance from their spouses, after suffering an AMI, since women generally marry men older than themselves, and the men may not be healthy enough to provide care to their wives. This is also argued in Young & Kahana's (1993) study where it is suggested that husbands “have not been socialised into caring and nurturance roles” (p. 25) and perhaps are not able to give the quality of care that is needed after women come home from having a late life heart attack.

Young and Kahana go on to suggest that, since women have greater longevity than men and the risk of heart disease escalates with age, future heart patients will be female, therefore access to aggressive treatment (e.g., coronary angioplasty and artery bypass procedures) in women with heart disease needs to improve (Young & Kahana, 1993). A gender bias of women not receiving coronary angioplasty and artery bypass procedures as frequently as men has been reported by a number of researchers (Hawthorne, 1994; King & Jensen, 1994; Wenger, 1990).

2.4.1 Women and cardiac rehabilitation

A cardiac rehabilitation program can be defined as "a program of progressive exercise, health education, and counselling designed to assist the patient and family through the illness stage, encourage faster recovery, and return the patient to optimum physical and psychological health" (Gawlinski, 1989, p.71).

The aims of cardiac rehabilitation should include preparation of patients and families sufficiently for modification to their illness (Worcester, 1986). The promotion of a return to a normal and healthier lifestyle is a main aim of rehabilitation program, advice about diet, smoking and exercise would be included to improve a person's lifestyle (Howard & Morieson, 1997).
Many studies in the area of cardiac rehabilitation have concentrated on male participants (eg. Mickus, 1986; Romeo & Saccucci, 1991; Walling et al., 1988). The participation of women in cardiac rehabilitation programs tends to be less than men and dropout rates from such programs have been greater for female participants (Oldridge 1991; Walling et al., 1988; Wingate, 1991).

A study by Hamilton and Seidman (1993) however, found no significant difference between twenty women and forty two men participating in a structured cardiac rehabilitation program, while hospitalised and after discharge. The main reasons given for not participating in cardiac rehabilitation were insurance coverage problems, physical problems or that rehabilitation had not been suggested. Although, for reasons not known, more than half the subjects in the study, both men and women, reported that cardiac rehabilitation was not received or even discussed. Hamilton and Seidman suggest that the patients might not have remembered the information, even if it was given.

Although, Salisbury, (1996) suggested that individualised rehabilitation packages needed to be developed and started within a week after patients were discharged to capitalise on a period “when motivation to change unhealthy patterns of behaviour is very high” (p.50).

Studies on women (which are expanded upon in the following paragraphs) have focused on factors which may effect recovery post myocardial infarction or coronary heart disease and have proposed a number of suggestions as to why womens’ participation in cardiac rehabilitation is less than men’s. According to Schuster and Waldron (1991), women are less able to tolerate exercise programs than men, and they may consider cardiac rehabilitation as an exercise program.
Oldridge, Ragowski and Gottlieb's (1992) study looked at factors associated with cardiac rehabilitation attendance. They found that fewer women are referred to cardiac rehabilitation than men in the first place, that the women have limited health benefit coverage, and are more often in a single parent situation.

Lack of women's awareness of the benefits of cardiac rehabilitation, such as attaining optimal activity levels and psychological well being, was seen as one of the implications from a study by Mickus (1986).

Limitations have been identified in cardiac rehabilitation programs, perhaps affecting women's participation and drop out rates. These include not considering the needs and contributions of the spouse during recovery, and patient education programs not taking into account individual coping styles (Runions, 1985). The actual planning and assessing of women's needs in cardiac rehabilitation have also not been taken into account (Pinneo, 1984). In more current literature, Moore (1996), suggested that cardiac rehabilitation programs have not changed essentially since they were designed in the late 1960s, when they were designed to meet the specific needs of middle-aged men.

Walling et al., (1988) suggested that women who have had myocardial infarctions are considered poor candidates for rehabilitation, as they tend to be both clinically and physiologically ineligible. They have significantly more medical limitations after an MI according to screening criteria, to be involved in a formal rehabilitation program.

Wingate (1991) surmised that family commitments and sociocultural factors explain why women do not attend rehabilitation programs and drop out from formal programs. Boogaard (1984) supported this as her study found that women after having an MI resisted help from the family around them, not
perceiving housework as strenuous activity and started household work early after discharge from hospital. The study also found that women expressed guilt feelings when they were unable to perform their usual household work.

Moore (1996) found the women interviewed for her study, agreed that social support was an important factor in their participation in cardiac rehabilitation, and, in fact, that friends and church associates were major providers of social support rather than their own children.

Low (1993), in a review the literature identified that women are referred less often to cardiac rehabilitation programs, enrol less frequently and have poorer attendance than men. Hawthorne's study (1994), found that almost all of the men participated in a formal rehabilitation program, but few of the women did. Although this study concerned recovery after coronary artery surgery, she suggested that home and "otherness" orientation may significantly reduce the time women have to participate in formal rehabilitation programs and risk - factor (for heart disease) reduction programs.

Changes in role identity and self definition impacting on women and their recovery could also be one of the factors contributing to a lack of womens' participation in cardiac rehabilitation programs. An emphasis on educational programs that are comprehensive and address the special needs of women could perhaps remedy the situation (Parchert & Creason, 1989).

The above literature is from the USA. There appears to be a paucity of studies on women and cardiac rehabilitation in Australia. For example, a study of cardiac rehabilitation programs in Australian hospitals by Worcester, for the National Heart Foundation of Australia, (1986) investigated the extent of cardiac rehabilitation in Australian hospitals. The results revealed serious deficits of outpatient cardiac rehabilitation programs in Australian hospitals.
These deficiencies included insufficient staff, poorly developed or non-existent exercise programs and inadequate education of patients. Gender issues were not taken into account.

The activities which occupy our life, so called activities of daily living, will now be discussed in relation to women and their recovery process.

2.4.2 Activities of daily living

Activities of daily living may include activities such as bathing, dressing, eating, sleeping, cooking, cleaning, and communication (Roper, Logan & Tierney, 1996). Married women who were recovering after a coronary artery bypass grafting operation because of coronary heart disease, expressed anxiety concerning their husband's ability to care for them and maintain the household, while men did not report being anxious about this (Moore, 1995).

Research concerning activities of daily living suggest that women feel less healthy than men, have feelings of guilt about their inability to resume usual activities, but maintain responsibilities for housework and resume housework early after an AMI and do not consider it as excessive activity (Boogaard & Briody, 1985; Cochrane, 1992; Hamilton & Seidman, 1993; Mickus, 1986). Women also are less likely to have help from their spouses during their recovery period compared to men that are recovering from MIs (Rankin, 1995).

Hamilton and Seidman (1993) found that 75% of women returned to household responsibilities within four weeks of having an AMI compared with one third of the men. This housework was perhaps not considered work by the health providers and the women themselves, and women received less counselling than men after their heart attack.
The "emotionalism" of housework accompanies "gnawing guilt" that any concern about oneself constitutes failing to care for others, for example, wives, feeling guilty if their bathrooms are not clean, and mothers, feeling guilty if school uniforms are dirty or unironed (Bittman & Pixley, 1997).

To prepare patients and their families for a change or modification to their activities and lifestyles involves investigation of the individual's decision making process, which will be explored next.

2.4.3 Decision making process

Johnson and Morse (1990) recognised that perceived self control and motivation are determinants of patient outcome after infarction. To make an informed decision concerning the rehabilitation process, that is, the decision making process, a person needs to explore a number of areas, which are discussed in the following paragraphs. These areas include personal control, autonomy, self efficacy, motivation and locus of control.

2.4.4 Personal control

There has not been extensive literature concerning personal control, particularly involving a person post myocardial infarction. Johnson and Morse (1990), indicated that regaining a feeling of being in control, is essential in a patient's rehabilitation process. For rehabilitation to be successful, the patient needs to adjust to physical, emotional and social changes in their lifestyle. A patient's feelings of perceived control can also affect their compliance with treatment, which can be promoted through active patient participation and decision making about the care that they receive (Ballard, 1986).

A person's control involves degrees of autonomy. Autonomy can be defined as "the personal liberties of the individual in making decisions regarding his or
her own life; ...assumes that others will respect the decisions made by the individual." (Rankin & Stallings, 1990, p. 377). Autonomy means "independence and self-governing" (Husted & Husted, 1991, p. 37), people have a freedom of choice and the ability to make decisions, thereby having some control over the environment around them.

Aspects to be considered to bring about some degree of control include self efficacy, motivation and locus of control.

2.4.5 Self efficacy

Self efficacy deals with an individual believing that they can achieve a desired action. Self efficacy refers to “beliefs in one’s capabilities to organize and execute the courses of action required to produce given attainments.” (Bandura, 1997, p. 3). Self efficacy is considered to be an important factor in the decision making process of the individual. Rankin and Stallings (1990), suggested that self-efficacy may be a theoretical basis for patient education, allowing the patient through information and perceived self confidence, to preform new behaviours.

To enable the nurse to comprehend the individual’s level of motivation or drive in a given situation (eg. in cardiac rehabilitation), knowledge of self efficacy will allow an individual and comprehensive assessment of the client (Rankin & Stallings, 1990).

2.4.6 Motivation

The premise of self responsibility underlies the effectiveness of a patient education program (Fleury, 1991). If an individual’s motivation is low, behaviour change is unlikely to occur, the individual will also be unlikely to accept responsibility for starting and maintaining health behaviours.
Loss of motivation, as previously suggested under anxiety and stress, can reduce recovery potential, but individual motivation can be helped by education, and there appears to be a correlation between motivation, compliance with changing behaviour and locus of control (Fleury, 1991).

2.4.7 Locus of control

An individual's expectations about the degree to which circumstances are directly under their own control, utilising their personal effort and initiative (internal locus of control), or other's control, with luck or fate having an input (external locus of control), may determine how that person will deal with a health problem (Lefcourt, 1984). Locus of control can determine whether a patient will participate and comply with decisions concerning their treatment and affect their belief in their own capabilities - their self efficacy.

As suggested by Lefcourt (1984), to have an internal locus of control is not always necessary for good health outcomes as being passive and accepting the situation may help with surviving health outcomes, more than striving and making an effort to participate in decision making.

Participatory control came out of the limitations of the locus of control concept and is a two-fold process. People first learn to accept the reality of their disease or disability and their reliance on others, and then learn to become instrumental in their lives through participating with others in controlling events of importance to them (Reid, cited in Lefcourt, 1984).

Therefore, as discussed, the decision making process is concerned with personal control, self efficacy, motivation and locus of control issues. A study
by Johnson and Morse (1990), suggested that, from the time of a myocardial infarction, until a state of perceived adjustment is attained, the major process used is the struggle to regain control. They go on to postulate that perceived control of the individual patient is an essential element of the rehabilitation process.

Johnson and Morse (1990) identified factors which influence the amount of perceived control involved three dimensions: firstly, predictability - the person’s ability to predict the consequences of an action, secondly, self-determination - the individual’s ability to make informed decisions, and thirdly, independence - the ability of the person to act on decisions. If the above dimensions have not been gained, then, Johnson and Morse suggest that the adjustment process of the individual is not complete. The adjustment process is directed towards regaining a sense of control and a process of maintaining and re-establishing a sense of control is necessary to achieve this end.

2.5 Summary and conclusions

There are relatively few studies that deal specifically with women and their experiences after having a heart attack. This recovery process, which includes rehabilitation and family support and involvement, is an area where research has concentrated largely on the male population.

The studies reviewed in this chapter presented a broad picture of recovery commencing with the physiological and the psychological aspects of people who have recovered from a cardiac event. Psychological factors including anxiety and stress and recovery were then discussed. Women, in particular, were then concentrated on, reviewing the recovery process which included literature and discussion on sense of self, support and relationships, inner strength and concluded with a focus on older women.
Women and heart disease was then discussed, focussing on cardiac rehabilitation, activities of daily living and the decision making process which involved exploring personal control, autonomy, self efficacy, motivation and locus of control.

The implications of this literature review includes the necessity of further investigation into women’s needs and recovery after a cardiac event. The impact on the individual and significant others, together with how this recovery experience effects partners, is an area that appears to have been neglected and is also worthy of further examination.

The purpose of my study was to explore women’s experiences of recovery after a heart attack and cardiac rehabilitation. Studies already reviewed suggest that women’s sense of self, and self definition are affected after a cardiac event, impacting on family and friends. Their inner strength and relationships with others are a significant part of their decision making process.

It was intended through my study to allow women to tell their stories concerning their path to recovery from their heart attacks, to gain an insight into the way women perceive illness and how they regain their health. This in turn will allow nurses and other health professionals to have a better understanding of how illness affects women after a heart attack and how women may be viewed in conjunction with their families, friends and other support networks during their recovery process.
CHAPTER 3
METHODOLOGY

This chapter presents an overview of phenomenology, why and how it is used. The chapter begins with a brief discussion of the origins of phenomenology as a qualitative research method. Then an overview of nursing and phenomenology will be provided. A brief look at the assumptions made in phenomenological inquiry are then examined, followed by a discussion on data management and analysis. The chapter concludes with an overview of the limitations and strengths of phenomenological inquiry.

3.1 Introduction

Phenomenology has been described in a variety of ways and in different settings, from being viewed as a philosophy or to being synonymous with naturalistic inquiry (Patton, 1990). It is also seen as being under the umbrella of qualitative research. Qualitative research methods allow "exploration of humans by humans in ways which acknowledge the value of all evidence" (Taylor, 1993a, p. 173).

The goal of phenomenological research can be seen as the description of the lived experience and the meanings it holds for each participant (Drew, 1989). A phenomenon can be an emotion, a relationship or a given situation (Burns & Groves, 1993; Patton 1990). This research approach allows participants to reflect and describe their own "lived experiences", in their own settings and backgrounds (Bartjes, 1991). The complexities and uniqueness of human experience are explored and reflected upon, giving the reader a 'whole' picture of this experience.
3.1.1 Origins of Phenomenology: Philosophical Tradition

The phenomenological method of investigation appeared in the 19th century writings of the philosopher, Franz Brentano, and developed by his student, Edmund Husserl. Husserl (1965) (cited in Munhall, 1989) introduced the idea of phenomenology in reaction to the positivist approach in the natural sciences. He endeavoured to reinstate the 'reality' of humans in their 'life worlds', so as to secure the 'meaning' of this experience, and renew philosophy with new humanism.

Martin Heidegger, an assistant of Husserl, involved himself with Being and with time, Dasein - being human - "human being is essentially simply self-interpreting" (Dreyfus, 1992, p.23). Heidegger, in investigating the question of Being, and in trying to understand our practices in life, saw himself doing thematically what all human beings do unselfconsciously all the time (Dreyfus, 1992, p. 29). This notion of Being underpins much of Heidegger's concept of hermeneutic phenomenology.

"Hermeneutic (or Interpretive) phenomenology is a human science which studies persons" (van Manen, 1990, p. 6), a study of lived experiences, "how one interprets the texts of life" (van Manen, 1990, p.4). Van Manen explains that hermeneutics is the theory and practice of interpretation, derived from the Greek god, Hermes, who had to communicate messages from Zeus and other gods to ordinary mortals. Spiegelberg (1960, cited in Cohen, 1987, & Taylor, 1993b) wrote a history of the "Phenomenological Movement". The term "movement" implies that it is not a stationary or a rigid philosophy.

Van Manen (1990, p.9), described phenomenology as a means of gaining a "deeper understanding of the nature of meaning in everyday life experiences". To do research from a phenomenological perspective, is "to question the way
we experience the world, to want to know the world in which we live as human beings" (p.5).

Heidegger influenced many French philosophers, such as Marcel, Satre, and Merleau-Ponty (Cohen, 1987). They have influenced the development of phenomenological inquiry to this present day.

3.1.2 Adaptation of Phenomenological Inquiry: Phenomenology as method

Phenomenology, when adapted by North American social scientists such as van Kaam (1959), Giorgi (1975) and Colaizzi (1978) (cited in Roberts & Taylor, 1998) became the basis for a research method. The North American version, or “new phenomenology” as suggested by Crotty (1996), who stated that there are problems with these North American phenomenologists not appreciating the value of the mainstream approach, and opting only for a “new” kind of phenomenological approach.

A number of nurse researchers such as Beck (1992), Benner et al., (1994), Munhall (1989) and Oiler (1986) have taken the North American phenomenological approach to explore individuals’ lived experiences and in my own study, I have deviated from the traditional phenomenological movement towards this "new" version.

In the traditional phenomenological approaches, the inquiry into what it is to be human is explored, the realities of everyday human experiences, the “being in the world” of human beings (van Manen, 1990), trying to see what sort of beings we are and how we fit in the world (Dreyfus, 1992).
In the North American approach, phenomenology is concerned with "the inner and experiential aspects of human behaviour" (i.e. how people define events or reality in relation to their beliefs) (Chenitz & Swanson, 1986 cited in Wilkes, 1991, p.241). That is, trying to find the meaning life events hold for the individual (Allen & Jensen, 1990).

Phenomenology may be used in situations in which one encounters meanings that are not immediately understandable and require interpretive effort (Allen & Jensen, 1990). This interpretation is a process which evolves, by studying and revising, correcting and refining the person's experience. This is a similar point of view shared by van Manen (1990) who suggested that "(phenomenological) 'facts' of lived experience are always already meaningfully (hermeneutically) experienced and because these 'facts' are captured in language, this is an interpretive process" (p. 181).

Phenomenology, then, attempts to go beyond superficial structures in order to examine the realities of human everyday experiences, and to describe the meaning that these experiences have for the people that are involved.

3.2 Nursing and Phenomenology

Heideggerian hermeneutics phenomenology offers nurse researchers an opportunity to understand the lived world of the human beings under their care. Their lived world is full of richness and complexities as they live their everyday lives (Leonard, 1989).

The patient's perspective, "their reality", is seen as very important by many nurse theorists (e.g. Leininger, 1976; Parse, 1981; Paterson & Zderad, 1976 cited in Cohen, 1987) in being central to the suitable care of that person.
Therefore, the study of a person who is ill and their experiences, may increase nursing knowledge of clients and their care. This is acknowledged also by Allen and Jenson (1990), who claimed that knowledge will be gained about a person’s responses to their life events and give us an insight into why these responses exist. They go on to suggest that, therefore, “hermeneutics is a relevant approach to the understanding of human beings and the meaning they attach to life events (p. 252).

Ray (1985) suggested that phenomenology reveals to the nurse qualities of an individual’s existence, in fact that it may increase “…knowledge of the significance and meaning of human experience” (p.94), ensuring a more comprehensive understanding of the nature of nursing. Swanson-Kauffman (1986, p.59), stated that nurses are in the business “of understanding and caring for humans”. Therefore, the comprehension of human behaviour would be fundamental to nurses looking after their clients, throughout illness and recovery periods.

3.3 Research Questions in Phenomenological Inquiry

Van Manen (1990) described what phenomenological inquiry intends to achieve. Phenomenological inquiry attempts to explicate meanings as we live them in our everyday existence, by being self-critical and studying the intersubjective nature of human beings. It focuses on people’s descriptions of their world, looking at their experiences (Patton, 1990), and is targeted towards understanding the lived experiences and meaning connected to human events and processes (Wilson, 1989, p.490).

In developing research questions Omery, (1983 cited in Burns & Grove, 1993) suggested that two questions need to be considered; (1). What constituents make up this feeling or experience? (2). What does this feeling or experience indicate about the nature of a human being?
3.4 Phenomenological Methodology

In phenomenology, there are no clearly defined steps to undertake in the methodology. Burns and Grove, 1993 suggested this is because it might limit the creativity of the researcher, or because phenomenologists tend not to place importance on the time or sequencing of events.

Burns and Grove go on to suggest certain attitudes by the researcher are needed in the methodology, however, such as the researcher needs to be aware that to understand a person’s lived experience, the researcher needs to interpret the explanation given by the person who has already self-interpreted their own experience.

In phenomenology, the methodology is considered to be an interpretive type, which is about generating meaning - “trying to explain and describe, in order to make sense out of things of interest” (Roberts & Taylor, 1998, p.102). The methodology should be chosen depending on the question you are trying to answer (Roberts & Taylor, 1998, p.223).

The method for research which is chosen helps to guide and uncover the nature of the phenomenon of interest. Roberts and Taylor suggested that the method for phenomenology can be derived from a number of sources such as Speigelberg (1976); van Kaam’s method (1959); Giorgi’s method (1975); Colaizzi (1978) and van Manen (1990). This was also described in Burns and Grove (1993) who suggested that adaptations of the above sources can help a researcher with analysis of their data.
3.4.1 Assumptions

As with most philosophical perspectives, phenomenology makes certain assumptions or conjectures about the world and the nature of reality and these should be identified if phenomenology is to be used. Oiler (1982) clearly classifies the subject matter of these assumptions. Generally these assumptions concern the nature of phenomena, reality and truth.

Phenomena can be considered to be "... objects and events as they appear" (Oiler, 1982, p.178). It is assumed that a world does exist and the importance attached to objects and events within the world only as these objects and events manifest themselves to individuals.

Reality is assumed to be "subjective and perspectival ... a matter of appearances" (Oiler, 1982, p.178). This means that no reality can be considered that is devoid of human involvement. Reality may thus only be considered real in the presence of human experience of that reality.

Truth is determined to be "... a composite of realities" (Oiler, 1982, p.179). This again involves the subjective understanding of individuals: individuals creating what is real by their experience and interpretation of phenomena. The data gathered from phenomenological research allows the researcher to be a part of the subject's reality.

3.4.2. Bracketing

Knaack (1984), suggested that for any qualitative study, the bracketing technique utilised by the researcher should be clarified and its effectiveness and use expoused. Bracketing occurs when the researcher attempts to
identify, acknowledge and then suspend assumptions and preconceptions that the he / she holds about the subject. Spiegelberg (1982), suggested that it is quite impossible to explain this technique, and that Husserl’s intentions in bracketing were not that a pretence be made of forgetting “a priori” knowledge, but that this knowledge would be identified and held in consciousness. By holding of “a priori” knowledge before the mind’s eye, the researcher would be more confident that the lived experience as related by the participants was interpreted with a minimum of bias, and prevent this knowledge from influencing the phenomena under scrutiny. As Oliver (1982, p. 180) suggested, this technique allows the researcher to be prepared “…to see rather than think about a phenomenon”.

3.4.3. Data Collection

Different strategies for collecting data have been identified, and a combination of these can be used (Burns & Groves, 1993) as listed below:

(1) Ask participants to describe their experiences of the phenomena being studied. The data would be verbal and collected in a relaxed atmosphere, allowing enough time for facilitation of the description by the subject.

(2) Ask participants to write their experiences down.

(3) Observation of participants during the experience, recording verbal and non-verbal behaviour, the environment and the researcher’s own responses to the situation.

After the research questions are identified, an interaction involving both the researcher and the participant begins. This interaction comprises of discussion of descriptions and reflection on experiences by the participants (Bergum, 1991). The researcher is involved in these experiences by
interacting and conversing with the participant, not acting only as an observer. The participant may be seen as a 'co-researcher' in the experience.

3.4.4 Data Management

An operational framework for phenomenological research that was outlined by Spiegelberg (1982) was used for data management in the current study:

Firstly, the researcher must identify and bracket “a priori” knowledge. Secondly, the intuition step, is accomplished, looking at the experience with anticipation, wonder and concentration, being absorbed by it. The third step in this process is analysis. This involves the identification of themes, their relationship to each other and the interpretation of the essential structure of their meaning. The final step is the actual describing the findings, what has been revealed by the analysis (Oiler, 1982).

The steps above have been described in a linear fashion, but the delineated steps do actually overlap and encompass each other. For example, the initial bracketing step, does not end when the intuiting begins. Bracketing must be done before intuiting and maintained throughout.

3.4.5 Data Analysis

While the steps described above formed a macroscopic framework for my study, Colaizzi’s (1978) method of data analysis was incorporated within Spiegelberg’s process (1982), and the following is a summary of his steps for phenomenological analysis.

Firstly, the participants’ descriptions are read to obtain a feel for them. Then significant statements, phrases and sentences are extracted that relate to the phenomena being investigated. Thirdly, meanings are then formulated from
these significant statements. These meanings are then organised into clusters of themes. After this, a thorough and exhaustive description of the phenomenon is reported. Lastly, a return to the individual participants with this description is employed, to confirm and validate the interpretations.

Similar phenomenological analysis has been discussed by Douglass and Moustakas (1984) and Moustakas (1990) (both cited in Patton, 1990). Moustakas suggested that the analytical vocabulary of phenomenological analysis can be alienating, until one gains an "holistic perspective".

Van Manen (1990) turns to the nature of the lived experience, and investigates and reflects on essential themes that characterise the phenomenon and balances the context of the research by considering the parts and the whole together.

Phenomenology has many complex concepts that make this approach to research a challenging and educative process. The methodology can be multivariated, so when considering a theoretical perspective, an understanding of the origins and purpose of phenomenology is necessary. The methods used in phenomenological inquiry may vary, as suggested by Roberts and Taylor (1998) according to the kinds of theoretical assumptions on which they were based. Assumptions which underline this type of research also need to explored and examined prior to undertaking phenomenological inquiry, so as to open oneself to the reality of the world and the phenomena in question.

3.5 Limitations and Strengths of Phenomenological Inquiry

As suggested by Sandelowski (1986), there are areas of concern in undertaking interpretive reflections. Firstly, there is the notion of credibility - is the researcher's interpretation similar to the subject's interpretation? Secondly, there is the idea of fittingness - can other readers, not only the
subjects, understand the findings, and find relevance for their own experiences? Thirdly, there is the issue of audibility - does the researcher give enough detail concerning analysis and other decisions involved in the study so that another researcher can follow and judge the decisions made? Lastly, there is the question of confirmability - is the researcher aware of his / her own biases which may have influenced the findings? The above areas of concern are also listed by Roberts and Taylor (1998), who suggested that these issues are useful in determining rigour in qualitative research.

Burns and Grove (1993) suggested that rigour in qualitative research needs to have an association with openness and scrupulous adherence to a philosophical perspective, being thorough in data collecting, and considering all the data subjectively. They also argued that the researcher needs to be willing to let go of old ideas (deconstructing) to be open to new ideas, and to examine the many dimensions to formulate new ideas (reconstructing). But, as Roberts and Taylor (1998) point out, these concepts of reconstructing and deconstructing do not actually give steps in how to obtain rigour, they give potential researchers an idea of what constitutes the exploratory and open nature of qualitative research.

Lynch-Sauer gives examples of criticisms of phenomenological methodology by Barritt, Beekman, Blecker and Mulderij (1982, cited in Lynch-Sauer, 1985). These include the problem of replication, and the difficulty of attending to this in a descriptive study of experience. Barritt et al., also believe that a phenomenological study is too subjective, and that researcher bias interferes with clean results. They also argue that the language of phenomenological research is too vague, and no procedural guidelines for conducting phenomenological research have been devised. Further they claim that the phenomenological method is ahistorical, frequently based on the memory of the informant.
Hinds, Scandrett - Hibdon and McAulay (1990) are of the opinion that qualitative research findings which have not been replicated or critically reviewed may be accepted prematurely and used in the clinical area. As Miles and Huberman (1984, cited in Hinds et al., 1990) eloquently stated, “qualitative research findings can be evocative, illuminating, masterful and wrong”.

Strengths of phenomenology include the view that, as we research possible meaning in structures of our lived experiences, we come to a fuller grasp of what it means to live in the world as, in my study, an older woman recovering from a heart attack. Hermeneutic phenomenological research is a search for the fullness of living, for the ways a woman possibly can experience the world as a woman, for what it is to be a woman (van Manen, 1990).

The holistic nature of phenomenology is seen as one of its major strengths, allowing a degree of insight into the phenomenon studied which quantitative methods may lack (Bassett, 1994).

Kretlow (1990), believes that the nurses’ role of advocacy can be seen in a much broader sense of being an advocate of the patient’s right “to gain meaning from an illness” (p. 10) and this can be achieved by using phenomenological inquiry into illness. She also suggests that phenomenological philosophising can enhance nurses’ personal development and creativity, at the same time improving nursing care.

In conclusion, phenomenology is a means of gaining an insight into the lives of people and a discovery of what a lived experience means to them. Phenomenology, as a qualitative research method, involves subjectivity and
places a high value on human experience and involvement. Philosophical underpinnings contain certain theoretical assumptions, which need to be taken notice of prior to undertaking research of this kind. Knowledge is relative and depends on the people, place, time and other circumstances of the setting (Roberts & Taylor, 1998).
CHAPTER 4  
METHODOLOGY APPLIED

This chapter is an introduction to my study and the use of phenomenology as the method of choice will be presented. I will be using the North American version of the phenomenological movement. A brief overview of the participants in my study, and how the interviews and conversations with the women were managed, will also be discussed. The data analysis techniques used will then be described and the chapter will conclude with a summary of ethical considerations.

4.1 Introduction to my study

As my study aimed to examine and illustrate the lived experiences of women during their recovery after a heart attack, phenomenology provides the best philosophical basis for achieving the research aims.

The purpose of my study was to address the question, from the perspective of women: What are women’s experiences of recovery after a heart attack and cardiac rehabilitation?

My study analysed qualitative data gained from conversations with six older women who had experienced a heart attack for the first time and had attended cardiac rehabilitation.

4.2 Selection of participants

Participants were recommended by the Nurse Unit Manager (NUM) and the Clinical Nurse Consultant of the out patient cardiac rehabilitation centre at a

Not “falling off the planet”
major Sydney hospital. The NUM obtained permission from women who attended the centre for me to make contact with them and explain the study. Appointments for suitable times were then made with the women who were interested in talking to me. Interviews took place in the participants’ homes and hospital private areas. All the women were English speaking and informed voluntary consent was obtained.

4.3 The Conversations

The conversations were recorded on audio tapes with permission of the women involved. Dialogue took place in the participant’s home or in a interview room in the hospital.

The interviews were more like conversations than interviews, which as Polit and Hungler (1983 cited in Bergum, 1991) suggested implies that one person asks another person questions, instead of a conversation which implies a discussion and involves an interaction.

Each conversation was comprised of three stages. Firstly, to ensure that the participants were freely willing to participate, they were given an explanation of what was required of them in writing, an information sheet which detailed the study’s purpose, participation required, the right to cease participation at any time, the intent to use audio tape recorder, and safeguards to protect anonymity. These were also reiterated verbally. Agreement was accepted both verbally and by signing a consent form. (Appendix 4)

Secondly, general questions were asked of the participants to endeavour to build rapport with them so as to decrease anxiety and convey a willingness to listen to them (Wilson, 1989). It also helped provide the participant with knowledge about the researcher, by sharing such personal information as marriage status, family, work experiences, future aspirations. This made the
interview less threatening, and showed that all information would be held in confidence, allowing the participant to be more at ease.

The third part was non-structured. I asked the participant to talk about their experiences of having a heart attack and their recovery, through cardiac rehabilitation. I spoke sparingly, giving encouragement when necessary, and getting back to the topic when it was needed.

4.4 My understanding of Bracketing

As already described in the Methodology chapter (Chapter 3, section 3.4.2), bracketing tends to be considered useful as it can help narrow “one’s attention in such a way as to be able to discover rational principals that underlie the phenomenon of concern” (Roberts & Taylor, 1998, p. 108).

Prior to and during the interviews I attended, and also when listening to the interviews, I suspended or laid aside explanations and any preconceived ideas that were already known of women and heart attacks and recovery. Although I have not shared their experience of heart attack, being a nurse and understanding some of what people may go through during this time meant a conscious effort on my part not to give my viewpoint on the subject. This allowed me to see and hear the data from the perspective of the women interviewed, and allowed me to be alert to the possibility of being influenced by prior knowledge and understanding.

4.5 Overview of data analysis

A combination of methods, using Colaizzi’s (1978) method of data analysis and Spiegelberg’s steps (1982) (as described in Chapter 3, section 3.6.1 & 3.6.2) was incorporated to study and analyse the audio taped interviews and
written transcripts. Also ideas from Riley (1990) were used to help with organisation of the data and trying to immerse myself in the data. The following steps were followed:

1. I transcribed the six audio tapes from the interviews.

2. I listened to the audio tapes whilst they were being transcribed and afterwards to verify that the transcripts were faithful to the audio tapes.

3. Each audio tape was listened to twice to become familiar with insinuated or empathic meanings expressed by the participants, and to be familiar with the participant’s way with language and the tones used in their speech. For example, one of the participants, Mary, was rather cautious and circumspect when talking about how her husband was overprotective of her, affecting her independence. On the day that our conversation took place she felt that he might hear her, as he was in the next room. She seemed ambivalent about the over concern of her family, and this was picked up in her insinuations and things that she did not say, as below.

I've been finished a couple of weeks ago (the rehabilitation program). Only in the last week they, {whisper} I won't mention more as my husband is in the next room. (the rehabilitation team said) Why don't you let her go on her own, just let her go. You know. Anyhow, so he (husband) did.

But they still sort of hover but,... it might take him fifteen minutes to come in. {Laughter}
4. I then reflected upon each participant's audio tape and transcript separately, to ponder over the uniqueness of the description of the participant's experiences. That is, each participant's interview was read a number of times, and each woman's experiences were reflected upon and considered to be unique to that particular woman.

5. The transcript of each interview was re-read and a summary was made at the bottom of each page. A summary helped give an overview of the data. It helped to identify main points and to become familiar with the data. A summary of the whole interview was completed by writing down themes or points in a few phrases (Riley, 1990).

6. Significant statements and phrases were identified from this summary which related to women's experiences of recovery from heart attack.

Meanings were formulated from these significant statements and sub-themes were identified as they emanated from the data. (Refer to Chapter 5, section 5.3 for sub-themes from each interview). The meanings were also compared and contrasted with each other for inter-relatedness. Interrelated sub-themes are discussed as they occur in Chapter 5 (eg. Dependence and Independence interrelates with the sub-theme of Family involvement and Over involvement).

7. Sub-themes which emerged were supported by significant statements and quotes direct from the data. For example, in Mary's interview, a significant statement relating to her recovery involved her family who needed help to adjust to her being better after her heart attack, to be able to "just let her go".

This was placed in the sub-theme of Dependence versus Independence. (Refer to Chapter 5, section 5.3 for sub-themes from each interview).
8. **Major themes** then emerged, after careful consideration, from the individual sub-themes, giving a description of the women's experiences of having a heart attack and recovery. For example, in another of the participant's interview, Anna referred to getting "back into it" and this significant statement was placed under the sub-theme of Surviving, which was then placed under the major theme of Coping (Refer to Chapter 5, section 5.4 concerning major themes from sub-themes).

9. A return to the individual participants with significant statements and sub-themes and major themes was employed, to confirm, clarify and validate the interpretations. This was done by telephone.

The above steps were revisited many times so that an intuiting process might occur - being absorbed by the data, and concentrating on it. The interpretation and meaning generated from this data is my own interpretation and it is limited to the situation studied (ie the six women and their experiences of recovery after a heart attack and cardiac rehabilitation).

### 4.6 Ethical considerations

As already mentioned in the section under “interviews” (section 4.3), participants were asked if they wanted to be involved in the study. They were informed about the study, both verbally and by written information and they could stop the interview at any time. Written details of my name, address and contact numbers were given to the women and they were aware of the intent to use audio tape recorder, and safeguards to protect anonymity. Agreement was accepted both verbally and by signing a consent form. (See appendix 4 for consent form and information sheet).
Confidentiality of the women was protected and respected by the use of pseudonyms. They were able to leave the study at any time, and were assured that there would be no disadvantages or adverse consequences of their actions which would impinge on their future or continued care and treatment by the area health team.

Approval was obtained for the study from the University of Western Sydney, Nepean Human Ethics Review Committee and also the Western Sydney Area Health Service Research Review Committee, to ensure that the methodology and application of these methods were considered ethically sound.

Audio tapes and identifying information used for recording and transcribing will be destroyed after completion of the thesis.
CHAPTER 5
DATA ANALYSIS AND INTERPRETATION

5.1 Introduction

This chapter will explore the data from the interviews and my analysis and interpretation of the data. Firstly, an overview of the participants will be given, followed by an overview of significant statements, sub-themes and major themes. Finally, the main focus of the chapter will be the exploration of each major theme, with data interpretation, supported by the women’s own words.

The analysis of the participant’s interviews revealed a number of themes that were mostly shared by all six participants. The themes which emerged from the women’s interviews are not isolated from one another. They intertwine and overlap. Some of the themes are seen in the literature (see Chapter 2), some are peculiar to the one woman’s experience, and others are experienced by the majority of the women. For example, all six women talked about relationship changes which became a major theme. Only one woman, Winifred, talked about fulfilment and enjoyment in her work which helped her survive during recovery, this was placed under the major theme of Coping.

Four major themes were identified from the data. These were: 1) loss of autonomy, 2) coping, 3) role changes and expectations and 4) changed relationships.

This chapter aims to give the reader an insight into women’s experiences of recovery after a heart attack and cardiac rehabilitation and how these themes emerged.
5.2 Introduction to the Participants

There were six participants in the study. They seemed to be very interested and enthusiastic about participating in the study when I contacted them. I think they wanted to help me as I am a nurse, and they said they had experienced good care from the nurses who had looked after them in hospital. Perhaps this was a way of thanking these nurses and nurses generally. I also think that they talked quite freely to me as I am also a woman and this put them at ease, especially when talking about their husbands and family relationships.

The age range of the women was fifty five to sixty seven, with the majority being in their middle sixties. Five women lived in their own homes, with their husbands and children, some with grandchildren. One woman had been widowed and was living with her brother. They all lived in Western and North Western Sydney during the time of their heart attack and recovery.

Most of the women seemed to have very supportive families who were concerned and interested in their health and well being. I interviewed one woman in a hospital interview room, and the other five women were interviewed in their own home or their relative’s home.

All the participants were born in Australia and spoke and understood English well. The participants had all had a heart attack for the first time and I interviewed them approximately two to six months after. They all attended cardiac rehabilitation within five months of having had their heart attack.

The following is a short introduction to each of the women who participated in the study. Discussion of my interpretation of their experiences are seen in the
different sub-themes and major themes, which follow the women’s stories. To maintain confidentiality, pseudonyms are used.

1st interview: Mary.

Interviewed at: own home.
Age: 65 years
Marital status: married, with three children.
Duration of Conversation: One and a half hours.

Mary was a pleasant woman who lived in Carlingford. Her husband was at home on the day, in the next room. Mary had a heart attack in March, 1993, by-pass surgery in May, and attended cardiac rehabilitation in August, 1993. We had our conversation in September, 1993.

Prior to the interview, and while she was signing the consent form and reading about the study, we exchanged information about our families, about my child and her children, and I talked about the study and why I was interested in this area.

Mary appeared to be slightly nervous, laughing readily during the interview. At times she would lower her voice, in case her husband overheard. She was very willing to talk, although not always on the topic. She appeared distracted and aware of the tape recorder being on at the beginning of the interview, but seemed to relax as we progressed. Her husband interrupted once during the interview to ask if all was well.

After the tape was turned off, we talked a little longer, about her grandchildren and her husband joined us, showing me pictures of their grandchildren and different craft work his wife had made. I talked about my family and also showed pictures of my daughter. The impression I received was that her
husband was concerned that she had talked too long, and had tired herself out.

I contacted Mary by telephone before Christmas and discussed my transcripts and the themes that had emerged from our conversation. I asked whether these themes and statements reflected her feelings at the time of our conversation. She appeared well and did not have anything to add or change to the statements that she already had made.

Interview 2 - Deborah

Interviewed at: hospital interview room.
Age: 63 years
Marital status: married, with two children.
Duration of Conversation: Two hours.

Deborah was a very friendly, talkative woman. She had a heart attack totally "out of the blue" in August, 1993. She was surprised about having been diagnosed as having had a heart attack, because she just woke up in pain, down her arm. She had thought that her husband had rolled onto it, but the pain did not go away and after a few tests at the hospital, she was diagnosed as having had a heart attack. She was surprised and a little shocked, as she thought that people having heart attacks clutch their chests and fall down to the ground.

She commenced cardiac rehabilitation late September, and found it beneficial in many ways. She appeared to be a very motivated woman, who was obviously positive in her outlook and eager to get better. She had a close, supportive husband and family, and she obviously depended on them for encouragement and also worried about them worrying about her.
We had our interview in an interview room at the Hospital, early November, 1993. I think that talking to her in this room allowed her to open up more than if we were at home with her husband being there. She told me that her husband would want to join in the conversation and she could not be as relaxed about her story if he did. She seemed very eager to tell her story and did not mind that we were being recorded. She was relaxed and we related well. She has a daughter at home in her late twenties who is a nurse, and I think this helped her interrelate with me, and also because we were both women, even though there was an age difference. In some ways, I thought of her as a woman of similar age to myself, perhaps because we had similar life views on certain issues, and we just seemed to "click".

At the end of the taped conversation, we talked for some time and she remained very friendly and interested in the research I was conducting. I contacted her two months later, to talk about the statements and themes that had emerged from our conversation, and whether they reflected what we had discussed. She seemed pleased with the result and did not have anything else to add to the conversation.

**Interview 3 - Winifred**

**Interviewed at:** in own home.

**Age:** 63 years.

**Marital status:** married, with two children.

**Duration of Conversation:** One hour 50 minutes.

Winifred was a quiet, reserved woman, who lived with her husband in a large home in Baulkham Hills. Both her children were married and lived away from home, but she saw them quite often. Winifred was rather a nervous and anxious person to interview. During the conversation, she was fidgety,

*Not "falling off the planet"*
looking about the room and rather monosyllabic in her answers. She relaxed
more when the tape recorder was turned off after the "interview".

She had her heart attack in October, 1993 and attended rehabilitation three
weeks after being home from hospital. During our interview, she was
conscious of her husband who was in the next room. Her husband (who was
ten years older than her) had been through a heart attack quite a few years
before. She seemed to want to talk more about his illness and condition (he
had a stroke a few weeks before her heart attack, but had recovered well)
than on her own life and illness.

She also seemed under pressure to make up her mind concerning a by-pass
operation and she was worried about her husband if she was to have this
done. She appeared to want to get the interview over with as soon as
possible.

I contacted her in the new year to clarify some of our conversation, and
discussed the statements and themes that had emerged from our
conversations. She did not have anything to add or change, except that she
was going ahead with the by-pass surgery and seemed more at ease that a
decision had been made concerning this.

**Interview 4 - Anna**

**Interviewed at:** at brother's home.

**Age:** 67 years.

**Marital status:** widowed, with three children.

**Duration of Conversation:** One hour 45 minutes.
Anna was a friendly, approachable woman who had some trouble hearing during the interview, and was wearing a hearing aid. She had been widowed for seven years and had until recently lived with her eldest son. She now lived with her brother in his home at Sutherland.

Anna had a heart attack and a by pass operation in July, 1993 and attended cardiac rehabilitation one month after the operation, in September, 1993. We had our discussion and interview in early January, 1994.

She appeared a little apprehensive at first, but seemed to warm to the discussion as we talked around the subject and about her life and her husband. She was emotional when she talked about her husband, who had died seven years ago. The anniversary of his death was the day before the interview.

She also appeared upset about leaving her son's house over a dispute with her daughter-in-law a couple of weeks ago, and did talk about this at some length. But now she enjoyed living with her brother, sharing his house. Her brother was at home during the interview, and interrupted a few times. I think he was making sure that his sister was comfortable and I was not tiring her out.

At times during the interview, she had trouble focussing on the matter at hand, and did seem tired at the end of our conversation. When the tape was turned off, she proudly showed me her family photos, mainly lots of pictures of her grandchildren.

Later that year I contacted her to see how she was getting on, and discussed the conversation we had had. We discussed the statements and themes that had emerged from our conversation and reflected on this time. She apologised for "going on a bit" and did not have anything to add or change from our conversation.

Not "falling off the planet"
Interview 5 - Janice

Interviewed at: at own home.
Age: 55 years.
Marital status: married, with two children.
Duration of conversation: One hour and 15 minutes.

Janice was a wary, anxious woman, who lived with her husband and children at their home in Rooty Hill. She had one daughter, from her husband’s marriage and one son from her previous marriage, who lived at home. I interviewed her at home, her husband was not well and was sleeping in the bedroom.

Janice had her heart attack in August and a by pass operation in October, 1993, and she attended rehabilitation five weeks after the operation, in November, 1993. Our conversation took place in March, 1994.

Janice and I talked for only a short period. She seemed tired and washed out. She was quite anxious and worried that she kept forgetting what she was talking about and thought that her husband would have given me better answers to my questions. She seemed preoccupied in her thoughts, and felt she could not talk to her husband about things that were happening in her life. She needed constant reassurance, and I felt that she would benefit from talking to the staff back at rehabilitation, whom she felt comfortable with. She agreed that she would possibly benefit from this. She did relax slightly at the end of our taped conversation, and she stated that she was recovering slowly from her heart attack and family problems.

I contacted her towards the end of the year, but found I could not talk to her in much detail. She appeared to be still rather anxious and depressed, but was...
now seeing a doctor that she felt comfortable with and was making some progress. She apologised again for not being able to think clearly for our previous conversation. I think she may have long term problems that are not related directly to her heart attack and recovery from it.

**Interview 6 - Lorraine**

**Interviewed at:** own home.

**Age:** 60 years.

**Family:** married, with one child.

**Duration of Conversation:** One and a half hours.

Lorraine was an interested and amiable woman who lived with her husband and daughter in their home at Castle Hill. She had her heart attack in April, 1994 and then attended cardiac rehabilitation two weeks later. I interviewed her in June, two months after rehabilitation.

She was very friendly and keen to talk to me, even though she did not think she had much to say. She seemed to take her illness as very matter of fact, and was relaxed and did not seem too concerned about her recovery.

At the time, she was worried about her daughter's divorce proceedings and she seemed impatient to be well again, and was quite positive about the present and the future. Her relationship with her family was very strong and important to her. She had support and love from her family and a strong, sympathetic network of friends.

When I contacted her later that year, we discussed our previous conversation and her statements and themes that had emerged. She felt that they reflected how she had been feeling at that time, but now was very much

Not “falling off the planet”
recovered, and getting on with her life, planning an overseas vacation with her husband for 1995.

The six women that I interviewed were all pleased to take part in our discussion, some, as seen, were more interested than others. I was also able to better relate to some more than others. Overall, our conversations were stimulating and broadened my knowledge concerning heart attack recovery.

The following section explores our conversations in more detail, drawing out inferences from the data, placing them, as seen in the Methodology Applied Chapter (Section 4.5), into significant statements and then, as in the following section, being categorised into sub-themes and then major themes.
**Table 5.1** below, sets out the *major themes* that were developed from the *sub-themes*.

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5.3 Sub Themes from each interview:

Sub-themes were drawn from the data and significant statements and phrases were identified from the data, relating to the women and their recovery experience. My own interpretation of how significant statements emerged from the data into a certain theme took place over a number of months. The meaning attributed to the participants’ statements involved being immersed in their data and deciding which significant statements belonged to which sub-theme and then deciding under which major theme the sub-theme belonged.

For example, Lorraine, (Interview 6), talked about her own positive attitude towards recovery, wanting to “get better and get on with it” and “not going to look back, ... think about the future”. This, I felt, belonged in the sub-theme \textit{Strengths / Attitudes}, as it concerned being positive and thinking about the future, and not giving up, which then seemed to belong to the major theme \textit{- Coping}. This was one way that Lorraine coped with her illness and recovery, to get on with life and not dwell on the past.

This attitude of being positive and getting on with life was also seen in Deborah (Interview 2), “\textit{I just thought to myself well, you’ve had it girl, nothing you can do about it, now go and get yourself better ... that wasn’t going to be it.”

A list of significant statements and how they were allocated into different sub-themes are given in \textbf{Appendix 1}. Each participant’s significant statements are given from their interview and then the allocated to a sub-theme for each individual significant statement is given. The sub-themes were contrasted and compared for interrelatedness. For example, under the sub-theme of “\textit{Dependence and Independence}”, Deborah talks about her independence being compromised, after she was temporarily blinded in one eye, making her

\textit{Not “falling off the planet”}
feel vulnerable about going out of the house by herself and affecting her independence. This also relates to the sub-theme of “Being Unwell” as this explores physical restrictions and limitations.

5.4 Major themes

The major themes emerged after careful deliberation concerning individual sub-themes and what best summed up the participant’s experiences. The relationship of the sub-themes to the major themes involved looking at the participants as a whole (ie which sub-theme re-occurred and was common in each interview and seemed to sum up the womens’ experiences as a whole).

Sub-themes were then placed under the heading of a major theme. For example, a sub-theme of being unwell, - limitations, restrictions, or being confined emerged in each interview and this was placed under the major theme of Loss of Autonomy.

Please refer to the list of sub-themes allocated to major themes from each interview in Appendix 2. In this appendix, some interviews had more sub-themes than others and similar sub-themes in the interviews are allocated to the same major theme. For example, in Anna’s list, the sub-theme of Thinking of others / concern for others and the sub-theme Family involvement / over involvement are both placed under the major theme of Changed Relationships.

Also refer to Appendix 3, which is a list of the sub-themes from significant statements with the allocated major theme alongside each statement. This list is a combined sub-theme list from all the interviews, allocated to all the major themes.
5.5 Themes explored and examined:

Each major theme, which was developed from the set of sub themes, will now be explored in more detail, with supportive data from each woman's interview, as appropriate.

Major theme:

5.5.1. Loss of autonomy

incorporating the sub-themes of:

1a. Being unwell - Restrictions and Limitations
1b. Dependence & Independence
1c. Loss of control
1d. Loss of self

The first major theme to be examined is *Loss of Autonomy*. The first relevant sub-theme of this theme is *being unwell*, having physical signs and symptoms of the illness and how this placed restrictions and limitations on the women. This was experienced in some degree by all of the participants, and appeared to be important to all women, as it affected their own view of their recovery and how expedient that recovery would be depended upon how they accepted the restrictions placed upon them.

Sub-theme:

1a. Being unwell - Restrictions and Limitations

The women in this study referred to being unwell and having restrictions and limitations placed upon them, affecting their life style and taking away the ability to act as before, to be as free as before, limiting their choice of options and losing some control of their lives. This led to a confinement of their lifestyle, keeping them to within certain limits. Because of losing some of the...
ability of their bodies to act as they had before, the women reflected on their life and the possibility of death.

Mary in particular focused on the physical limitations of her life style, which occurred after her heart attack. These symptoms of her confined lifestyle led her to question whether life was worth continuing in her present state.

*I could not walk or climb stairs... I was gasping for breath... I felt I was going to pass out... I didn't have very much longer the way I was.*

... *I thought about the way I was, ... and I thought, perhaps it is time to go.*

*I couldn't talk for longer than five minutes, I couldn't walk. I was really sure that they sent me home to die in other words.*

When asked to describe their heart attacks, Deborah talked about the pain and body sensations which did not fit her idea of a heart attack, and not knowing what was happening to her body and not believing she had suffered a heart attack. It restricted her physically for some time.

... *I started to get some pain across my chest, ... I thought it was indigestion. ... it wouldn't go away that day and I felt nauseous with it as well.*

... *I was still in a lot of pain, unable to move much and feeling sick. The pain by this stage also went down my arm and shoulders too...*
Lorraine did not believe that she had suffered a heart attack at first, thinking her symptoms not important enough to warrant this label of "heart attack" and the general connotations associated with it. It particularly affected Lorraine's social life, which was important to her.

... I couldn't believe it. I had been perfectly OK that morning and now I was told I was sick with a heart attack. I didn't think that it was that serious. You know, when people talk about having heart attacks I always see them going unconscious and not being able to talk or anything. I didn't think I was that bad.

Winifred was gardening at the time of her attack and she went and layed down, believing she had done too much gardening at the time. Her husband had a stroke five weeks previously, so she was doing the heavier gardening that he used to do. She did not consider that it was a heart attack, it was an acute attack and limited her for only a short time compared to the others.

... I said to my husband, I feel a bit funny and I will lay down for a while ... but then I started vomiting with diarrhoea - the whole works and then it hit me in the chest and down my arms again. This went on for about 3 hours.

Janice appeared to have many limitations and restrictions placed on her through her heart attack and subsequent by pass operation. She also found it difficult to believe that what had occurred to her was a heart attack, and she appeared to have lacked sufficient information concerning her illness and operation. This in itself made her feel insecure and limited her understanding of her recovery.
...I had been very breathless, not being able to walk around as well as I used to. In fact, I got more breathless as I walked around. ... I had a terrible ache down my right side of my body, and I felt nauseous as well.

...just didn't believe it. It was all too sudden and quick. This wasn't what I had heard about heart attacks, you know, I didn't feel sick enough.

Janice also seemed to be under pressure when talking to me, wanting to feel that she was helping me, and getting the story right. She also felt that her mind was not working as well as it should, limiting her expression and ability to speak clearly and wondering if she was being understood, restricting her conversation and communication.

... but my brain doesn't seem to want to work these days...Well, I had got to the stage where I was at the end of my tether. And the depression had got to me.

...Oh, I just wish I could reply a lot better. ... oh, dear me, I have forgotten what I was going to say.

Janice seemed concerned over her own abilities and her ability to cope. She lacked confidence in her own version of events, making her conversation at times strained and disjointed. She appeared to be ill at ease concerning her inability to 'help' me with the facts, and this in itself, limited her ability to express her real concerns.

... I'm not going to be very clear for you, I'm afraid. If my husband was well enough for you, he could be much better on the details than I am... I'm not helping you.
...where was I. This is not helping you. I should have my husband here to give you the answers.

Anna’s heart attack was quite sudden, and it happened while out with a friend. She didn’t want to worry about it while there with her friend, and waited until the next day to see the doctor, even though she was in pain and discomfort for some time. She was an energetic and active woman, used to her own independence and running her own life.

...... When I came back (from rehabilitation) my son asked me how I went and I said I was terrific - I can do the vacuuming. But they wouldn't let me touch anything. And I said the only thing I can’t do is house maintenance, ....... I felt really good.

...I was very energetic and I used to do things pretty fast and liked to get things in order.

... you know, um, I don't like sitting around doing nothing, and maybe I felt a little like, well, it (the housework) is something I had always done, and I felt able to do it, and probably could do it faster than they would. {Laughter}.

Anna seemed to want permission to do things and wanted reassurance that she could go ahead and get on with her life, which included the housework she had always done, which, I think, made her feel useful and part of the family. She might have felt obliged to her son and daughter-in-law for being able to live with them, their relationship was strained at the time, and she wanted to be seen as a needed and valued member of the family. She was frustrated by limitations placed on her by her family and rehabilitation.
...I felt I could go home and they told me what I could do and couldn't do - the same as the family - nothing actually. That was very frustrating...

...I just take one day at a time. Slowing down the pace to what I used to do.

Under the sub-theme of being unwell - restrictions & limitations, the women talked about how their lives had been interrupted by their heart attacks, and how this interruption involved restricting their previous lifestyle in some degree. This restriction of being unwell resulted in physical limitations such as pain, respiratory problems, and psychological limitations such as anxiety, depression, lack of confidence and frustration. For any illness, being unwell and having restrictions and limitations could be considered as part of the recovery process.

Sub-theme:
1b. Dependence & independence
As mentioned previously, independence and dependence are entwined with autonomy and restrictions on lifestyle, but perhaps dependence and independence have a different focus. Dependence and independence involve families and other support people and their reactions to the person's illness, how they cope with that illness. Under this sub-theme, I explored what helped make the women feel more independent and what contributed to their feelings of dependence.

Mary suggested that rehabilitation gave her more confidence and helped increase her feeling of independence and her family also was helped by realising that she was capable of some degree of freedom whilst recuperating from her heart attack. She appeared ambivalent about her family's attention
and over involvement in her recovery process, and this frustration of wanting to be relatively free to do what she wanted versus her feelings of being over cared for made her feel relatively trapped.

(After rehabilitation)... more positive, I feel more confident. I don't worry about things so very much. Well, I don't worry about them at all, actually.

(The rehabilitation) program has helped them (the family) handle it all a lot better. It has helped them very much. By helping them, it has helped me. Because they wouldn't let go of me.

I've been finished a couple of weeks ago (the rehabilitation program). Only in the last week they, {whisper} I won't mention more as my husband is in the next room. Why don't you let her go on her own, just let her go. You know. Anyhow, so he did. But they still sort of hover but,... it might take him fifteen minutes to come in. {Laughter}

While discussing going home after hospital, Mary began to realise how her life was to be changed and how her independence was impeded. She felt some remorse, but accepted the change with her family's help.

The first thing that hit me, you know, was that I realised that I had to take this medication for the rest of my life. Whereas I've never been a

person to take drugs... my son, sets out the containers for me, he likes to do that.

Not “falling off the planet”
Although she accepted the family's help and concern and interest, Mary still considered herself to be independent and relatively free to make up her own mind.

...I'm rather an independent woman, not under my husband's thumb.

A body sensation, which affected Deborah, was going blind in one eye for a short length of time. A clot had gone to her retina. This was something that scared her more than having the heart attack. Although this can also be seen as "being unwell" as it is a physical restriction, it affected her independence more as being blind made her worry about going out by herself after she was better, as she was scared it might happen again, making her feel less secure and vulnerable.

"Well, I've gone blind in one eye. ..... actually it was more scary than the heart attack. It really was."

"And I wouldn't go into the shopping centre on my own in case I had another heart attack or had another clot."

When asked how she felt about all the tests that she went through and taking medication, Deborah thought that she had lost some independence, but accepted that there was no other choice.

I think you feel that you have lost a bit of your independence, but again you accept it or I did 'cause ...well it's either that or fall off the planet - not much choice is there.
... so that's the way I have to go. I've had medicine for quite a while now because of my heart ..., it becomes part of your routine... You don't even think about it.

Lorraine also felt that her independence had been compromised, but accepted it to some extent so as to recover faster.

...I didn't like it (not being able to do all the things she had done previously) but I had to be realistic. I knew deep down they (family) could cope with everything but ...I still was ... overseeing the work, so that made me feel better

...And I had to tell myself to slow down and take it easy, so I would be back on my feet faster.

Under the sub-theme of dependence and independence, some of the women experienced the frustration of having families interfere with their recovery process to the extent of feeling dependent on them. Other women talked of becoming more confident after rehabilitation and accepting that for recovery to occur, their independence was compromised somewhat.

Sub-theme:

1c. Loss of control

Two of the women talked about their sense of losing control, and how this affected their sense of being able to look after themselves and have a say in their recovery process.

Winifred, as discussed previously, started to have pains and became physically unwell while gardening. She seemed to lose control over the situation, both physically and emotionally and was embarrassed over this and how she needed the help of her family to correct the situation.
......but then I started vomiting with diarrhoea - the whole works and then it hit me in the chest and down my arms again. This went on for about 3 hours.

...... I was worried because I lost complete control of myself. He rang my daughter-in-law who cleaned me up and got the ambulance.

...It was the vomiting that I could not put up with and the diarrhoea - everything at once.

Mary, after the heart attack, seemed to be being patronised and perhaps did not feel in control of her own health. She felt that there was a limit as to what the doctors could do, and believed it was out of her control.

... the doctors patted me on the head and sent me home, oh dear, that was it... Too risky to do anything about the damage as I have got 15% heart function, which isn't very much.

...that my heart was so badly damaged I would never make it back home again (from the hospital).

Mary and Winifred talked about being ill and the concept of losing control, not having the ability to look after and cope with the physical and emotional side of being unwell. This theme connects to the next, losing the sense of self.
Sub-theme:

1d. Loss of self

Only one women talked about this issue of being made to feel something she was not, not being seen for what she felt she really was and not feeling strong enough to change it.

Mary was made to consider her age, and to see herself as an old woman. This loss of who she was in her own eyes, (ie. not an old woman), could be seen as a loss of her own self.

...an elderly woman of 65 - well, I was so mad because I don't think old and I don't act old.

Mary talked about changing doctors, and she had a realisation of her condition. Because of losing some of the ability of her body to act as it had before, she seemed to reflect on her life and the restrictions she had to live with. She was quite ready to accept by-pass surgery to improve her condition.

She was told to focus on her physical limitations and to abide by rules and regulations, so as to get well. She seemed to want to be told things she could do, not only focus on the negatives.

I came out of the hospital, you know, and I was told to take it easy; don't walk up hills, don't drive the car. I was told all the negative things.

This feeling of negativity restricted Mary in her recovery period, which is a manifestation of all the sub-themes under the major theme of loss of autonomy.

Not “falling off the planet”
To summarise, the inability of interested parties, be they health professionals, family, or friends, to allow the person to make decisions for themselves regarding their own health and recovery, could make that person feel vulnerable and unable to take care of themselves. This could affect the degree of how they cope with this period of their life and whether they should have an active part in getting better and preventing further problems from occurring.

**Major theme:**

**5.5.2. Coping**

incorporating the **sub-themes** of:

2a. Support
2b. Surviving
2c. Acceptance
2d. Strength / Attitudes

Coping is seen as something desirable and necessary in our day to day lives. It has also been seen as “practical reasoning about present situations in terms of concrete past experiences,” (Benner, et al., 1994). The women in this study talked about what helped them cope with their recovery from having a heart attack and how they were not alone in this coping.

**Sub-theme:**

2a. Support

Most of the women had very good support systems. Most had caring and helpful families, who involved themselves with their rehabilitation and this obvious support helped the women to cope with their illness and recovery period, allowing them to concentrate on getting better quicker. They all spoke
highly of cardiac rehabilitation and how this was a source of great support to them.

Lorraine seemed to be a very positive woman, who coped with her illness by thinking about all the things she had been missing, and by having the support of family and friends around her. She felt she had something to live for, and did not believe in playing the sick role, she felt too well for that.

*I am not a sickly type of woman. I thought, well, I haven't got time for this.*

*...So, I know it takes time to get better and stronger, but I'll get there.*

*...I think myself lucky as I have a lot of friends from a pottery club I joined years back, and we see each other regularly.*

*...taking up your hobbies again... we get together once a week and talk about our lives, and discuss things, support each other*

She compared herself to others, and felt that she was fortunate in having family and friends that she could rely on. This, and cardiac rehabilitation, helped her recovery process enormously.

*(cardiac rehabilitation) also helped my husband as well. You know, just spending some time every week on building myself up and listening to others having the same feelings helped a lot. He got to know things that I had to change or improve.*

*I knew it (cardiac rehabilitation) was to help me get my strength back, through exercise and to get myself back on my feet. Also, it was to help educate me on my lifestyle and to help my husband understand about what had happened also.*

Not “falling off the planet”
Also having benefited from attending rehabilitation, Winifred was more confident in her approach to daily living activities. Her husband’s support and example of his determination to get better after his illness helped her to go through her recovery process. Her sons also helped and supported both parents about which she seemed to be pragmatic. Her neighbours, whom she had known for many years, were also very important to her and helped support and occupy her during her recovery.

...I think it (rehabilitation) gives you confidence to do things, it makes you understand your body a lot better. ... I think it gives you the confidence to come down and do more.

... I think it is sheer determination, and he (her husband) has set the example for me. ... My son and grandson come around and help with the lawns and whatever we want done. At the moment we are managing between us. We just take it in our stride.

We (women neighbours) still get together and are supportive. The Farmers crowd, we have lunch once a month and the Mothers club crowd we are in contact by phone if we don’t see each other, or we have a cup day lunch, a Melbourne Cup day lunch.

Janice, out of all the women interviewed, seemed to have the most difficulty in coping with her life at that time. She was under a lot of stress from being physically unwell, and other family problems that she did not want to elaborate on during our conversation.
...I just found it difficult to cope with the whole ... operation and... after the operation, I was on anti-depressants.

...Oh, a terrible lot has happened in the last few months or year... I don't want to go into it... I was at the end of my tether. And the depression had got to me so...(attended rehabilitation).

I had the impression that her husband was not very sympathetic to her depression period. She appeared under pressure, seemingly from herself, to cope with her life again. She felt that cardiac rehabilitation helped her in many ways to cope and get on with her life, but did not want to be reminded how frail she was to begin with.

... I wanted to build myself up... get my health back. I suppose it also made me less worried and anxious about things.

... I thought about death a lot,... well, I should not have worried so and got back on my feet, because I have seen so many people who have had this operation and are back on their feet,...

......I think it (rehabilitation) is a marvellous idea... although during the course ... I just didn't want to be reminded of my frailties.

Anna appeared to cope well with the operation and rehabilitation. She found the group work, support and being able to share her experiences with others paramount to her recovery.

...(the rehabilitation program) helps you to come to terms with everything and they gave you an exercise program so that you could find out what it was like. So that they actually didn't dump you.
...there was a couple of people who had by-passes. And I used to get this funny little pain here {indicates chest} a flutter and I was getting a bit worried but everyone else had had it. I was also concerned about the different ways I felt and how I was, they {the other group members} and I had the same - and were alright.

I felt that she was perhaps rather lonely, and enjoyed the company of others her own age. She had a lot of support from her family, but she appeared to need the rehabilitation program to help focus her and to make her realise that she could cope.

... I realised you are not on your own. The last day I went they asked are you worried about anything in particular, we are only on the end of the phone.

... the zipper club we were called. They all had a heart attack and... it made you feel like one of a group... didn't make you feel left out. But you weren't pressured into anything.

......I thought it (rehabilitation) was fantastic, and as I said to the staff, they should make people come to do the program...The first two weeks after (rehabilitation) I was lost. It was a set thing. The staff were all very nice and they all knew their stuff.

As the above suggests, support for the women was crucial in their recovery period. Support in the form of cardiac rehabilitation programs seemed to benefit the women enormously, allowing them to take some responsibility for their own recovery time frame. Having their families become involved in the rehabilitation, as well as keeping up with friends and company also featured strongly in their idea of support, increasing the likelihood of a complete recovery being made.

Not “falling off the planet”
2b. Surviving

The survival instinct seemed prominent in most of the women interviewed. The background history of these women, such as growing up to survive, to be patient and not to complain, seemed to be an important component of the resilience that was part of the womens' make-up.

Anna showed that she was independent in a lot of ways, for example, when she was thinking of others, she wanted to get back on her feet so that she was not a burden to others. She talked about her past, and how she grew up quickly, needing to survive.

......You see, my mum died when I was four and my brother was only eleven months old, and my grandmother reared him and me. We had to get up and help around the house ... made me independent and ready to work if things need to get done. I left school early and worked until I got married. You didn't complain, you just did it...... to, um, survive, we didn't think about what we wanted to become, you just pitched in and helped out.

...You aren't the only patient they have. You can lie there and complain, but you have to get back into it.

Mary wanted to show her capabilities which she thought would also help with her survival, making her become more independent. She took up new interests to become active and interested again in her everyday life.
I think that keeping an interest in things... being active... it is fascinating. I also have books on studying the bible, also I am doing the history of mathematics,"

... it is absolutely fascinating... taking up new interests

Winifred was able to know her own limitations, especially of her capacity to do the house work, which helped her cope and survive with her heart condition. Her patience in taking time with the chores and household duties seemed to be the right thing to do for her to get her life back on track.

...Sometimes, um, I feel that I am fine and things around the house need doing. But then I'm thinking I will be able to do it eventually. If I do the right things. If I don't exert myself at these early stages, I should be alright because I haven't done a lot of damage to the heart.

Winifred also talked about how being fulfilled in her work helped her in her recovery time. This taking pride in her activities was important, and she felt accomplished attending to them. She liked to be kept busy and enjoyed working for others, (eg. fundraising for the hospital with her husband, and being socially active with friends). She took a lot of pleasure in her housework and gardening, not thinking of it as 'work', but as pleasure.

...And we used to fund raise and go around to the different shopping centres and talk to people. We had a lot of pictures showing the machines (of rehabilitation) and what people would do.

.....Well, I like to keep busy. I can't sit still without doing anything. I've arthritis in my hands - best to keep them active. But rehab has kept me busy as well.
...(housework) is just pleasure, and I like to keep my house clean and tidy. In fact since I've had the heart attack I've cleaned my curtains and windows, you know when I came home I was sitting looking at my dirty windows and curtains, can I start? Well, they said you can do a room at a time. So I have been doing that. And I've managed nearly to finish. I've only one room to go. {laughter}.

Wanting to survive, and believing that recovery is all about surviving, had a beneficial effect on the women mentioned above. Being active and taking an interest in life, doing things that were pleasurable, but also knowing your limitations, helped these women set out their own survival plans, thereby coping with their illness and recovery in a positive way.

Sub-theme:
2c. Acceptance

Acceptance can be described as an alternative way of understanding oneself in relation to one’s own body. It is not a form of resignation or giving in to an illness but can be seen as a positive movement towards coming to terms with living with an illness (Benner, 1994). Two of the women interviewed seemed to accept their condition as perhaps being part of God's plan, and talked about the eventuality of death, perhaps as a consequence of this illness, and an acceptance of this occurring, and not being concerned if it did occur.

Mary accepted her condition and the thought of death in a number of ways. When told of her condition, she talked about her religious faith and how this had been important in how she has coped with her illness and how her body functions had deteriorated during this time. I asked her how she felt about this happening to her.

Not “falling off the planet”
Well, I'm a Christian, and I thought, well, if this has got to be, this has got to be. The world has been made this way for reasons we aren't aware of. I felt that I couldn't do much about it....., perhaps it is my time to go, then I thought, it is not going to be without a fight. {Laughter}

... I started getting a bit despondent a few times, but coming back to my religion and my faith in the Lord and everything they said, I'm leaving it up to you, to the higher powers. And I'm glad about that.

I think I am a survivor. I thought perhaps life does have to go on ... I take things as they come...I learn to cope with things.

This also shows her being light-hearted, and perhaps a little nervous, talking about death. It also shows that perhaps she had accepted the inevitable, but she was not going to stand aside passively, and let fate take the only hand.

Janice thought that her religious beliefs also helped her cope and were important for her to accept that God was involved in her life to some extent, although her religious beliefs needed to be worked upon, when she was better.

... I'm a Christian and... I believe that God has my life in his hands. And he is working things out the way he wants things to be. ... I think what worried me was the pain I would have to go through before the death.. To see if I could cope with it.

Deborah also coped by accepting the restrictions that she went through, that of having to know her own limitations as to her physical capabilities around the home, and accepting that she had to be patient and learn when she had spent her energy.

Not “falling off the planet”
...they (rehabilitation team) said you got to space yourself ... and I know that by 2 o'clock in the afternoon, I'm zonked out and I need a rest.

... but you have got to listen to what your body tells you, which I wasn't doing. And now I can see it and I think well it is just not worth it and I pick up a book or do some embroidery, and don't feel guilty.

Therefore, acceptance in itself seemed to allow the women a freedom of acquiescence, of knowing where you are in a situation and moving on, in their case to recovery in some form or another.

**Sub-theme:**

**2d. Strength & attitudes**

The majority of the women had positive feelings and attitudes concerning their abilities to get over their illness and to get on with life. They showed that they had the strength of their convictions, and proved to themselves and to their families, that they could and would get better.

Lorraine showed a positive attitude to getting back into her life and enjoying it again. Her spouse also was an incentive to get well and increased her interest in getting better.

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......... I just think the faster you pick yourself up and get back into your life again, the better.
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........ I don't like people taking pity on themselves and giving up the fight. You have to get on with it, or you may as well not bother at all and lay down and die. Maybe I am stubborn and impatient. ... I always thought, well, that I wasn't as sick as some people around me at the time.

........ I think being a positive person and just saying to myself, well you have to get better and get on with it. Also, it is my family and knowing that we want to get on with our lives ...that gives me an incentive to carry on and get well and stay well.

........ But I am not going to look back, I think about the future and what is happening now, that is what is important.

Anna also was a realist and quite a positive person. She had seen her husband die with no known sickness, and felt that she had been given another chance to carry on with life so she had better continue with it and be prepared to take the consequences. This was reflected in the way she coped with her family life as well.

...Since when I said to the Doctor - what is the success rate after the operation. He said 99%. So if I was that 1%, why worry, that's it, I didn't worry about it. I'm old enough. I don't worry...I'm fairly easy going. I just got that way now that I don't care.

...I am not over religious but I feel that God gave me this chance and I have to take it, that's it, it's his will and I've always said, - we are not here to ask why, and that's it and ... I thought my husband went just like that, wasn't sick or anything and I got the chance to ,... it must have been given to me for something ...
Deborah showed herself to be willing to fight for her health not to just accept that she was recovering from a heart attack, but to make herself well again. Rehabilitation helped her regain the confidence that she had lost, by helping her be informed and aware of what was happening to her body.

"Well, I guess I just thought to myself well, you've had it girl, nothing you can do about it, now go and get yourself better.

...that wasn't going to be it. {laughter}

Her own positive attitude to life helped her to be less worried and willing to go on with life and to cope with being unwell for a period. Also, she felt that she needed to show others that she was coping. Her own religious beliefs also contributed to her coping.

...just holding everything back because if you cracked up yourself...I never noticed it, ..... I just did it. If you have to do it, you do it.

Let's face it. When you are sick it's up to you what you are going to do about it. You have got your doctor that will co-operate, you have got the nursing staff, if you have got a good family they support you, but really in the long run, it is up to you

.... I think he (husband) coped quite well, ...he's a bit like me I think, I keep a lot to myself, and he shows his concern by getting cross and angry.

...I do have my own (religious) beliefs, yes...has helped...
When asked about women's roles, she talked about how her mother influenced her and how the lack of choice guides you into a specific area, and how you just cope, no matter what.

"I think I learnt it from my mother... My father died when I was 16... and I had to leave school, as did my twin sister and go and get a job, cause there wasn't the support in those days as there is now. ... You went out, you got a job, and you worked. And if you were sick, you worked.

...you grew up very quickly, you had to.

The women interviewed seemed to have had, with the exception of one, a great repository of positive attitude and strength coming from that attitude. Characteristics such as being stubborn, being pragmatic, having strong family involvement and interest helped these women to cope with this period in their lives and to carry on getting well, or accepting their position.

Major Theme:
5.5.3. Role changes and expectations
incorporating the sub-themes of:
3a. Impediment of role
3b. Different roles

Sub-theme:
3a. Impediment of role
Most of the women felt that their role in their family had become restricted and they were prevented from undertaking their rightful place because of their illness. This seemed to bring about feelings of resentment and concern about their inability to act in the role that they had before.

Not "falling off the planet"
Mary’s role in the family had changed after her cardiac event. This is seen especially when talking about the area in which she participated the most (ie. the housework). She considered that the family worked as a team and that she has a partnership with her husband in this area. Even so, during the interview, she discretely, so as not to embarrass her husband, who was in the room next door, suggested that her way of doing the cleaning of the house was better but conceded that the family were trying to help, and she was happy about that.

*I don’t really think that I am working terribly hard. I feel as if I am being useful...They (the family) have it (the housework) under control themselves. They let me do so much and that’s it.*

*.... I think we help each other. It’s a partnership {lowers voice} - I sometimes think, well, I could do this better than him, or that hasn't been cleaned as well as I would have done it, but, you know, they are helping and it’s not that bad! {Laughter.}*  

When asked about her limitations of helping with the housework, Mary did seem somewhat resentful of the fact that her family were taking over some of her activities, which she felt capable of doing. Again, during the interview, she lowered her voice so that her husband would not be able to hear her in the room next door. She felt that her say in the way things are done had been taken away from her.

*Well, at first I thought, I feel well and I can do this. But my husband wanted to help... So I gave in {lowers voice} - although they really can’t cook as well as I can! {laughter}. Sometimes I wish they would let me get on with it, you know, the working out what to make, the*
shopping, and the preparation all by myself. Sometimes I feel a bit claustrophobic, you know - all hemmed in, not being able to move without them wanting to take over.

Deborah perhaps thought her duty laid in not only thinking of herself, but being aware of how her illness affected others and also allowing others to help her. This seemed to be a big problem for her, to accept that she was ill, and to rest and allow others to look out for her and to help her with household duties that she considered to be her domain. These changes of her role in the house were difficult for her to accept.

Well I suppose I've have been doing it (the washing & laundry) for so long, to see him (her husband) hanging up the washing {laughter}... I think I then began to realise what it must have been like for him when he retired, to suddenly not fronting up to the office everyday, taking on the job that he had to do. I will admit that I used to get cross about it.

... and you can't say anything because he is helping me. If he hung the clothes up the wrong way I used to bite my tongue, it's very difficult, as you are so used to doing everything yourself and to have someone come and say, no you can't do that, I'll do it and do it exactly opposite to the way you are doing it. It's hard.

But now I'm learning, he's doing his best and I'm grateful for that because I know that hanging the clothes out I was getting pains doing it, and that was no good.

Winifred felt that her way of doing the housework was different and better than her husband's, and she felt that she was changing her standards of work, making her feel compromised somewhat, although she was not that concerned about it.
... But I do things (the housework) differently than he does, I am rather more particular, you know, a bit fussy.

The role for most of these women had been somewhat stymied after their cardiac event, causing frustration on their part. The taking over of their duties, their work, made them feel they could not complain, because they were being helped. They did not feel comfortable in the sick role, nor in their changed role.

Sub-theme:

3b. Different roles

This follows on from above, with half the women finding themselves in undertaking a changed or different role in the family. This seemed to be accepted as being a generational issue. They accepted their roles as their mothers had before them.

Janice felt quite restricted and impeded in her role as her husband had retired and was at home more than before and this added more strain on Janice as she had to cope with both of their changing circumstances. She states that her role has been taken over, and she is quite despondent about this.

... well, it wasn't too bad at first (not being able to do the housework). But then my husband G was home again after the operation and he wanted to do things. He gets sensitive about doing things.

..., like for instance he would do the cooking. Well, I want to come back and do the cooking, but then, I wasn't well enough.
... I just wanted to carry on and do all the things that I had done before hand, but he said... he had nothing else to do. So, he just went ahead and, um, ... now I have got to get to the stage where, you see he doesn't {whispering} do things very well, he doesn't take the same care as, well, .... it is a very bad point between the two of us.

... {Whispering} What I mean is sometimes he gets to things before I have a chance to do them. I feel he has taken over.

Janice seemed to miss her teaching activities in the local school, and felt that she wanted to get back into this, but did not feel well enough at this time. She compared her illness with others, and felt that she should be back on her feet and coping as other people do. Her relationship with her husband had also changed, and this caused her some distress. She felt unable to talk to her local doctors about her problems and also to her husband, because of the changes in her.

...I did consider myself quite sick, but when I look back, you know, I couldn't have been that bad, looking at some of these people and their operations, I have taken months to get over it, when I could have done it a lot quicker.

...I find that I am even different in my attitude to my husband. Before the operation, I would let him go ahead and let him do what he wants to do, but now I'm sort of um, keeping an eye on him all the time, which is most unusual for me. .... It might be the nerves.

Not “falling off the planet”
We talked about her role as a woman and how this had changed since her heart attack and operation. She appeared frustrated with her life as it was now, and stated that her life had gone downhill, in a holistic sense - physically, mentally, spiritually, socially and emotionally. Her changes may have something to do with her husband's changing circumstances, and she seemed to resent the changes that had occurred.

... My role (as a woman) has completely changed; before August last year I was going ahead, and I was doing all the things you are supposed to do, working, my husband was working, then we both gave up our jobs, and he had to have something to do, and I had to have something to do, ...so, things have changed for the worst ... I have given up a lot and since the operation I really have changed...

... mentally I have gone downhill.... physically I have lost so much weight; ...my spiritual beliefs are something I have to build up again.

... I have got to try and be positive and see the positive side and not share my problems with him. So, I try and carry on and ..., be positive.

Lorraine felt that her work was inside the home, and she believed that it was her domain and responsibility. After the heart attack and rehabilitation, her role changed somewhat, and she had to take on the role of a supervisor more than a worker. She did not particularly enjoy these changes in her domain, but felt she had to be realistic and recover.

.... The house is my area of work and he (husband) lets me run it.
{Laughter}. 

Not “falling off the planet”
... my daughter was home then and she and my husband helped each other to find their way (laughter). I mean, I don’t think either of them had much idea about the way I had run the place. But then again, that was probably my fault, I always said to them, stay out of the kitchen, don’t worry about the washing and vacuuming, that’s my job ... I always felt that that was my work, you know, my responsibility.

... I didn’t like it (not being able to do all the things she had done previously) but I had to be realistic. I knew deep down they (family) could cope with everything but...I still ... oversee the work, so that made me feel better.

... as a housewife, my job, if you like, changed, and I had to accept that I couldn’t do things as I had done them before, you know, just do what I wanted to do and getting on with it. I have had to change my way of doing things, letting some things alone and worrying about the most important things.

Deborah’s role in the household was something she had accepted in the past, even though it seemed to frustrate her, she accepted that was how it had been, and it was too late to change things now. The way that her mother treated her father had been the same, ie being a good housewife and not questioning the rules, she rationalises that it was a generational issue, and she was going along with the ideas of her time, although she has suppressed anger about it.

... either he (her husband) feels inept at it (cooking) or he feels it is womens’ work. Again, he is of my generation.
...it's the Victorian era I call it. You know, dad went out to work and came home and put his feet up and mum placed the meal in front of him, he had that, and got up from the table.

... my mother did it ... I've been out and got home late, which I have on occasions, my husbands been sitting in the lounge chair with (whispered voice) not even the kettle on!

...I've accepted that that is the way it is...(although) it makes me a bit angry ... That is the way it is and there is nothing I can do about it. There is no good lying on the floor and kicking my legs up in the air.

Deborah's intimate relationship with her husband is very important. She feels that they have been through a lot together and even though she has a few close friends, her family and her close relationship with them is pivotal to her life. Perhaps she also feels that her husband has not got any close friends as she has, and is somewhat dependent on her for friendship. This could change and consolidate her role in his life, although she might be ambivalent about it.

...It's been pretty good, we (husband and herself) have grown old together and gone through hard times together,... shared experiences, family matters, and members.

.....Men are different, they don't have the same relationships that women do.

.....I've got, well I had until 12 months ago two friends, my very special friends that I have known for 55 years. We grew up together. One of them died unfortunately last year. But men don't seem to have that. Long lasting friendship.
The changed roles and expectations that the women discussed were centred around their families and, for some of them, it involved their partner’s role also changing. This was due to retirement in two of the cases, thereby having role delineation problems with the wife, whom they were at home with, and whose work they were encroaching upon. Most women talked about the responsibility of being a wife at home, and then having this taken away from them. Also, the women talked about looking after the house and looking after the husband being a generation thing, something that they were brought up to do and believe and hard to change their behaviour in their lifetime.

Major theme:

5.5.4. Changed relationships
incorporating the sub-themes of:
4a. Thinking / concern of others
4b. Family involvement / over involvement
4c. Guilt & anger versus gratitude

Sub-theme:
4a. Thinking of others / concern for others
Most of the women had family support and their families were very close and important to them. Four of the women talked about worrying about their family more than themselves and wanting improvement for the sake of the family unit, not just for themselves. This selflessness on the part of the women perhaps occurred because relationships were more important than just them alone, at this time in their lives.

Dorothy was very close to her family, and she did not want to upset them or cause any change in their lives. She again talked about how the heart attack and recovery was her responsibility and she didn't want to rely on others for
anything. She also did not want her family to worry about her, and she felt that she should be helping them to allay their fears. It was her responsibility to get well and by going to rehabilitation, she was fulfilling this duty.

...I wanted to get back on my feet, I don't like being sick. I don't like being...not exactly a burden, but I don't like relying on other people.

I've got good family but they're married with children of their own ... we're a very close family and I knew that they were worried about me. So I said don't worry, everything will be ok.

Winifred's relationship with her husband was very close and sharing. She referred a lot to his experiences and how these experiences, especially with his heart attack and rehabilitation, had helped her through her recovery time and lessened her worry about rehabilitation. Sharing a similar experience to her husband perhaps gave her a bond with him and an empathy concerning her illness and also his other illness (ie. his stroke). Also, the lack of other close family around her may have drawn her towards her husband more in their time of need.

...because I knew all about it (rehabilitation), because of my husband see.

...he (husband) was concerned, very worried (about her illness). I think he always felt I was the healthy one. But then, I'm ten years younger than him, ... I suppose it was a bit of a concern for him. I am going through now what he went through.

...we share things (the housework). We learnt to share when he was sick... we supported each other.... we share (the cooking).
Even while she was having her heart attack, Winifred was concerned more about her husband's health than her own situation. She also showed her worry about going for a bypass operation, not for herself, but how would her husband cope with her not being there, for him. Having her heart attack made her think more about life and those around her, but, again, her husband's well being seemed more important than her own feelings and needs.

...mostly I felt quite calm about it (the heart attack). My husband had to drag me over to the lounge. I kept saying to him, are you alright? as he was running around clutching his chest.

...Yes, I was more worried about him than myself, because of his stroke, you know. ... I was trying to keep calm inside, and try to keep him calm...

...But I would rather go without it (the by-pass operation) if I could. mainly because {whispering} I am a bit concerned about my husband - he's had the stroke although he has recovered so far, but he can't be operated on again because of his angina so I don't want to give him any more worry to go though at this stage.

Mary's relationship with her husband appeared to be very important and she talked about how she valued their relationship more after her heart attack. This cardiac event had made her think more about her life and family and loved ones and she saw them in a new light.

... I suppose we have always been close. But, sometimes in a marriage you start to get a bit sick of each other and you know, you
start thinking, Oh, dear, will this be always like this. But then something like this happens and you find you have a really good relationship,... so sometimes you can benefit by having... it probably sounds a silly thing to say... from having a heart attack and being very sick. You appreciate more of what you have got.

...I have to get on with life and try to help my family and me... enjoy our time and life together more.

Anna enjoyed having her family around her. She spoke for some time about her grandchildren and family, and also about her late husband. She seemed to want to be better for her family, not for just herself. She didn't seem to want any fuss made of her illness, and that she would get better by herself in time.

...He (local doctor) said "I think you have had a heart attack".
And I said "Well, I'm alright now, don't worry about it!"

...he (the doctor) said to me, well, it's (the by pass operation) up to you, you can't be forced, but he said you're worried about how your family's coping with the heart attack and you're worried about them worrying and they're going to be worried more. He said you could have another one and then you will have a whopper. And that whopper could leave you incapacitated and would you like to put your family through that? And I said no, no. I don't, but I've always have tried to be independent. But you know, he was right. I was more worried about my family and how they were worrying than about me coping.
Janice seemed overwhelmed by the problems she was having with her family, and was more concerned about their welfare than her own. I think she resented all the added stress these problems added to her failing health and seemed trapped in this predicament. Her husband, although supportive, to some degree, seemed also to be unable to help her and didn't seem able to cope himself with the changes that the family were dealing with.

... I was concerned about my family. ... And they were concerned about me. Although, you see, um, I'm, my husband and I - this is our second marriage ...but his daughter decided to leave us just before the operation and go and live with her mother, so I didn't have her there, which was very hurtful. ... It was difficult.

... oh, it's difficult situation; also we've come down to one wage now, well it's a pension; another problem we could do without. (my husband) was very supportive (about rehabilitation). I think because the program was going to be good for me, this will be good for both of us. He came along and jollied me along. I am very blessed to have him. ..... 

Throughout her talk on her relationships, Lorraine showed her concern for others, and did not like to dwell on her own illness and recovery. Her husband seemed to be very upset at her being ill, and she felt a responsibility to allay his fears. Also, her concern about her daughter made her feel that it was a family problem, and that she also suffered when her daughter had problems (ie. divorce).

... I did think about my family and how they would cope, but I knew that they would.
... he (the husband) was more shaken than I was about the whole thing. He doesn't take things in his stride as much as I do. I knew I would get better...Although I have been under a bit of pressure from worrying about our daughter at the moment. ... and because my daughter has suffered, well, we have suffered also.

Lorraine, as seen above, had found that as a result of her heart attack, she had to reassess her priorities in life and felt that her family and friends were more important than she previously thought. She felt that they had helped her with her recovery and felt that because of all she had been through she felt more committed to her relationship with them.

... I have had a lot of time to think about things, since being home... that's something this heart attack has made me do, you know, think about my life and my husband and daughter and family, which is good, I suppose. I think you realise how unimportant certain things in your life are and how important other things.

... you realise how important family is and depending on family and friends to see you through difficult times. I know when I wasn't well, I was lucky to be surrounded by family and friends. ... They (the family) have been very supportive.

...being able to rely on them for help and support. ... think our relationship has become stronger because of it.

The need to reassure and take care of the family around them, seemed to influence the women and how they saw themselves, as women in relation to their families, not as thinking of themselves as individuals with an illness. Their family relationship also seemed to be stronger after the heart attack, for a few of the women, and was also more important after that event.
Sub-theme:

4b. Family Involvement / over-involvement

Again, as previously stated, the women seemed to have loving, caring and involved families, but the majority of the women seemed ambivalent about this care or protection. At times, most women seemed to feel constricted within this involvement, but they could understand the family’s concern. This sub-theme of family involvement / over-involvement ties in with the sub-theme of dependence versus independence, (under the major theme of Loss of Autonomy) as the family’s reaction is involved in both sections. The difference between family involvement / over-involvement and dependence versus independence is that the women are seen as having support and care from their families, not just the feeling of being dependent on them.

Mary’s family was involved and interested in her recovery. She gave the impression that she found their attention rather stifling and not necessary. During the interview, her husband interrupted us to ask if all was well. Her family appeared justifiably concerned, possibly over concerned in her recovery and progress. This did not give Mary very much confidence in her own abilities and actions.

... they were in a panic - they wouldn’t let me out of their sight. If I sneezed they would come running to see if I was alright...If I went into the back yard they would come out and see what I was doing.

... it didn’t give me terribly much confidence in myself because it made me feel, well, they must know something I don’t {Laughter}.
Mary suggested that rehabilitation gave her more confidence and helped increase her feeling of independence and her family also was helped by realising that she was capable of some degree of freedom whilst recuperating from her heart attack. She appeared ambivalent about her family’s attention and over involvement in her recovery process, and this frustration of wanting to be relatively free to do what she wanted, versus her feelings of being over cared for, made her feel relatively trapped.

(After rehabilitation)... more positive, I feel more confident. I don't worry about things so very much. Well, I don't worry about them at all, actually.

(The rehabilitation) . program has helped them (the family) handle it all a lot better. It has helped them very much. By helping them, it has helped me. Because they wouldn't let go of me.

Anna had a lot of support and interest from her family, especially from her eldest son, with whom she was living. At times, their concern seemed to take the form of taking over the decision process for Anna, who was rather unconcerned about her illness and did not seem to worry about making decisions. I think she somehow enjoyed her son taking over the decision making from her, possibly showing that he cared and was concerned.

...and he (doctor) said, yes, definitely that I had blockages and he wanted me to see a surgeon and I said I've got news for you - I'm not seeing a surgeon, and he said oh yes you are.

...Dr J came in and said I needed a bypass and I said, you know, I'd think about it and he said... you need it and need it badly, and he said that there was a vacancy, a cancellation I mean, on the Monday and he would do me then and otherwise I would have to wait for weeks.
So D (son) said well book Mum in, she will have it and I said I'd think about it and he said you'll have it Mum.

Family involvement and over-involvement, therefore, seemed to be a balancing act. The women felt protected and cared for with their family involved in their recovery, but they also needed to be able to have some say in this involvement, and to have ultimate responsibility for their recovery.

Sub-theme:

4c. Guilt & anger versus gratitude

This sub-theme flows on from the last, some women feeling guilty that they could not manage without the involvement of family members taking over their own duties and the women feeling concerned about not being able to do what were their usual duties. This feeling of guilt was tempered with feelings of gratefulness, for the help and care that their family members gave them.

Lorraine started to feel that the family was only trying to help and not wanting to make her feel useless and redundant. She started to talk about the positive things about the situation although she was still ambivalent about it. She felt that if she accepted the situation, it would not be long and things would return to be as they were before.

...But, then I stop and think how lucky I am to have them caring and fussing. Not many have that.

They (the family) are settling down now, much better than they used to be. As I get stronger and more confident I think they will understand that things have changed and that I'm OK again. In the meantime, I will have to be more patient and be happy to take a back seat.
To Deborah, being "fair" to her husband also was very important to her. An element of guilt was evident here, as she talked about being unwell, but not wanting to upset others by being unwell, so they could get on with their lives.

... my husband has retired and I don't think it's fair to him anyway, I don't want to be lying on the bed saying, goodness I feel so sick I can't get out of the bed today.

... and you can't say anything because he is helping me.

Guilt was evident when talking about her husband doing things for her, but, on the other hand, she was grateful for that help. She also felt guilty when resting, remembering her mother's hard work, and feeling guilty for not being able to do it all.

"I used to feel very guilty about it (needing a rest). Because I had not done it before. ....I think women of my age are brought up, my mother was a hard worker...my mother worked from sun up way past...we were just brought up to do it.

...and then my husband would be working and I would be sitting down and I'd think, oh hell, this isn't right.

...but then I found that he would be sitting down with me too. Whether to keep me company or whether he had had enough himself I'm not sure....I didn't feel guilty.

Janice also had a tendency to feel that she should be doing more about the house and feeling that it was hard to get back on her feet again. She concentrated on her negative aspects, which, as seen under the sub-theme
Role Changes and Expectations, was perhaps part of her depressed state. She perhaps did not see herself as unwell or sick, but as being lazy and unable to prevent this from happening.

... *the more I look at it, the more I think I have been lazing around and being a lazy person for too long.* {laughter}.

This sub-theme of guilt and anger versus gratitude that they felt for their families, is incorporated in the overall theme of changed relationships, which all the women to some degree talked about and experienced. This gratefulness to, and involvement of, the family, the concern that the women showed for family members, all contributed to how the relationships in their families had changed and how they had coped with these changes.

One of the problems with the interviews above was the lack of a safe and secure environment for some of the interviews, thereby increasing the womens’ anxiety and possibly restricting the data obtained from the women. This can be seen in Mary’s and Winifred’s case. They were anxious not to be overheard by their husbands who were at home during the interview. This contrasts with Deborah, who I interviewed in the hospital interview room, who stated that she would not be as relaxed about telling me her story if her husband was in close proximity.

In conclusion, this data analysis and interpretation chapter has given an overall view of each of the six women interviewed concerning their views on their heart attack and recovery process. An understanding of how significant statements, sub-themes and major themes emerged from the data was given, and supporting data from the womens’ own stories, exploring the sub-themes and major themes made up the body of the chapter.
CHAPTER 6
SUMMARY, DISCUSSION AND CONCLUSIONS

This chapter concludes the thesis with firstly, the research findings. The relationship to previous research and literature is then examined. Implications of this research are discussed and limitations of the study identified. The chapter concludes with an overview of future research needs or directions which this thesis has identified.

6.1 Research findings

This study revealed an insight into women recovering from a heart attack and going through cardiac rehabilitation. Each woman's story was individual, but many of the conversations with the women tended to revolve around similar major themes, which will now be discussed in more detail.

The first major theme identified from the women's experiences was **loss of autonomy**. This theme incorporated the women's sense of being unwell leading to restrictions and limitations on their lifestyles, dependence and independence from their families, health care staff and friends, the sense of loss of control in their lives and loss of the idea of who they were - loss of self.

Most of the women were not given the freedom to make decisions affecting their health outcomes during their recovery period. They needed, or thought they needed, other people’s input to help them throughout this period. This placed them in a vulnerable and frustrating position, which could have impeded their progress in making a complete recovery.

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The second major theme explored the experience of **coping**, incorporating how the women coped with their illness through support from family and friends and cardiac rehabilitation. The survival mechanism that helped women throughout their illness, acceptance of their condition and strength that they portrayed were also identified.

Coping with their illness and their survival in the recovery period, allowed the women to work through issues that they had to face during this time. The feeling of positive attitudes towards getting better seemed to dominate throughout the conversations and the women actually worked towards having this attitude to make their recovery happen.

The third major theme involved looking at **role changes and expectations** which incorporated how the women felt concerning the impediment of their role and the different roles that they had to take on. The restriction on their role as housewife seemed to be important for the women to explore, and this bought about feelings of resentment and concern about their abilities to act as they had before.

The women were not comfortable in the “sick role” and felt unable to do much about it. The responsibility of looking after their house and family had changed and had been taken up by someone else, this placed the women in a frustrating position.

The final major theme explored the **changed relationships** that the women went through, which incorporated thinking of and concern for other people, such as partners and family, the involvement of these partners and family, and guilt and anger versus the gratitude that they experienced during their recovery period. The women talked about their illness in relationship with

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their families, and how the illness affected them all. Their relationships were important and seemed more so after their illness and recovery.

Involvement from the family in the women's recovery period was, on the whole, appreciated, but sometimes the over-involvement of their families created problems for the women, taking away ultimate responsibility. The guilt and anger that some women experienced by being unwell and not looking after the house and other work as they used to was balanced with feelings of gratitude for the family helping them when they needed it the most. In all, the relationships that the women had forged with their family and friends were very important to them and a reason to get better and recover quickly.

6.2 Aims achieved
This study has achieved the aims set out in the introduction (Chapter 1), and as given below.

Firstly, the study described themes and personal meanings of women who had experienced a heart attack and who had participated in an outpatient cardiac rehabilitation program.

Secondly, it explored women's understanding of having a heart attack and factors underlying their participation in rehabilitation (i.e. their decision-making process was described).

Thirdly, there was clarification of women's experiences of having a heart attack and of the influences underlying participation in rehabilitation (i.e. their own knowledge and realities was explored).
Finally, the study investigated the **meaning of recovery** from heart attack and cardiac rehabilitation for women who participate in rehabilitation.

### 6.3 Relationship to previous research

This section will explore each major theme and discuss and examine the relationship that the themes have with previous research. A small amount of data will be given, which relates to the themes and what is uncovered in previous research.

#### 6.3.1 Loss of autonomy

As previously mentioned, this major theme was concerned with being unwell and loss, loss of independence, loss of control and loss of self.

Autonomy in the individual involves making decisions regarding one's own life and assumes that one's decisions will be respected by others (Rankin & Stallings, 1990). Autonomy implies being independent and having self-governance (Husted & Husted, 1991).

Anxiety and stress, as seen in the literature, can result in knowledge deficit concerning the cardiac event (Thompson, 1989) and restrict an individual's learning capacity and rehabilitation prospects (Rakel, 1992). Anxiety, in turn, will affect an individual's decision making process (Johnson & Morse, 1990) which may impinge on an individual's personal control, self efficacy, motivation and locus of control.

The women in my study talked about how their own lives and those around them, had been significantly interrupted by their heart attacks, and this interruption involved restriction of their lifestyle because of being unwell. This un-wellness included physical problems such as pain, respiratory problems,
and psychological problems such as anxiety, depression, lack of confidence and frustration.

They wouldn't let me touch anything ... I don't like sitting around doing nothing (Anna)

...but my brain doesn't seem to want to work these days ... the depression had got to me. (Janice).

Independence, which has been suggested, is necessary for an individual to be able to act on decisions (Johnson & Morse, 1990), influences the perceived control of an individual. To adjust after a cardiac event, a sense of control and maintaining and re-establishing that sense of control is needed. The women in my study talked about rehabilitation and how this helped themselves and their families gain some control back in their lives and helped with their recovery.

...It (rehabilitation) has helped them (family) very much. By helping them, it has helped me. Because they wouldn't let go. (Mary).

Some of the women talked about feeling dependent on their family and how frustrating this was, but still trying to be their own person.

...I didn't like it (not being able to do all the things she had done previously) but I had to be realistic. ...I still was ... overseeing the work, so that made me feel better. ... And I had to tell myself to slow down and take it easy, so I would be back on my feet faster. (Lorraine).
...I’m rather an independent women, not under my husband’s thumb. (Mary).

A sense of loss of control, not being able to cope with physical and emotional aspects of illness, occurred for two women in my study. Individual coping styles have not been taken into account in cardiac rehabilitation programs and womens’ needs in particular (Moore, 1996; Pinneo, 1984; Runions, 1985).

...I was worried because I lost complete control of myself. (Winifred).

...I was almost paranoid about being left in the house on my own...and I wouldn’t go into the shopping centre on my own in case I had another heart attack... (Deborah).

The issue of loss of self can be seen in the literature as pertaining to womens’ self-definition and how womens’ relationships and events can impinge on the health and wellness, lifestyle and self knowledge development of an individual (Parchet & Creason, 1989).

Mary didn’t see herself as an old lady, but was made to consider herself one. This sense of being patronised and not feeling in control of the situation perhaps contributed to her feelings of anxiety and helplessness.

...an elderly women of 65 - well, I was so mad because I don’t think old and I don’t act old. (Mary).
...the doctors patted me on the head and sent me home, ... that was it...Too risky to do anything about the damage ...my heart was so badly damaged I would never make it back home again (from hospital). (Mary).

How people cope with recovery can be determined by their decision making ability. This lack of autonomy may make an individual feel vulnerable and lack confidence in their lifestyle choices. Patients and their families need to be involved in decision making as far as possible, to prevent relapses from occurring.

6.3.2 Coping

As previously discussed, this theme was concerned with how the women coped, through support, through survival tactics, through acceptance of the events and through their attitudes and strength.

Benner et al., (1994) suggested that coping involves practical reasoning about the situation one is in, with some past experience helping in the present situation. Support from families and friends, in most of the womens' situations, helped the women cope during their recovery period. This is consistent with the literature (Keller, 1991; Moore, 1996; Oldridge, 1991) which emphasises the importance of family and friends, during recovery time.

... you realise how important family is and depending on family and friends to see you through difficult times. I know when I wasn’t well, I was lucky to be surrounded by family and friends. ... They (the family) have been very supportive. (Lorraine)
Social support was seen as significant in women’s recovery after cardiac surgery and one recommendation from one study suggested that close family and friends be involved in post illness and recovery planning (Riegel & Dracup, 1992).

...I think myself lucky as I have a lot of friends... we see each other regularly...we talk about our lives, and discuss things, support each other...(Lorraine).

...We (women neighbours) still get together and are supportive... we have lunch one a month, we are in contact by phone... (Winifred).

Another important component of how the women coped was their strong feelings of survival and resilience. It has been suggested that in-built inner strength helps with the process of recovery through focusing on alternatives to the situation, re-evaluating one’s life goals, re-assessing priorities and appreciating the impermanence of situations in life (Fleury et al., 1995).

I think that keeping an interest in things... being active... it is absolutely fascinating... taking up new interests (Mary)

Let’s face it. When you are sick it’s up to you what you are going to do about it.. You have got your doctor that will co-operate, you have got the nursing staff, if you have got a good family that will support you, but really in the long run, it is up to you (Deborah)
Acceptance of the situation involves coming to terms with living with an illness (Benner, et al., 1994), by comprehending that a heart attack has taken place, understanding why this has occurred and thinking about the future significance of this event (Johnson & Morse, 1990). Some women in my study talked about accepting their situations with help, mainly from a higher power, God.

Well, I'm a Christian, and I thought, well, if this has got to be, this has got to be. The world has been made this way for reasons we aren't aware of. I felt that I couldn't do much about it....., perhaps it is my time to go, then I thought, it is not going to be without a fight. {Laughter} ... coming back to my religion and my faith in the Lord and everything they said, I'm leaving it up to you, to the higher powers. And I'm glad about that. (Mary)

... I'm a Christian and... I believe that God has my life in his hands. And he is working things out the way he wants things to be. ... I think what worried me was the pain I would have to go through before the death.. To see if I could cope with it. (Janice).

One of the women coped by accepting the restrictions and limitations she had to go through and knowing it was all part of the recovery process. Rose (1990) suggested that acceptance was experienced by learning who one's true self was, listening and respecting, believing and trusting in that true self and then acting accordingly to what the true self wanted and needed.

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... I had to accept that I couldn’t do things as I had done them before, you know, just do what I wanted to do and getting on with it. I have had to change my way of doing things, letting some things alone and worrying about the most important things. (Deborah)

... but you have got to listen to what your body tells you, which I wasn't doing. And now I can see it and I think well it is just not worth it and I pick up a book or do some embroidery, and don’t feel guilty. (Deborah)

The women in my study coped with their illness by having a positive attitude and strength, both inner and from a ‘higher power’, being pragmatic, having support from family and friends and outside interests in their life.

6.3.3 Role changes and expectations

This theme explored the role of the women and how this role was impeded and how their role became different during their illness and recovery.

The literature suggests that women maintain responsibilities for housework after AMIs and do not consider it an excessive activity. They also have feelings of guilt about not resuming usual activities (Boogaard & Briody, 1985; Cochrane, 1992; Murdaugh & O’Rourke, 1988).

Housework in one study (Hamilton & Seidman, 1993) was perhaps not considered work by the women and their health providers and Hamilton and Seidman found that 75% women resumed this housework within four weeks of their AMIs compared to one third of men. Women also expressed anxiety
about maintaining the household, while men did not report being anxious about this (Moore, 1995).

The women in my study appeared resentful and concerned about their roles being impeded and changed. The role that they once had was now taken over by their husband and family, and these changes were hard to accept by most of the women, as this was their domain and responsibility.

... I wish they would let me get on with it, you know, the working out what to make, the shopping, and the preparation all by myself. Sometimes I feel a bit claustrophobic, you know - all hemmed in, not being able to move without them wanting to take over. (Mary)

Well I suppose I've have been doing it (the washing & laundry) for so long, to see him (her husband) hanging up the washing, {laughter},... I think I then began to realise what it must have been like for him when he retired, to suddenly not fronting up to the office everyday, taking on the job that he had to do. I will admit that I used to get cross about it. (Deborah)

One of the women felt that her role had been taken over and felt angry over this.

... like for instance he would do the cooking. Well, I want to come back and do the cooking, but then, I wasn't well enough.

... I just wanted to carry on and do all the things that I had done before hand, but he said... he had nothing else to do. So, he
just went ahead and, um, ... you see he doesn't {whispering} do things very well, he doesn't take the same care as, well, .... it is a very bad point between the two of us...I feel he has taken over.  (Janice)

Another women felt her role had changed somewhat, and she did not enjoy these changes but was realistic that she had no choice.

....I didn't like it (not being able to do all the things she had done previously) but I had to be realistic.  I knew deep down they (family) could cope with everything but...I still ... oversee the work, so that made me feel better.

... as a housewife, my job, if you like, changed,...I've accepted that that is the way it is...(although) it makes me a bit angry ...
That is the way it is and there is nothing I can do about it.  There is no good lying on the floor and kicking my legs up in the air.  (Deborah)

The changed roles and expectations that the women discussed, were centred around their families and, for some of them, it involved their partner's role also changing.  This was due to retirement in two of the cases, thereby having role delineation problems with the wife, who they were at home with, and whose work they were encroaching upon.

The literature appears to support my findings concerning women and their role changes.  Most of the women took on the responsibility of housework early in their recovery period, some expressed feelings of guilt, others tolerated that they could not take up their responsibilities and feelings of frustration, anger and resentment were expressed.

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6.3.4 Changed relationships

Under this theme, issues of concern for others, family involvement and over-involvement and the guilt and anger that these women felt about their illness and recovery, versus their gratitude from their family and friends were explored.

Peck (1986) suggested a model that looks at the impact of relationships and events in a women’s life, affecting her own definition of herself. These relationships can foster or impede self-knowledge development, affecting lifestyle changes, and attitudes to health. Peck noted the flexibility and elasticity in women’s relationships, noting that women try to remove themselves from total dependence in a relationship while, at the same time, trying not to hurt other people whom they care about.

Parchet and Creason (1989) argued that relationships and roles are changed after a cardiac event, also impacting on a woman’s self-definition, and that specific problems of women need to be identified. King and Jenson (1994) suggested that a woman’s sense of self is not only related to her role, but related to relationships around her.

The women in my study wanted to get well and not rely on other people, not wanting to worry others, and having concern for others.

...I wanted to get back on my feet, I don't like being sick. I don't like being...not exactly a burden, but I don't like relying on other people...I knew that they (family) were worried about me. So I said don't worry, everything will be ok. (Dorothy)

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...he (husband) was concerned, very worried (about her illness).
I think he always felt I was the healthy one...Yes, I was more worried about him than myself, because of his stroke, you know.
... I was trying to keep calm inside, and try to keep him calm...

...But I would rather go without it (the by-pass operation) if I could. mainly because {whispering} I am a bit concerned about my husband - he's had the stroke although he has recovered so far, but he can't be operated on again for he's angina so I don't want to give him any more worry to go through at this stage. (Winifred)

Having a heart attack also seemed to bring the family closer together and the women felt the family unit was more important than before. The women wanted things to be better for their family, not for just for themselves.

...I suppose we have always been close. But, sometimes in a marriage you start to get a bit sick of each other and you know, you start thinking, Oh, dear, will this be always like this. But then something like this happens and you find you have a really good relationship,...so sometimes you can benefit by having...it probably sounds a silly thing to say...from having a heart attack and being very sick. You appreciate more of what you have got.

...I have to get on with life and try to help my family and me...enjoy our time and life together more. (Mary)

I was more worried about my family and how they were worrying than about me coping. (Anna)
Janice seemed overwhelmed by the problems she was having with her family, and was more concerned about their welfare than her own. I think she resented all the added stress these problems added to her failing health and seemed trapped in this predicament. Her husband, although supportive, to some degree, seemed also to be unable to lift the problems she was having and did not seem able to cope himself with the changes that the family were dealing with.

... I was concerned about my family....And they were concerned about me.

(my husband) was very supportive (about rehabilitation). I think because the program was going to be good for me, this will be good for both of us. He came along and jollied me along. I am very blessed to have him. ..... (Janice)

Priorities in life and family and friends seemed more important than previously. The women felt that their family had helped with their recovery and that because of all they had been through the family felt more committed in their relationship with each other.

... I have had a lot of time to think about things, since being home... that's something this heart attack has made me do, you know, think about my life and my husband and daughter and family, which is good, I suppose. I think you realise how unimportant certain things in your life are and how important other things.

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...being able to rely on them for help and support. ... think our relationship has become stronger because of it. (Lorraine).

The need to reassure and take care of the family around them seemed to influence the women and how they saw themselves, as women in relation to their families, not as thinking of themselves as individuals with an illness. Their family relationships also seemed to be stronger after the heart attack, for a few of the women, and was also more important after that event.

Ambivalence about family involvement seemed to affect most of the women in the study. They seemed to feel constricted with over-involvement and concern of the family, but could understand the family's concern.

... they were in a panic - they wouldn't let me out of their sight. If I sneezed they would come running to see if I was alright...If I went into the back yard they would come out and see what I was doing ... it didn't give me terribly much confidence in myself because it made me feel, well, they must know something I don't {Laughter}. (Mary)

(The rehabilitation) program has helped them (the family) handle it all a lot better. It has helped them very much. By helping them, it has helped me. Because they wouldn't let go of me.

(The rehabilitation team stated) Why don't you let her go on her own, just let her go. You know. Anyhow, so he (husband) did. But they still sort of hover but,... it might take him fifteen minutes to come in. {Laughter} (Mary)
Some women expressed guilt that they could not manage without involving the family taking over their household duties, but also gratitude was felt for the care and attention that their family was giving them. Boogard (1984) surmised that women after having an AMI felt guilty when unable to perform their usual household work and wanted to commence household work straight after discharge. Some women talked about not wanting to upset others by being unwell, so as the family could get on with their lives.

...But, then I stop and think how lucky I am to have them caring and fussing. Not many have that.

They (the family) are settling down now, much better than they used to be. As I get stronger and more confident I think they will understand that things have changed and that I'm OK again. In the meantime, I will have to be more patient and be happy to take a back seat. (Lorraine)

... and you can't say anything because he is helping me. If he hung the clothes up the wrong way I used to um...bite my tongue,..., he's doing his best and I'm grateful for that because I know that hanging the clothes out I was getting pains doing it, and that was no good. (Deborah)

Guilt was evident when Deborah was talking about her husband doing things for her, but, on the other hand, she was grateful for that help. She also felt guilty when resting, remembering her mother's hard work, and feeling guilty for not being able to do it all.
"I used to feel very guilty about it (needing a rest). Because I had not done it before. ...I think women of my age are brought up, my mother was a hard worker...my mother worked from sun up way past...we were just brought up to do it.

...and then my husband would be working and I would be sitting down and I'd think, oh hell, this isn't right.

...but then I found that he would be sitting down with me too. Whether to keep me company or whether he had had enough himself I'm not sure....I didn't feel guilty.

This sub-theme of guilt and anger versus gratitude that they felt for their families is incorporated in the overall theme of changed relationships, which all the women to some degree talked about and experienced. This gratefulness to and involvement of the family, the concern that the women showed for family members all contributed to how the relationships in their families had changed and how they had coped with these changes.

6.4 Implications of the research

This research has implications for nursing curricula as it gives nurses an insight into women and their recovery process. It would be of specific interest to nurses involved in the cardiac rehabilitation programs and perhaps help improve education programs involving women, rehabilitation and cardiovascular disease.
This study contributes to knowledge concerning the needs of women who have experienced a cardiac event and how important their family and friends are in helping throughout their recovery process.

The women's needs and issues after having a heart attack and attending rehabilitation include:

- Having an understanding of the degree of autonomy lost through being unwell and how this affects women's sense of dependence, sense of control and sense of self.

- An understanding of how women cope with their heart attack, and being aware of, and not underestimating, the importance of family and friends support.

- An appreciation of the strength and attitude that women portray about their illness and how this may bring about acceptance of their illness, so that the recovery process can occur, needs to be acknowledged.

- An acceptance of the role changes and expectations that women may have after their heart attack, which may cause resentment and anxiety about returning to their homes. Communication concerning these changes between partners and families would help women perhaps be prepared to accept changes, for the interim.

Families might be made aware of how their changed relationships have affected their wife and mother (ie stifle or impede their recovery) allowing for more open communication to exist concerning over-involvement on behalf of the family. Women's feelings of guilt in not taking on her usual role and how
women may be more concerned for their family than for themselves needs to be addressed by the family and openly communicated on both sides.

An understanding of recovery from heart attack in women can be important so that discharge planning can be tailored to meet the specific needs of women and to take the above points into consideration. Families may need to be helped to become sensitive to women's sense of self, respect their need for some independence, and understand and comply with their need for support during this stressful time. An appreciation of how women see their roles in the family and their relationships within the family and how this might change during the recovery period also needs to be considered.

To enhance individual recovery after a cardiac event, a comprehensive development of interventions and evaluation of cardiac rehabilitation programs was seen by Fleury, et al., (1995) to be very important and necessary. These authors also suggested that working with women and their families to identify and resolve different expectations and perceptions concerning role, abilities, and support through the recovery process would also improve the recovery process.

Hamilton and Seidman (1993) argued that education and counselling programs need to be more individualised for women after AMI and believed that nursing knowledge was inadequate to deliver high quality nursing to these women. Low (1993) also recommended the need for cardiac rehabilitation programs to be tailored to the needs of women.

This has implications concerning the undergraduate and post graduate curriculum for nurses, and also specific programs run in the hospitals and rehabilitation centres.
6.5 Future research

This study incorporated six women and their experiences in recovery from a heart attack and their experiences in cardiac rehabilitation. Many implications were raised concerning their experiences. This research into women at a later stage in life attempted to identify their experiences at this time in their lives, particularly giving a picture of their reality. This reality can be quite different from men in the same age group, and is particular to that generation, therefore giving us a picture of life for this age group at this point in time.

Women in this study were all English speaking and had families around them. They were all within a certain age group, with an age range of 55 to 67 years of age. They were all interested in gaining their health back and obviously, this was why they attended rehabilitation in the first place.

To obtain other perceptions of women and their experiences of recovery from a heart attack and cardiac rehabilitation, a much larger study is required that would incorporate women from different ethnic groups, different age groups, marital status and socio-economic backgrounds. This would help increase knowledge, not only for nurses, but for women, other health professionals and society in general.

A limitation of the study, in hindsight, was the choice of interview venue for the participants. The women should have been interviewed in a more secure and private environment than their own homes, such as in a hospital interview room. The stories obtained from women in their own homes may have been restricted and the women may have been prevented from being as explicit as possible, due to anxiety about being possibly overheard by their husbands.
Inclusion of partners' perceptions and other family members would give a more rounded view of the women as their illness affects the family as a whole, it does not affect them in isolation. A study is still needed concerning women (and men) who do not become involved in cardiac rehabilitation, or who decide to drop out of a cardiac rehabilitation program, because, as suggested in the literature, morbidity and mortality rates of heart disease could improve after rehabilitation. Education programs for nurses and other health professionals involved in cardiac rehabilitation need to be examined to see if the individual needs and assessment of women undergoing recovery from a heart attack and cardiac rehabilitation are included.

6.6 Summary and Conclusion

This study has achieved the examination of the lived experiences of older women, who were going through their recovery period after a heart attack and cardiac rehabilitation. This study has been a reflection of a group of older women's life during a recovery period. It has given different perspectives on women's lives and how women cope with illness and recovery in similar and in different ways. An understanding of how older women use the innate strength that they draw upon when they are unwell and recovering from a major illness has also been explored.

The themes that have emerged from this study give the reader a sense of the personal meanings that women who have experienced a heart attack can go through during a recovery period. It has explored women's understanding of having a heart attack and their decision making processes. The knowledge concerning participation in a rehabilitation program was clarified and the meaning of the recovery process was investigated. A view of a group of Australian women surviving has been shared with you.
Implications of the research include re-examination of education and counselling programs and evaluation of cardiac programs, to see if they are suitable for older women. A recognition of family and friends involvement in the recovery process and the encouragement of open communication between all concerned about problems coping with roles, expectations, limitations and family involvement would hopefully allow an expeditious and holistic recovery process.

In conclusion, the women themselves have the final say:

...let's face it, when you are sick it's up to you what you are going to do about it.

...I think being a positive person and just saying to myself, well you have to get better and get on with it. Also, it is my family and knowing that we want to get on with our lives...

...so sometimes you can benefit by having...from having a heart attack and being very sick. You appreciate more of what you have got.
References:


**APPENDIX 1.**

**SIGNIFICANT STATEMENTS:**
Significant statements and phrases were identified from a summary of each interview, which related to each woman’s heart attack and recovery. Meanings were formulated from these significant statements and allocated a sub-theme for each interview (see following pages).

**Interview 1 - Mary**

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</tr>
<tr>
<td>13. Coping</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>14. Concern about family</td>
<td>Concern for family</td>
</tr>
<tr>
<td>15. Concern about husband</td>
<td>Concern for family</td>
</tr>
<tr>
<td>16. Being lazy</td>
<td>Role changes</td>
</tr>
<tr>
<td>17. Caring more [about house]</td>
<td>Role changes</td>
</tr>
<tr>
<td>18. Being &quot;taken over&quot;</td>
<td>Role changes</td>
</tr>
<tr>
<td>19. Financial problems</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>20. Comparing to others</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>21. &quot;Not being myself&quot;</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>22. Different attitude [to husband]</td>
<td>Concern for family</td>
</tr>
<tr>
<td>23. Nerves</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>24. Frailities</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>25. Role change</td>
<td>Role changes</td>
</tr>
<tr>
<td>26. Giving &quot;up a lot&quot;</td>
<td>Role changes</td>
</tr>
<tr>
<td>27. Mentally downhill</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>28. Spiritual beliefs need building up</td>
<td>Limitations/restrictions</td>
</tr>
<tr>
<td>29. Social changes</td>
<td>Role changes</td>
</tr>
<tr>
<td>30. Being positive</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td>31. Bottling things up</td>
<td>Coping / not coping</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>This interview is about the following significant statements:</strong></td>
<td><strong>Allocated Sub-Theme:</strong></td>
</tr>
<tr>
<td>1. Physical signs of being unwell</td>
<td>Being unwell - Restrictions</td>
</tr>
<tr>
<td>2. Not being &quot;that bad&quot;</td>
<td>Coping</td>
</tr>
<tr>
<td>3. Being too &quot;busy&quot; to be unwell</td>
<td>Coping</td>
</tr>
<tr>
<td>4. Family history</td>
<td>Limitations / restrictions</td>
</tr>
<tr>
<td>5. Health conscious</td>
<td>Coping</td>
</tr>
<tr>
<td>6. Surprised (about heart attack)</td>
<td>Being unwell - Restrictions</td>
</tr>
<tr>
<td>7. Pressure from worrying</td>
<td>Coping</td>
</tr>
<tr>
<td>8. Shared suffering</td>
<td>Coping</td>
</tr>
<tr>
<td>9. Reflections on life</td>
<td>Changes in role</td>
</tr>
<tr>
<td>10. Important / unimportant things in life</td>
<td>Coping</td>
</tr>
<tr>
<td>11. Depending on family / friends</td>
<td>Relationships</td>
</tr>
<tr>
<td>12. Lucky to have family / friends</td>
<td>Relationships</td>
</tr>
<tr>
<td>13. Supportive family / friends</td>
<td>Relationships</td>
</tr>
<tr>
<td>14. Rehabilitation &quot;Educate on lifestyle&quot;</td>
<td>Coping</td>
</tr>
<tr>
<td>15. &quot;Help husband understand&quot;</td>
<td>Relationships</td>
</tr>
<tr>
<td>16. &quot;Building myself up&quot;</td>
<td>Coping</td>
</tr>
<tr>
<td>17. Listening to &quot;others have same feelings&quot;.</td>
<td>Coping</td>
</tr>
<tr>
<td>18. (he) &quot;Let me run it&quot; (house)</td>
<td>Changes in role</td>
</tr>
<tr>
<td>19. &quot;That's my job&quot;</td>
<td>Changes in role</td>
</tr>
<tr>
<td>20. &quot;my responsibility&quot;</td>
<td>Changes in role</td>
</tr>
<tr>
<td>21. Taking things &quot;one at a time&quot;</td>
<td>Dependence</td>
</tr>
<tr>
<td>22. Overseeing the work (household)</td>
<td>Changes in role</td>
</tr>
<tr>
<td>23. Positive person</td>
<td>Coping</td>
</tr>
<tr>
<td>24. &quot;Get on with life&quot;</td>
<td>Coping</td>
</tr>
<tr>
<td>25. Family / friends help</td>
<td>Relationships</td>
</tr>
<tr>
<td>26. Loving family</td>
<td>Relationships</td>
</tr>
<tr>
<td>27. Outside interests</td>
<td>Coping</td>
</tr>
<tr>
<td>28. Being stubborn &amp; impatient</td>
<td>Coping</td>
</tr>
<tr>
<td>29. Getting on with life</td>
<td>Coping</td>
</tr>
<tr>
<td>30. Comparing self to others</td>
<td>Coping</td>
</tr>
<tr>
<td>31. Only one life</td>
<td>Coping</td>
</tr>
<tr>
<td>32. Rehab. group supportive</td>
<td>Coping</td>
</tr>
<tr>
<td>33. Thinking of family &amp; friends</td>
<td>Relationships</td>
</tr>
<tr>
<td>34. Change way of doing things</td>
<td>Changes in role</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>35. Relationship stronger</td>
<td>Relationships</td>
</tr>
<tr>
<td>36. Not thinking of past</td>
<td>Coping</td>
</tr>
</tbody>
</table>
Appendix 2:

Sub-themes from each interview to Major themes
APPENDIX 2

This appendix looks at the list of sub-themes from each interview, being allocated to a major theme category. These major themes emerged after consideration of the individual sub-themes and the relationship of the sub-themes to the major themes involved looking at the participants as a whole. Some interviews had more sub-themes than others and similar sub-themes in the interviews are allocated to the same major theme (see following pages).

Interview 1 - Mary

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Major theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being unwell, restrictions</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>2. Acceptance and strength</td>
<td>Coping</td>
</tr>
<tr>
<td>3. Dependence and independence</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>4. Impediment of role</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>5. Guilt and anger versus gratitude</td>
<td>Changed relationship</td>
</tr>
<tr>
<td>6. Changed relationship</td>
<td>Changed relationship</td>
</tr>
</tbody>
</table>

Interview 2 - Deborah

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Major theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Strength (attitudes)</td>
<td>Coping</td>
</tr>
<tr>
<td>2. Being unwell, restrictions</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>3. Responsibility / Duty</td>
<td>Changed relationships</td>
</tr>
<tr>
<td>4. Role changes and expectations</td>
<td>Role changes and expectations</td>
</tr>
<tr>
<td>5. Thinking of others / concern</td>
<td>Changed relationships</td>
</tr>
</tbody>
</table>
### Interview 3 - Winifred

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Major theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Loss of self,</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>2. Being unwell,</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>3. Enjoyment &amp; fulfilment, surviving</td>
<td>Coping</td>
</tr>
<tr>
<td>4. Relationships - thinking of others</td>
<td>Changed relationships</td>
</tr>
<tr>
<td>5. Strength and coping</td>
<td>Coping</td>
</tr>
</tbody>
</table>

### Interview 4 - Anna

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Major theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being unwell, restrictions, limitations</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>2. Thinking of others / concern for others</td>
<td>Changed relationships</td>
</tr>
<tr>
<td>3. Surviving / being well</td>
<td>Coping</td>
</tr>
<tr>
<td>4. Support / coping</td>
<td>Coping</td>
</tr>
<tr>
<td>5. Family involvement / over involvement</td>
<td>Changed relationships</td>
</tr>
</tbody>
</table>
### Interview 5 - Janice

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Major theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being unwell, limitations</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>2. Role changes</td>
<td>Role changes and expectations</td>
</tr>
<tr>
<td>3. Coping and not coping</td>
<td>Coping</td>
</tr>
<tr>
<td>4. Concern for family</td>
<td>Changed relationships</td>
</tr>
</tbody>
</table>

### Interview 6 - Lorraine

<table>
<thead>
<tr>
<th>Sub-theme</th>
<th>Major theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Being unwell, limitations</td>
<td>Loss of autonomy</td>
</tr>
<tr>
<td>2. Coping</td>
<td>Coping</td>
</tr>
<tr>
<td>3. Changes in role</td>
<td>Role changes and expectations</td>
</tr>
<tr>
<td>4. Relationships</td>
<td>Changed relationships</td>
</tr>
</tbody>
</table>
Appendix 3

Sub-themes to
Major themes
APPENDIX 3

This appendix looks at the list of the **sub-themes** from significant statements with the allocated **major theme** along side each statement. This list is a **combined** sub-theme list from all the interviews, allocated to all the major themes.

<table>
<thead>
<tr>
<th>Sub-themes from significant statements</th>
<th>Allocated Major Theme:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restrictions, Limitations</td>
<td>1. Loss of autonomy</td>
</tr>
<tr>
<td>Being unwell, body restrictions and sensations</td>
<td>1. Loss of autonomy</td>
</tr>
<tr>
<td>Acceptance,</td>
<td>2. Coping</td>
</tr>
<tr>
<td>Strength</td>
<td>2. Coping</td>
</tr>
<tr>
<td>Attitude</td>
<td>2. Coping</td>
</tr>
<tr>
<td>Surviving - being well</td>
<td>2. Coping</td>
</tr>
<tr>
<td>Dependence</td>
<td>1. Loss of autonomy</td>
</tr>
<tr>
<td>Independence</td>
<td>1. Loss of autonomy</td>
</tr>
<tr>
<td>Impeding role</td>
<td>1. Loss of autonomy</td>
</tr>
<tr>
<td>Guilt, anger</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Gratitude</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Support</td>
<td>2. Coping</td>
</tr>
<tr>
<td>Changed relationship</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Relationships</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Family involvement / overinvolvement</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Responsibility</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Duty</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Coping and not coping</td>
<td>2. Coping</td>
</tr>
<tr>
<td>Thinking of others</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Role expectations</td>
<td>3. Role changes and expectations</td>
</tr>
<tr>
<td>Changes</td>
<td>3. Role changes and expectations</td>
</tr>
<tr>
<td>Concern for others</td>
<td>4. Changed relationships</td>
</tr>
<tr>
<td>Enjoyment, fulfilment</td>
<td>3. Role changes and expectations</td>
</tr>
<tr>
<td>Worry / fear</td>
<td>1. Loss of autonomy</td>
</tr>
</tbody>
</table>
Appendix 4

Participation Information Sheet
and Consent Form
PARTICIPANT INFORMATION SHEET

Women's views on having a heart attack and attending cardiac rehabilitation

This research study is part of a Master of Nursing (Honours) course for the Faculty of Health Sciences, University of Western Sydney, Nepean.

The purpose of this study is to investigate women's views on having had a heart attack and then participating in an outpatient cardiac rehabilitation program.

Findings will be shared with the outpatient rehabilitation program and will help expand nursing knowledge in this area.

As a participant, you will be asked to take part in two interviews with the undersigned investigator. This will involve tape-recording of our conversation, which will be then transcribed and the participant will be asked for feedback.

Participation will be voluntary and your name is not required for the study, except for the consent form. You can withdraw from the study at any time after giving consent to participate. There will be no disadvantages or adverse consequences to not participating, or withdrawing from the study.

Please feel free to phone the researcher if you have any questions about the study.

Thank you for your participation.

Rose McMaster -
Master of Nursing (Honours) student,
Faculty of Health Sciences,
University of Western Sydney, Nepean.

Phone: 646 6249 (work)
        798 6955 (home)
CONSENT FORM

Women's views on having a heart attack and attending cardiac rehabilitation

I, ___________________________ hereby voluntarily consent to participate in the research study as above. I understand that I will be interviewed on two occasions and the conversation will be taped recorded.

I also understand that the information obtained from this research may be shared with others (for example, nursing colleagues and through professional publications). However, my right to privacy will be retained, i.e. I will not be identified individually. The research study, as set out in the attached Participant Information Sheet, has been explained to me and I understand what is expected of me.

My decision whether or not to participate will not affect my future relationship with any part of the Western Sydney Area Health Service. If I decide to participate I am free to withdraw my consent and to discontinue my participation at any time. Any such withdrawal will not affect any future treatment, or my relationship with the Western Sydney Area Health Service, or any person treating me.

Participant's Name: ___________________________

Participant's Signature: _______________________

Date: ______________

Investigator's Name: _________________________

Investigator's Signature: _______________________

Date: ______________
Not "falling off the planet"

Womens’ experiences of recovery after a heart attack and cardiac rehabilitation.

Rose McMaster

A thesis submitted in partial fulfilment of the Master of Nursing (Honours) degree.

1999
PLEASE NOTE

The greatest amount of care has been taken while scanning this thesis,

and the best possible result has been obtained.
STUDENT STATEMENT

This is to certify that this thesis has not been submitted for a higher degree to any other University or Institution. The source of the information herein is original and is solely the work of the author, except as indicated in the text.

Rose McMaster
ABSTRACT

Heart disease is one of the leading causes of mortality in industrialised countries. There have been major changes in world wide population demographics with an increase in heart disease in those over sixty five years of age. The incidence of Coronary Heart Disease in women increases with age. There has been little research into cardiovascular disease in women; treatment and rehabilitation programs have mainly been focused towards men and their needs.

In light of the above, research needs to concentrate on women who have experienced a cardiac event, and their rehabilitation needs. The impact of having a heart attack on women, particularly post menopausal women, needs to be explored and reported upon. Women and their cardiac event need to be focused on, not only on how women can differ from men, but what is unique about their experience and the contribution this knowledge can make to other women and health professionals.

In this study, to gain a perspective of how women recover after a heart attack, a phenomenological approach was used to explore womens’ experiences of having a heart attack and their subsequent recovery.

The population for this study consisted of women who had a heart attack for the first time, and who had attended cardiac rehabilitation. The sample was therefore purposeful, to include women who had experienced the phenomenon being studied. Six women, ranging in age from fifty five to sixty seven were interviewed. A combination of methods was incorporated to analyse the womens’ experiences and to organise the data.
Four major themes emerged from the data: loss of autonomy; coping; role changes and expectations; and changed relationships. The loss of autonomy felt by these women incorporated feelings of restrictions, dependence, loss of control and loss of self. The theme of coping involved support, surviving, acceptance and strength. The theme of role changes and expectations incorporated impediment of role and different roles. The last theme explored was changed relationships and incorporated thinking of others, family involvement and guilt and anger versus gratitude.

This study has explored the personal meanings of women who have experienced a heart attack and womens' understanding of having a heart attack and their decision making processes. Also, the womens' knowledge and meaning concerning participation in a rehabilitation program was investigated.

Implications of the research include restructuring education and counselling programs to suit womens' needs, evaluation of cardiac programs, recognition of family and friends' involvement in the recovery process. There needs to be encouragement of open communication between all concerned about problems coping with roles, expectations, limitations and family involvement.

Suggestions for future research include a larger study being attended, with different sociocultural, economic and age group participants. Family and friends' involvement and viewpoint into the recovery process and cardiac rehabilitation would also help enrich health professionals' knowledge base.
ACKNOWLEDGMENTS

All the women who participated in this study are thanked for their time in helping me to complete this research project and trusting me with their information. Their contribution has made this project a rewarding and learning experience.

In providing supervision throughout my interrupted progress, Tim Griffin was patient and supportive and provided me with constructive advice and evaluations of my work and was understanding when that work was late or not forthcoming. The assistant supervisors that left the University of Western Sydney before my completion of this work, I also thank for their contributions and support, namely Jan Neary and Daniel Nicholls.

My colleagues at work who have been in the same situation I have been I thank for their kind assistance and pearls of wisdom.

My husband and family have been incredibly patient as I have struggled through this project and are very thankful that it has come to an end. Their encouragement and support has been invaluable.

Finally, I would like to thank the NSW Nurses’ Registration Board for granting a scholarship for this project in the first place, and who have also been very patient awaiting its completion.
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