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The Lived Experience of Women with First-Time Myocardial Infarction: A Phenomenological Study

Submitted by
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In partial fulfillment of the requirements for the degree of Master of Science in Nursing

Date of Defense: December 14, 2006

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A Phenomenological Study

Sheila Ann Olson

University of Toledo

2006
DEDICATION

This thesis is dedicated first, to all those women who have suffered from myocardial infarction who have inspired me to begin this study; and second, to my husband, Gordon, who has provided me unconditional love, courage, and strength to continue my journey. Finally, to all the women who did not win the battle against heart disease I dedicate this work.
ACKNOWLEDGMENTS

I wish to extend my sincere appreciation to my major advisor, Dr. Joanne Ehrmin, for her unconditional support, patience, guidance and professionalism. Her understanding has allowed me to take my passion for women’s heart health and develop this thesis. Her knowledge and wisdom of qualitative research has taught me to listen to the women in a way that would help me tell their meaningful stories. I am especially grateful for her sharing in one of the most life changing experiences during my nursing journey.

I would like to thank my committee member, Dr. Diana French, for her encouragement and willingness to engage in this journey with me. Her mentorship, leadership and professionalism are unrelenting and never forgotten.

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I express my eternal gratitude to my husband, Gordon Olson, my son, Jason Olson, my deceased mother-in-law, Virginia Olson, and deceased beloved teacher and mentor, Mary Beth Hayward for their support during my nursing journey.
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CHAPTER I
Introduction

When one reviews the most current statistics about women with heart disease it is alarming. Given the technological advances in heart care today, the mortality rates of women have changed very little over the past several decades. Cardiovascular disease continues to be the leading cause of death for American women. Annually, in the U.S. approximately 2.5 million women are hospitalized for cardiovascular disease, of which 500,000 women die and half of these deaths are due to coronary heart disease (Wenger, Speroff, & Packard, 1993). In the year 2002, cardiovascular disease (CVD) claimed the lives of 493,690 females and coronary heart disease (CHD) claimed the lives of 241,622 females (American Heart Association [AHA], 2005). Yet we know little about the experiences of women suffering from first-time myocardial infarction (MI). In this chapter, the statement of the problem, statement of the purpose, nursing conceptual framework, research question, definition of terms, significance of the study, assumptions, and limitations of the study will be discussed.

Statement of Problem

As the mortality and morbidity rates of women have risen, explanations for this increase are discussed with little knowledge of the lived experiences of women suffering from first-time MI. The main reason for this gap in knowledge is that the information used for prevention, detection, and treatment historically has been based on quantitative studies in a population dominated by middle-aged men (Gibbons, 2004; Kelly & Cordell, 1996; Spencer & Wingate, 2005). Nurses need to discover what the experience of having a first-time myocardial infarction means to women so that care is focused on the real life needs of women. A qualitative, phenomenological study to
discover the lived experiences of women with a first-time MI will help discover what is not known about the real world experiences of women.

According to Leininger (1985):

> Human care is the critical and essential element of nursing...to discover the elusive, vague, and still largely unexplored nature of human care necessitates research skills and techniques mainly associated with qualitative types of research (p. xi).

### Statement of Purpose

The purpose of this study is to increase nursing knowledge about the lived experience of women with first-time MI. Utilizing a phenomenological approach, the focus of inquiry is to obtain, review, and interpret data from the participants for “essences” or meanings and essential themes. Using the phenomenological method will assist in discovering the “essence” of the phenomenon of the lived experience of women with first-time MI. “A universal or essence may only be intuited or grasped through a study of the particulars or instances as they are encountered in lived experience” (van Manen, 1990, p. 10).

### Identification of Nursing Conceptual Framework

In qualitative research nursing theories and frameworks can be used differently than in quantitative research. In qualitative research the goal is discovering meaning—not testing a theory (Burns & Grove, 2001). For this study, nursing conceptual framework will be discussed after data analysis. The rationale for delaying the selection of a nursing conceptual model is based on the underlying philosophy of phenomenology, to avoid giving direction to data results and to establish how the study results broaden, expand, or are compatible with a specific nursing conceptual model or theory (Munhall, 2000). Selecting a nursing theory after the results of the study are obtained
helps the researcher avoid bringing preconceived biases to the study during the data collection. Data analysis begins with the first interview and contact with any participant. In this study the nursing conceptual model or conceptual framework will be identified based on the results of this study. At that time the study findings will be discussed in the context of what is already known. The nursing conceptual model will be applied to the study findings and will be discussed in Chapter 5.

**Phenomenology**

Phenomenology is both a research method and a philosophy that focuses on the lived experiences of humans with the purpose of describing experiences as they are lived by the study participants (Burns & Grove, 2001). Phenomenology is the study of the essences of our experiences as we live in the real time of our life journey. The goal of phenomenology is to explore and describe the lived experience, including the meanings that the experience had for those who lived the experience (Omery, 1983). In other words, the goal of the phenomenological research method is to describe experience as it is lived (Oiler, 1982).

In phenomenology, the researcher’s preconceived notions are made known and not put aside because all humans are integral to the worlds of meaning. Nonetheless, the researcher must remain open to new discoveries and to capture the essential meanings of truth. To capture essential meaning and discover the unknowns of the phenomenon under study, the participant’s own words are used at the first level of analysis (Parse, 1996).

The main source of data is an interview between the participant and the researcher. The researcher helps the participant to describe lived experiences without leading the participant. During the interactions the researcher strives to be in the world of the participant. The researcher not only inquires but also attempts to understand the participant’s world by introspective reflection
(Speziale & Carpenter, 2003). According to Speziale and Carpenter (2003), there are a number of methodological interpretations of phenomenology. In general, the following steps are used in the phenomenological method: bracketing, intuiting, analyzing, and describing. Bracketing refers to the process of identifying and putting aside preconceived beliefs, biases, or opinions about the phenomenon; intuiting occurs when the researcher remains open to the meanings of the phenomenon by those who experience it; analysis is the making sense of the essential meanings; and describing is when the researcher comes to understand and define the phenomenon.

Phenomenologists believe that the lived experience gives meaning to each person’s perception of a particular phenomenon and the challenge is in accurately describing those experiences so that a greater true understanding is obtained (Speziale & Carpenter, 2003). It is the goal of this researcher to conduct this study in order to bring greater awareness and knowledge about women with first-time MI.

According to Speziale and Carpenter (2003) philosophical underpinnings of phenomenology are complex. Given this understanding one can appreciate why the methodological application remains dynamic and evolving. A more detailed description of the phenomenological research method that will be used in this study will be discussed in Chapter 3.

Based on current findings documented in the literature, this qualitative phenomenological study will add to the current body of nursing research and to the art of caring. According to Leininger (1985): As an approach to nursing research and practice, phenomenology can offer continued growth and revelation, attentiveness, and awareness…In this way phenomenology is the answer to the enduring process of the ever-experiencing, ever-changing reality of those involved in
the world of nursing (p. 91). Through the use of the phenomenological method and structured reflection the nurse can discover and describe the essence of caring.

Research Question

The research question addressed in this study is: What is the lived experience of women who have had a first-time myocardial infarction?

Definition of Terms

Since this study was not conceptualized within a conceptual framework, it would not be possible to discuss conceptual or theoretical definitions. In keeping with the philosophical underpinnings of the qualitative paradigm the following orientational definitions will be used in this study to maintain an open inquiry approach to discovery: lived experience, women, and first-time MI.

Lived experience

*Orientational definition.* “Lived experience” is orientationally defined as “experiences as they are lived” which is to capture the “lived experience” of study participants (Burns & Grove, 2001; Cody, 1995). In this study, the lived experience is the personal, individualized, experiential account of having a first-time MI as described by the participants during audiotaped recorded interview sessions. The participants were asked to respond to the following question: Tell me about your experience of having a heart attack for the first time?

Women

*Orientational definition.* Women are orientationally defined as the adult female which includes non-pregnant women, age 20 years and older, who have no terminal illness (Uphold & Graham, 2003) and who have experienced a first-time MI.
First-time myocardial infarction

Orientational definition. First-time myocardial infarction is orientationally defined as the first the first time a woman has been diagnosed with a myocardial infarction. Myocardial infarction refers to irreversible death of myocardium due to lack of blood supply is a medial diagnosis made by a physician and is identified by specific criterion (Tierney, McPhee, & Papadakis, 2005; Uphold & Graham, 2003)

Tierney et al. (2002) identified essentials for diagnosis of myocardial infarction such as:

1. Sudden but not instantaneous development of prolonged (>30 minutes) anterior chest discomfort (sometimes felt as “gas” or pressure) that may produce arrhythmias, hypotension, shock, or cardiac failure.
2. Rarely painless, masquerading as acute congestive heart failure, syncope, stroke, or shock.
3. Electrocardiography: ST segment elevation or depression, evolving Q waves, symmetrical inversion of T waves.
5. Appearance of segmental wall motion abnormality by imaging techniques. (p. 389).

Significance

One only needs to review health statistics dating back to 1993 to realize that issues about women’s heart health have not improved over the past 10 years. According to McFetridge, Hanley, Allen, Cheek, Kelly, and Cheek (2000), despite efforts by the Food and Drug Administration (FDA) and National Institutes of Health (NIH) multiple problems still exist in women’s heart health. Although CVD is a significant problem for women, little is known regarding the presentation,
diagnosis, and treatment of CVD in women (Trupp, 2005). The American Heart Association (2005) revealed the following update on women and cardiovascular disease: (a) cardiovascular disease (CVD) ranks first among all disease categories in hospital discharges for women; (b) in 2002, CVD claimed the lives of 493,690 females: cancer (all forms combined) 268,503; (c) nearly 40 percent of all female deaths in the US occur from CVD, particularly coronary heart disease (CHD) and stroke; (d) in 2002, CHD claimed the lives of 241,622 females compared with 41,514 lives from breast cancer and 67,542 from lung cancer; (e) CVD is a particularly important problem among minority women because the death rate due to CVD is substantially higher in black women that in white women; (f) 38 percent of women compared with 25 percent of men will die within 1 year after a heart attack; (g) stroke is the leading cause of serious, long-term disability with an estimated 15 to 30 percent of stroke survivors are permanently disabled; (h) women are more likely than men are to die of stroke; (i) risk of heart disease and stroke increases with age, and as of the year 2002 nearly 44 million American women were 50 and older; (j) trends point to more women smokers (23 percent) than men (20 percent) by year 2000; (k) misperceptions still exist that CVD is not a real problem for women. In reviewing these statistics the magnitude of the problem becomes clear. As women with CVD continue to be misunderstood the mortality and morbidity rates related to coronary heart disease will continue to rise.

Nurses need a better understanding of women who have experienced a first-time MI. Through a phenomenological approach, the study findings can help nurses better understand the lived experiences of women who have survived a first-time MI. Information from this study may help nurses and other healthcare providers who care for women who have experienced a first-time MI. The results of this study could be used to educate families, significant others, and other
healthcare professionals about the experiences of women with first-time MI. The benefits of the increased awareness of women during the experience of a first-time MI may lead to improved care based on a higher level of knowledge of this client population.

Summary

The purpose of this study is to allow women with first-time MI to tell their stories. Through this study nurses can increase their understanding of the meanings of the experiences of women with first-time MI. When a deeper understanding exists, care will be focused on meeting the care needs of women who have had a first-time MI. It is the goal of the researcher that the nursing care of women will be enhanced, thereby having an influence on the lives of women in this study and possibly those women in the future. Knowledge gained from this study will expand the body of nursing knowledge, science, and research. In addition to the purpose of this study, the statement of the problem, rationale for not including a nursing conceptual framework prior to the study, research question, orientational definition of terms, and significance of the study all were discussed.
CHAPTER II

Literature

The purpose of this study is to discover the lived experiences of women who have had a first-time myocardial infarction (MI). This chapter is intended to discuss the use of a nursing conceptual framework and review of the research. A limited literature review will present studies pertinent to women with heart disease. The most often concepts sited in the literature and noted in this literature review are: experiences of not being understood, role change, guilt and shame; complex recovery process and perceptions of illness beliefs.

Nursing Conceptual Framework

As discussed earlier, the nursing conceptual framework is discussed after the study data analysis was completed. The rationale for delaying the selection of a nursing conceptual theory is based on the underlying philosophy of phenomenology i.e., to avoid giving direction to data results and to establish how the study results broaden, expand, or are compatible with a specific nursing conceptual model or theory (Munhall, 2000). Selecting a nursing theory after the results of the findings of the study are obtained helps the researcher avoid bringing preconceived biases to the study during the data collection. The data analysis begins with the first interview and contact with any participant. In this study the nursing conceptual framework will be identified based on the results of this study. At that time the study findings will be discussed in the context of what is already known. The nursing conceptual theory will be applied to the study findings and will be discussed in Chapter 5.
Review of Research

Qualitative research may begin with a cursory review of the literature or no literature review. The rationale not to conduct an initial extensive literature review is to: (a) minimize or reduce the development of preconceived ideas or biases by the investigator regarding the study topic; (b) protect the researcher from leading participants during the interview process; (c) help the researcher remain a stranger to the phenomenon of the study so more can be learned about the phenomena being studied (Speziale & Carpenter, 2003). A limited review of the literature will be provided to demonstrate necessity of the study. The purpose of minimizing the review of the literature is to help the researcher maintain vision that is open in order to decrease presuppositions and to achieve a pure description of the phenomenon being studied (Munhall, 2000; Speziale & Carpenter, 2003).

A limited literature review will be discussed in this chapter. Specific topics noted in the literature are experiences of not being understood, role change, guilt and shame; complex recovery process and perceptions of illness beliefs. A more thorough review of the literature will be provided after data analysis and study findings are presented. After data analysis the researcher reviewed the literature to place the study findings within the context of what is already known about the topic (Speziale and Carpenter, 2003).

The National Center for Health Statistics (2002) revealed that cardiovascular disease is the leading cause of mortality among American women. Although there has been a decline in the cardiovascular disease mortality rates over the past few decades, the absolute number of women dying of cardiovascular disease continues to rise…cardiovascular disease is responsible for 45 percent of all deaths in women with one woman dying every minute from cardiovascular disease
(Trupp, 2005; AHA, 2005). Women account for approximately one-half of all deaths due to cardiovascular disease annually. Women are nearly twice as likely as men to die in the hospital during the first few weeks, and within the first and second year after a myocardial infarction (MI) (Lemcke, Pattison, Marshall, & Cowley, 2004). Yet, myths and misperceptions persist that cardiovascular disease is a disease of middle-aged men. Historically, women have been understudied as participants contributing to a lack of nursing knowledge about women and heart disease (Doiron-Maillet & Meagher-Stewart, 2003). Furthermore, information, detection, prevention, and treatment of women have been largely based on studies of men. Alarmingly, given these grave statistics, American women with heart disease remain understudied and not understood.

Experiences of not being understood, role change, guilt and shame

Myocardial infarction is the leading cause of mortality and morbidity among women internationally. Yet, little known about women’s recovery after a first-time MI following discharge from the hospital. Research indicates that little is known about women’s perceptions, coping and specific needs during recovery after an MI (Doiron-Maillet & Meagher-Stewart, 2003; Kamm-Steingelman, Kimble, Dunbar, Sowell, & Bairan, 2006; Kristofferzon, Lofmark, & Carlsson, 2003; Worrall-Carter, Jones, & Driscoll, 2005). Women with MI are not listened to or taken as seriously as men, given written information about acute events and rehabilitation resources, or educated about emotional transition phases that may occur. Findings indicate health professionals need to provide listening, open discussions, written information about the disease process, prevention, and rehabilitation. Women need to be taken seriously throughout the initial and recovery phases after
an MI. Understanding begins with asking the women and having sensitivity to listen to their stories and experiences (LeClerc, Wells, Craig, & Wilson, 2002).

Women experience changes in role expectations after an MI. (Kerr & Fothergill-Bourbannais, 2002; Svedlund & Danielson, 2004; Varvaro, 2002). Role expectation and role tensions surround expectations that women had of themselves and the expectations others had of women. Women equated the loss of the homemaker role as job loss. Special emphasis for ongoing support after MI is imperative, because during this time women are resistant to communication because of the perceived need to protect others and because of overriding feelings of guilt over role change. Women may need to experience the phenomena of guilt and shame after an MI in order to cope with the loss of their old self so that a new self may be developed (Svedlund, Danielson, & Norberg, 2001). It was identified that nurses need to support women through this time of great burden. Women’s care should focus on preparing the women for what to expect during the initial and recovery of an MI. It is essential to understand the feelings of each individual woman in order to plan care more effectively, appropriately, and optimally. Nurses need to provide support and education to women regarding coping mechanisms used for adapting to health crisis.

Complex recovery process

Very little is known about the specific needs of women throughout the recovery process after an MI. Research indicates women experience a complex recovery process after experiencing an MI (Doiron-Maillet & Meagher-Stewart, 2003; Kristofferzon, Lofmark, & Carlsson, 2005; McSweeney, Lefler, & Crowder, 2005; Worrall-Carter et al., 2005). Initially, women experienced feelings of being in an unreal situation, fear of death, and distancing oneself. Avoidance was used to protect others and to provide the women with time to integrate the event into their new self.
Then, as time passed, making sense and discovering a new meaning of live developed. As time evolved, women started to have more optimistic views of their health and survival.

Providing emotional support to women during the recovery process is essential. Research indicates that women value emotional support throughout the initial and recovery phase and it was identified as imperative to health recovery (Kamm-Steigelman et al., 2006; Kristofferzon et al., 2003; Svedlund & Danielson, 2004; Worrall-Carter et al., 2005). Additionally, women identified friends, religion, and family as sources of support after an MI. Women who perceived less support experienced increased levels of anxiety and stress during recovery. Women with increased stress are at greater risk for poor outcomes during recovery after an MI. Thus, reduction of stress is an important predictor to optimal outcomes after an MI. Findings indicated nurses need to consider the involvement and education of family, friends and significant others in developing care that provides support and decreases stress during the recovery process after an MI.

*Perceptions of illness beliefs*

The time period after discharge from the hospital is stressful and anxiety producing for women with an MI. Research indicates that perception of illness can influence emotional status, adjustment, and coping (Clark, 2003; King, 2000). Additionally, women identified stress as the most common cause of illness demonstrating distinct differences in illness attribution when compared to men. Women focused on loss of autonomy and difficult relationships as providing the greatest stressor and source of anxiety. Emphasis indicated the need for nurses to provide opportunity to listen to the illness story of women. By doing so, nurses can initiate therapeutic communication and help identify target areas to help women create strategies for
self-empowerment. Women could benefit from teaching to help with adjustment, stress reduction, and creating change to decrease recurrent episodes of MI.

Summary

Cardiovascular disease remains the leading cause of mortality in American women. As identified, American women remain understudied and not understood. This limited review of the research provided a brief glimpse of the current qualitative and quantitative literature about women who have had an MI. Specific topics discussed in this limited review included: experiences of not being understood, role change, guilt and shame, complex recovery process and perceptions of illness beliefs.

Through qualitative research an increased awareness of the experiences and needs of women can be understood. We need to ask the women about their individual experiences to bring greater depth to understanding women with first time MI. Qualitative studies of the experiences of women survivors of first-time MI are few; but stories of the women with first-time MI need to be heard. Through an increased understanding of the experiences of women with first-time MI, and by conducting qualitative studies with this population, nurses can individualize care of women.

Nurses need to understand the experiences, perceptions, coping mechanisms, and roles of American women with an MI. Therefore, this qualitative research will add to the current body of nursing knowledge relating to the understanding of experiences of American women with cardiovascular disease.
CHAPTER III

Method

The purpose of this study is to discover the lived experiences of women with a first-time myocardial infarction (MI). In this chapter a description of the design of this study, selection of participants and materials used in the study are presented. Additionally, the method of data collection, including sampling, protection of human rights, assumptions and limitations are discussed. Finally, the specific method of data analysis is identified and discussed in detail.

Design

A phenomenological research design is used in this qualitative study to discover the lived experiences of women with a first-time MI. According to Munhall (1994), nursing embraces the whole of the human condition with values that include respect for each individual and the individual's cultural interpretation of meaning in experiences and events…“In this regard, the phenomenological method becomes essential for nursing research as well as the actual implementation of a holistic, empathic, individualized delivery of care (p. 21).”

Merleau-Ponty (1962) believed that the lived experience, through attention to the perceived world in the context to which it belongs, was the focus of phenomenology. Phenomenology is the act of turning to the phenomena of lived experiences as a means of relearning and reawakening (Merleau-Ponty, 1962). Van Manen (1984) was strongly influenced by Merleau-Ponty. According to van Manen (1990), phenomenology is the descriptive study of lived experiences, or phenomena, in a search for what it means to be human. The van Manen method of phenomenological inquiry and analysis was used to conduct this nursing research study on the
lived experiences of women with a first-time MI and will be discussed in the data analysis section of this study.

The phenomenon to be discovered in this study is the lived experience of women with a first-time MI. The research question is: What is the lived experience of women who have had a first-time myocardial infarction?

Participants

Participants were recruited from one large Midwestern cardiology practice setting with 18 cardiologists. These offices are located in one large Midwestern cardiac outpatient office. Generally, in qualitative research the number of participants is not predicted. Instead, the researcher will stop the research when saturation is achieved (Burns & Grove, 2001). Saturation refers to the repetition of data collected to provide confirmation of previously collected data (Speziale & Carpenter, 2003). This study is limited to 3 women who meet the inclusion criteria. A purposive sampling is sought of women with a first-time MI. In this study, saturation was not reached due to a limited number of participants and to time restraints.

Women who have experienced a first-time MI over the past 12 months learned about the study upon their visit to the cardiologist. An information sheet about the study was provided to the women (Appendix A). Through the information sheet, the participant was made aware that participation was voluntary, participating or not participating had no bearing on the quality of care they would receive currently or in the future, cardiologists did not have access to participant study information and were not able to identify the participant responses from the study results.

The participant information sheet (Appendix A) provided at the cardiologists’ office, provided information that participation was voluntary and a phone number was available for those
who voluntarily chose to participate. Protection of the participants was provided by: (a) caller identification blocked on the researcher’s incoming phone calls; (b) participant identifiers did not appear on the questionnaire, audiotapes, or study notes, publications, or presentations; (c) participants were identified with a letter and number: P1, P2 respectively, to identify the information obtained in the study; (d) the information sheet was reviewed at the interview session prior to beginning the interview audiotaping and time was provided to answer participant questions; (e) the participant was asked if they were voluntarily participating of their own free will, were non-pregnant and had no terminal illness. The interview was continued if the participant answered yes; (f) audiotapes were provided to a stenographer, without participant identifiers, to create documents of the taped interview; (g) during the study, and for 7 years after completion of the study, audiotapes, transcripts and questionnaires are stored in a locked file cabinet in the Center for Nursing Research and Evaluation in the College of Nursing at the University of Toledo and will be destroyed after 7 years by shredding after data analysis has taken place; (h) the participant was forewarned of the potential for feelings of anxiety while sharing their experiences of having a first-time MI and a resource phone number of Rescue Mental Health Services at 419-255-9585 was provided for support; (i) the information letter and discussion prior to the beginning of the audiotaped interview reinforced that participation or non-participation did not affect care provided; (j) template for conducting the interview (Appendix B) served as a guide as to how the interview was conducted; (k) participant was informed, via the written information sheet and verbal instruction prior to the beginning of the audiotaped session, that the participant may stop the interview or participation at any time; (l) the only people in the interview sessions were the participant and the researcher.
Criteria for inclusion are: (a) adult females, at least 20 years of age; (b) have sustained a first-time myocardial infarction over the past 12 months, as identified by meeting diagnostic criteria (cardiac enzyme rise, pain, 12 lead EKG, cardiac catheterization, or echocardiogram); (c) have been hospitalized for the myocardial infarction; (d) have been discharged from the hospital after the myocardial infarction; and (e) able to speak, read and understand the English language.

Criteria for exclusion are: (a) women who have had more than one MI; (b) females younger than 20 years of age; (c) pregnant women; (d) women who do not speak, read, and understand the English language; or (e) having terminal illness.

The setting for the interviews was based on what was most comfortable to the women and mutually agreed upon by both the participant and researcher. Options included but were not limited to a secluded outpatient meeting room or library meeting room. A second interview, by phone, was offered and at the sole discretion of the participant, if the participant found it necessary to notify the researcher of any other information to share about her experience of having a first-time heart attack.

Criteria for qualitative evaluation.

According to Munhall (1994) “rigor and merit are as critical to a phenomenologist as they are to an experimental researcher…If the phenomenological baseline has not been meticulously explored and described, then what follows, as in an experiment, will not be congruent with the connected underpinnings” (p. 188). Rigor is the use of discipline, scrupulous adherence to detail, and strict accuracy in an attempt to achieve research excellence (Burns & Grove, 2001).
Rigor for this study will be evaluated using qualitative criteria developed by Leininger (1991a, 1991b). According to Leininger the use of the following evaluative criteria for qualitative studies are imperative:

1. **Meaning-in-context**—This criterion focuses on the significance of interpretations and the understanding of actions, events, symbols, communications and many other human activities within the total contexts in which it has occurred. This refers to the data that has become understandable with meanings to the participants or people in different or similar environments.

2. **Recurrent Patterning**—Refers to repeated instances, experiences, sequence of events that tend to reoccur over a period of time in designated ways and contexts. Repeated expressions, experiences, events, or activities that reflect identifiable sequenced patterns of behavior over time are used to substantiate this criterion.

3. **Saturation**—Means that the researcher has conducted an exhaustive exploration of whatever is being studied and that there is no further data or insights that will come from the informants or observed situations. Data reveals redundancy and duplication of content with similar meanings, ideas, experiences, descriptions, and other expression from the informants or from repeated observations of the phenomena.

4. **Transferability**—Refers to whether specific findings from a qualitative study can be transferred to another similar context or situation and still preserve the particular meanings, interpretations, and inferences of the completed study.
Material

Demographic data were obtained using a simple study questionnaire form (Appendix C) that was administered during the first interview session, prior to the audiotaped interview. Information gathered included age, gender, race, marital status, length of time (weeks) hospitalized with the MI, length of time (weeks) since discharge from the hospital. The purpose of collecting demographic information was to validate the inclusion criteria and for observation of patterns that may evolve during this study. Additionally, this data may be useful in future studies about women’s heart health.

Interviews consisted of one conversational, open-ended, unstructured individual interview, lasting 30 minutes to 60 minutes. This type of interview provides a great deal of information about the experiences of the individual (van Manen, 1990). Open-ended questions (Appendix D) are questions that require more than one word responses (Egan, 2002). The researcher used open-ended questions, probes, and non-verbal prompts such as body language, gestures, and eye contact to encourage the women to tell the story of their experience of having a first-time MI. This approach provided direction, focus and a comfortable environment for the interview.

Each interview was audiotaped and transcribed. Prior to the beginning of the audiotaping, the information sheet was reviewed and the participant was informed. Upon starting the audiotaping, voluntary participation was confirmed. Then, participants were asked, “Tell me about your experience of having a heart attack for the first time?” Use of the words “myocardial infarction” may create an immediate barrier to communication. Thus, the researcher used language that is universal and the words “heart attack” were included to denote an MI. Each participant determined the direction of the interview. Only if necessary, the researcher used open-ended probes (Appendix
D) to prompt the participant in proceeding to tell their story (Egan, 2002; Munhall, 1994). As discussed and defined earlier, the small sample size of this study did not permit saturation. However, recurrent patterns, themes and essences of the experiences of the women in this study were discovered.

Data Collection

Sampling

Justification of the number of participants

This study included 3 participants. According to Speziale & Carpenter (2003), unlike quantitative research, there is no need to randomly select individuals, because manipulation, control, and generalization of findings are not the intent of the inquiry (p. 24). The intent was to increase understanding of phenomena. Saturation was sought but did not occur due to the limited sample in this study. Saturation refers to the repetition of discovered information from the participants. “This means that rather than sampling a specific number of individuals to gain significance based on statistical manipulation, the qualitative researcher is looking for repetition and confirmation of previously collected data” (Speziale & Carpenter, 2003, p. 25). After the researcher was contacted by phone, by women who choose to take part in the study and who meet inclusion criteria, an interview was arranged with clarification and confirmation of the date, time, and location.

Protection of human rights.

In order to protect human rights, approval of this study was obtained from the Institutional Review Board of the Medical University of Ohio at Toledo (Appendix E). A participant information sheet (Appendix A) was provided and confirmation of voluntary participation, of own free will, was
obtained at the beginning of the audiotaped interview. All participants were reminded that involvement in this study was strictly voluntary; they were free to stop the interview at any time, or withdraw from the study at any time and their care would not be influenced or jeopardized.

All information and names of participants were confidential. Participant names did not appear on the questionnaires, transcripts or researcher field notes. Each participant was given a number code (P1, P2, P3) to denote each participant by a letter and number rather than by name. All data used in this study were not identifiable with the participant. Participant names were not placed on any of the data obtained. The researcher removed the proper names identified by the participants and assigned a fictitious name to each participant to ensure confidentiality. Physicians and other healthcare providers and institutions did not have knowledge of client participation.

A professional stenographer transcribed all audiotapes verbatim. Audiotapes were labeled with the numeric code assigned rather than participant names. The researcher reviewed the accuracy of transcription. During the study, and for 7 years after completion of the study, audiotapes, transcripts and questionnaires will be stored and locked file cabinet in the Center for Nursing Research and Evaluation in the College of Nursing at the University of Toledo and will be destroyed by shredding after 7 years. Data were clarified with the participants throughout the research process and were reported in aggregate form.

Assumptions

In research, assumptions refer to statements that are presumed to be completely true when there may not be evidence to support them. Identifying assumptions within a study is considered positive, introspective, and important to liberating one’s own judgments and perceptions of the phenomenon being studied (Burns & Grove, 2001; Speziale & Carpenter, 2003).
Phenomenon should be explored without preconceived expectations or biases (Omery, 1983). However, every researcher brings his or her own life experiences and values. These experiences and values help create preconceptions that must be made explicit from the very beginning of the study (Parse, 1996). Bracketing is used so the researcher's preconceptions are identified. This researcher's preconceptions have roots in greater than 30 years experience as a cardiac nurse working with women are as follows: (a) women want appropriate healthcare; (b) women want to be in control of their health; (c) women have many responsibilities and roles that may affect how they respond to meeting their own needs; (d) women with heart disease have not been understood; (e) it will be beneficial for the women to tell their stories; (f) suffering from an MI is traumatic for the participant, spouse and significant others; (g) women who have experienced a first-time MI have specific are needs; and (h) psychosocial issues such as stress, anxiety, hopelessness, loss, and pain may be discovered.

Identification of preconceptions is important so that the researcher will remain open to the discovery of meaning related to the phenomenon being studied (Parse, 1996). Understanding of the world of others is only possible through inquiry. This researcher’s self-inquiry provided a mechanism to identify and declare preconceptions about the phenomenon, thus providing a way to self-understanding. Through self-understanding one can begin to better understand the world of others.

Limitations.

The sample size of 3 participants is appropriate for this study. However, saturation was not met because of the lack of depth in this study, as discussed earlier. There are several limitations that are applicable to this study at this time: (a) the inexperience of the researcher in conducting
research interviews; (b) methodological limitations or the limitations experienced throughout the study and are not known at this time but will be identified at the conclusion of the study; (c) women may find it difficult to describe the lived experience of a first-time MI because of painful feelings and anxiety associated with the experience; and (d) small sample size.

Data Analysis

Van Manen’s (1990) phenomenological method of human science inquiry guided the data collection and analysis of this study. Van Manen (1990) proclaimed:

Phenomenology is the quest to become more human as we search to better understand and gain insight into the depth of life and the meaning of living…phenomenology is the study of essences…the term essence is best explained as a linguistic construction: a description of a phenomenon (p. 6).

His method includes the interplay of four procedural steps.

The four steps for this method are:

1. *Turning to the nature of lived experience.* In this step it is essential to ensure that the researcher turns to a phenomenon that seriously interests them and commits to the world that surrounds our being (van Manen, 1984). This step involves being oriented to the phenomena of the experiences of women with a first-time MI and questioning the essential nature of this phenomenon as being meaningfully experienced. The researcher is oriented to this phenomenon as a cardiac nurse. The specific interest in women’s cardiac health began in 1997 as an undergraduate community assignment that included exploration of the cardiac statistics of the mortality and morbidity rates among women. What is more noteworthy is that since then, even with national
initiatives to improve women’s heart health and care, there have been little to no improvements. This researcher wants to learn more and has a deep interest in the lived experiences of women with a first-time MI. Interest in the lived experiences of women may bring about a better understanding of what the experiences of women are who have had a first-time MI. The phenomenological question is, “What is the lived experience of women who have had a first-time myocardial infarction?” Assumptions and pre-conceived notions are bracketed or suspended in phenomenological research. To do this the researcher will put aside or bracket theories, assumptions, beliefs, biases, and presuppositions, in an attempt to place the phenomenon in the forefront. These were brought forward and declared for the purpose of avoiding coloring the data with researcher biases.

2. **Investigating experience as we live it.** In this step it is essential that the researcher is investigating experiences as they are lived, here and now, rather than as the researcher thinks they should be (van Manen, 1984). This step is concerned with data collection, including using personal experiences as a starting point. The researcher has the personal experience of providing nursing care for women with MI for over 30 years. Additionally the researcher lectures and teaches professionals, non-professionals, and community members about women and cardiac disease health promotion and disease prevention. Thus, the researcher has demonstrated an interest prior to beginning this research study. Experiential descriptions will be obtained through observation and interviewing. Conversational interviews will be conducted in the van Manen style of being open-ended probes or unstructured. During this step the
researcher is to remain as close as possible to the participants and the phenomenon in an attempt to understand the lived experience from the participants’ world from their point of view. According to van Manen (1984), the phenomenologist may acquire insight by turning to poetry, art, literature, personal biographies, journals, logs, and diaries as sources of lived experience data (p. 70). The researcher will be alert to inquire about these as sources that may reflect lived experiences of women with a first-time MI.

3. **Phenomenological reflection.** In this step it is essential that the researcher is reflecting on the essential themes that give form to, or that characterize the phenomenon of interest (van Manen, 1984). This step is the process of conducting and constructing thematic analysis occurs. This is the act of reflection by the researcher, of the lived experience while seeking the essential meanings. The uncovering of thematic structures come from the narrative descriptions of the participants and this occurs with performing two procedures. First, the researcher must read the transcript line by line and determine how each line reveals parts of the phenomenon. Secondly, the researcher reads the transcript over and over until certain aspects of the text are revealed as essential in the description of the experiences of the participants. Paragraphs are developed to describe the themes more thoroughly. This is the capturing of the essence of the themes by the researcher’s reflection in an attempt to recreate experiences. According to van Manen, “A theme is the experience of focus, the meaning, of point…themes describe an aspect of the structure of the lived experience” (p. 87). The question to be asked here is “What statements or phrases
seem particularly essential or revealing about the phenomenon or experience being
described?” (van Manen, 1990, p. 93). Selection of themes is the critical element of
this step. The researcher will determine the primary themes that project or reflect the
essential meanings of the phenomenon.

4. **Phenomenological writing.** In this step it is essential that the researcher is describing
the phenomenon of interest through the art of writing and rewriting (van Manen, 1984).
The fourth step is the writing and rewriting of text, utilizing the researcher’s personal
experiences and utilizes descriptions located in art and literature, while focusing on
experiences as they are lived (van Manen, 1984). The main goal of the researcher is
to transform the lived experience of women with a first-time MI into textual expression
of the essence of their lived experience. Structuring the phenomenological
descriptions may be achieved by all or any of the following: patterning around the
themes; generating the essence of the phenomena by illustrating examples as they
are determined, or weaving existential themes with descriptions or engaging in a
dialogue with another phenomenological author. The researcher may write and rewrite
many times so that the expression of meaning or the essences of that experience from
the view of the women is better known through illumination of the meaning of their
lived experience. Phenomenological writing should contain examples and descriptions
of the human experience as it “reawakens our basic experience of the phenomenon it
describes…in such a manner that we experience the more foundational grounds of the
experience” (van Manen, 1984, p. 65).
Procedures and Schedule

Cardiologists were sent an information sheet about the study and a letter requesting they provide the information sheet to women who meet criteria to participate in the study. The interested participants called the researcher by phone to set up a date to meet. The researcher’s phone had blocked caller identification. The participants who met inclusion criteria were accepted into the study as they notified the researcher of their voluntary choice to participate in the study. A template for conducting the interviews was created to help increase understanding of what the participant could expect (Appendix B). Prior to the audiotaped interview the researcher explained the normal course of the meeting and interview. Then, a review of the information sheet was provided and the participant’s questions were answered. The researcher asked questions to confirm that the participant was volunteering for the study of her own free will, that she was not pregnant and did not have a terminal illness. The study continued if understanding of the study, voluntary participation of own free will, non-pregnancy and non-terminal illness status existed. Then, the non-audiotaped portion of the interview began by providing the study questionnaire. The participant reviewed the questionnaire with the researcher, completed the questionnaire and returned it to the researcher.

Next, the audiotaped interview began. Each participant was informed prior to the start of the audiotaping. Upon starting the audiotaping the researcher started by confirming that the participant was volunteering for the study of her own free will. After the participants confirmed voluntary participation audiotaping the interview continued. The interview was congruent with the van Manen method, which is non-structured dialogue between the researcher and the participant.
Open-ended prompts were used as needed (Appendix D). The participant was asked to respond to the following question: “Tell me about your experience of having a heart attack for the first time?”

A second interview could occur, by phone, only if the participant chose to call the researcher on a specific date established. The date for the phone interview was established at the end of the face-to-face interview. The participant was informed that she had the choice of calling the researcher on the date chosen. The purpose of the second interview was to provide the participant with an opportunity to have contact with the researcher to bring clarity and enhance understanding of the experiences of the participant. A professional stenographer transcribed the audiotapes. No identifying information was on the audiotapes. The transcripts were evaluated for accuracy by the researcher. Demographic information was compiled for descriptive information via a computer. No identifying information was on the data.

Summary

The purpose of this qualitative phenomenological study was to discover the lived experience of women with a first-time MI. This chapter described the design of the study, selection of participants, and materials used. Additionally, the method of data collection, including sampling, protection of human rights, assumptions and limitations were discussed. Lastly, data analysis with van Manen’s method of inquiry required turning to the nature of the lived experience, investigating the lived experience, phenomenological reflection, and phenomenological writing.
CHAPTER IV

Results

The purpose of this study was to explore the lived experience of women with a first-time myocardial infarction (MI). In this chapter, the results of this study are presented. Data were thoroughly examined and three themes were discovered. The essential themes were discovered from the reflection of the transcribed interviews from the participants as they describe their lived experience of having a first-time MI. The themes, or essences, are discussed in verbatim excerpts taken from the participants’ interviews as they described their lived experience of having a first-time MI. Van Manen’s (1990) method of phenomenology was used as the method for data collection and analysis in this study. For a more in depth discussion of van Manen’s method, the researcher refers the reader to Chapter III. Selection of a nursing theory will be guided by the results of the study. The rationale for delaying the selection of a nursing conceptual model is based on the underlying philosophy of phenomenology as discussed in Chapter I.

Participants

Three participants volunteered to participate in this study. In Table 1 the demographics of the participants in this study are identified. The participants were all Caucasian married females. One participant was hospitalized for the heart attack for greater than 4 weeks and the other two participants were hospitalized for less than 1 week. Two participants had been discharged from the hospital for more than 4 weeks prior to participating in this study. One participant was discharged for 2½ weeks prior to participating in this study. Included in this chapter are excerpts taken from the participants’ interviews as they described their lived experience of having an MI for the first time.
Table 1

Participants Demographic Data

<table>
<thead>
<tr>
<th></th>
<th>Participant # 1 (Mary)</th>
<th>Participant # 2 (Ann)</th>
<th>Participant # 3 (Jean)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>43</td>
</tr>
<tr>
<td>Gender</td>
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<td>Female</td>
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</tr>
<tr>
<td>Race</td>
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<td>Caucasian</td>
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<tr>
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<td>Number of weeks</td>
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<td>Less than 1 week</td>
<td>Less than 1 week</td>
</tr>
<tr>
<td>hospitalized for the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>heart attack</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of weeks</td>
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</tr>
<tr>
<td>since discharge from</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>the hospital</td>
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</tbody>
</table>
Findings

Van Manen’s method of phenomenological reflection was used to identify common themes. Three themes were discovered that revealed the structure of the lived experience of women with first-time myocardial infarction (MI): (a) the lived experience of an MI elicited the process of grief to help the women cope with the stress of the loss. Following the sudden traumatic loss of the health status of the old self or pre-myocardial infarction, the women experienced denial, bargaining and feelings of anger, guilt, and fear as they explored the expectations and meaning of this new self after the MI; (b) the women experienced the process of change throughout their recovery as they began to integrate the experience of an MI into the old self and create the new self or changed self. The women began to integrate the change to help them move towards new levels of personal growth as they engaged in behaviors that promoted recovery. Change occurred for the women in the valuing of self, family and others, activity level, and how they responded to recurrent chest pain; (c) the women experienced caring interactions with healthcare providers such as nurses and physicians, that provided an environment which fostered the process of integration of change, recovery and healing, and were crucial in promoting health-seeking behaviors. The caring interactions with healthcare providers provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery.

Themes were identified and specific verbatim excerpts from the interviews of the participants were used to support each theme. The common themes discovered in this study help to discover the meaning of being a woman with a first-time MI. The phenomenon is described in words of those who lived the experience, which brings us closer to understanding the participants’ lived experience. Although the themes presented in this study are important to understand the lived
experience of women with a first-time MI, according to van Manen (1990), “no conceptual formulation or single statement can possibly capture the full mystery of this experience” (p. 92). Although these themes are not a comprehensive description of this phenomenon, the discovered themes will add valuable knowledge for nurses in caring for this client population and beginning to understand the phenomenon of the lived experience of a first-time MI.

Theme One:
The lived experience of an MI elicited the process of grief to help the women cope with the stress of the loss. Following the sudden traumatic loss of the health status of the old self or pre-myocardial infarction, the women experienced denial, bargaining, and feelings of anger, guilt, and fear as they explored the expectations and meaning of this new self after the MI.

Theme Two:
The women experienced the process of change throughout their recovery as they began to integrate the experience of an MI into the old self and create the new self or changed self. The women began to integrate the change to help them move towards new levels of personal growth as they engaged in behaviors that promoted recovery. Change occurred for the women in the valuing of self, family and others, activity level and responses to recurrent chest pain.

Theme Three:
The women experienced caring interactions with healthcare providers, such as nurses and physicians, that provided an environment which fostered the process of integration of change, recovery and healing and were crucial in promoting health-seeking behaviors. The
caring interactions with healthcare providers provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery.

The essence of the lived experience of women with first-time MI was discovered through the participants’ responses when the researcher asked the women to describe their experience. Each theme is presented here with supporting excerpts from the verbatim excerpts from the participants.

Theme One:

The lived experience of an MI elicited the process of grief to help the women cope with the stress of the loss. Following the sudden traumatic loss of the health status of the old self or pre-myocardial infarction, the women experienced denial, bargaining and feelings of anger, guilt, and fear as they explored the expectations and meaning of this new self after the MI.

All participants experienced grief after having an MI. The grief process was experienced to help the women cope with the loss of their old self and previous heath status. The women’s grief process included experiences of denial, bargaining and feelings of anger, guilt and fear. Denial helped the women when they were not able to face or accept what was happening in their lives. At times the participants experienced one feeling more than another, or, at times, the women experienced several feelings all at the same time. All the participants waited before seeking immediate healthcare assistance and provided rationale for their decision to wait before seeking healthcare attention.

When Ann started having chest pain she could not accept that she was having an MI because she was very health conscious. Ann also expressed that at the time she experienced chest pain, she refused to listen to her body. She discussed her past history of having five
cesarean section surgeries and that she learned women need to endure pain. Ann took pride in having a high threshold for pain and shared her perceptions of why women are dying from heart disease.

Denial helped Ann cope when she was not able to face or accept that she was having an MI. Ann expressed her lack of acceptance that she was having an MI. Ann recalls:

I guess I was totally shocked that I would have a heart attack. I work out every day. I have probably since I quit smoking 20 some years ago. Been very conscientious about what I eat. And the way I cook food and you know, monitoring that for myself and my husband as well. And the family [sic]. So I did not believe that I was having a heart attack. And probably, maybe, would have to suspect that I had some symptoms prior, some clues, but put them aside…I felt the pain in my arm and my chest and my back shoulder an I was like, this can't be. Well, I think I've always had a high threshold of pain, you know, I had 5 C sections and you come home and you just get with it and you just say, it isn't there, it's not happening, and I think we do the same thing with, and maybe that's why women die. Cause we think this is nothing. I can gut through this.

Ann expressed her perception that men do not have the same threshold for pain that women do and that has contributed to men seeking healthcare assistance in a timelier manner than women and, therefore, men have experienced better survival rates than women. Ann recalled the reasons for delaying getting healthcare attention because she was having guests for dinner and she did not want to be inconsiderate and tell her guests she needed to leave abruptly. Another reason she delayed treatment was because she did not want to wake her neighbors with the siren of the ambulance vehicle. She did not want to believe or accept that she was having an MI and
thought if she waited it would go away. Her husband drove her to the hospital, which later she
recognized as a “mistake” because she needed immediate healthcare attention. Ann recalled her
feelings of guilt for not listening to her body and for not seeking healthcare attention immediately.
She said, “Had I gone in when I first felt pain Monday morning maybe I wouldn’t have had the
heart attack. And maybe I would have heard the signal to get something done.”

Ann experienced bargaining when her pain began on the first day of her MI. She was
bargaining with God to give her more time. Ann bargained with God to let her have dinner with
family and friends that night then He could bring the MI back the next morning. Ann said, “All right
God if this is, let it come back tomorrow morning, after I get these people out of here.” Ann
continued to bargain with God for more time during her recovery. Ann bargained that she was
going to do everything she was supposed to do if she could live to attend her daughter’s wedding.
Ann recalls bargaining with God:

I’m not going beyond what the doctor says I can do. I am going to do it their way…. Like I
said I think that God has His way for all of us, because you’re special and I love you and, I
was not afraid to die and I told everybody that, I was not, I know that I’m going to heaven
when I die so I’m not afraid of dying. I did say, I’d like to be around for (daughter’s name)
wedding. If I could just add that to the agenda [sic].

When Ann was in the hospital cardiac catheterization laboratory, she remembered being
fully awake and alert because she was not given medications to sedate her for the procedure. The
usual sedation was withheld because she had a negative reaction to the drugs during her last
hospitalization. While Ann was lying on the catheterization table, awaiting her coronary artery
stents, she observed the cardiologist speaking to other healthcare workers as if Ann was not
present in the same room. Ann also remembered trying to make sense of what was happening when noone was speaking directly to her. Ann experienced anger regarding the lack of acknowledgment of her presence and the lack of information about what was happening. Ann recalled:

But you were in there for 2½ hours, not sedated. Not sedated. And you know, listening, and you’re listening and I’m not stupid, when the girl in the booth is going heart…blood pressure, she would go, I see it, I see it. And he’d back away. I’m like well, you know, obviously things are a little tight right now.

After receiving five intracoronary artery stents a procedure to remove the catheter in her femoral artery was performed. Ann spoke about the painful “negative” experience several times throughout the interview. During the removal of the catheter from her femoral artery Ann experienced fear of the severe pain and called upon God for help. Ann recalls:

I had pain when he pulled out the catheter…and I remember at the end when they pulled that catheter out it felt like they had put a sword up me. And at first I started to scream and then I just started to praise God…ok God, you and I are here and we’re together and we’ll get through this and whatever You want.

When Mary started having chest pain at home she was in denial and could not accept that she was having an MI. She believed that she could not be having a heart attack because 8 years ago, when her coronary disease was so advanced, her coronary arteries had been fixed with coronary bypass surgery. During this time when she could not accept that she was having a myocardial infarction Mary recalled:
Yes, I was at home, crushing pain, waited just a little bit but had bypass surgery 8 years prior, so didn’t really know what was goin’ on [sic]. I didn’t have a heart attack at that time.

This is my first experience with a heart attack.

Mary expressed that she waited before seeking help because she had open-heart surgery 8 years prior and thought it unlikely to be a heart attack. Mary expressed that her care was expedited as they rushed her to the hospital and she had a cardiac catheterization and a stent placement to keep one of the coronary artery grafts open. Mary also expressed much fear about her future longevity because of the tentative nature of the patency of the new stent, which could cause a “fatal heart attack” in the next 1-5 years if it becomes occluded. Mary recalls the ever-present feelings of fear:

It’s scary to think that, you know, my life could be cut very short. I’m 49 years old. And when I had that heart attack in February I was 48, so my bypass graft I was 40. So it’s pretty young…the fear is there. Yes, the fear will never leave, I don’t believe. And even if I went 6 years, even if I went 10 years, it’s still, it would probably be, probably be worse, because then I would be past it, but it could happen at any minute…Just can’t get rid of that fear, that fear just won’t, it won’t leave.

As Mary attempted to have some control over her disease process and postpone death she bargained for more time as her reward for the good behaviors of eating right, exercising and self-education. Mary said:

I eat healthy. I’ve always, I notice myself buying and picking up any kind of health book now. Not just for the heart, diet, exercise, every magazine made out there now I order. I’m
trying to read more and more and more, educate myself. Longer. Yeah, longevity is the key here.

During the interview Mary spoke of her two children and her grandson several times. Mary took pride in her role as a mother and grandmother. Though it had been “a struggle” to physically care for her grandson, she wanted to spend as much time as possible with her grandson because she may not be alive. Mary spoke of her grandson and correlated his aging with the possibility of when her death could occur. Mary expressed feelings of guilt about the possibility of her death and not having enough time to spend with her grandson as he grows older. Mary recalled:

I sat and looked at him and again, thoughts of my heart attack and it’s always, always there, thinking well, he’ll be 7, in 5 years he’ll be 7, okay, in 4 years he’ll be 6 and I’ll know this. And I just kind of went through the stages up until 5 years, almost saying I have 5 years to live and that’s it.

Throughout the interview Mary discussed that she acknowledges the need to “slow down” after the MI. Mary also expressed feelings of anger for the persistent and repetitive nature in which other people told her that she needed to slow down. Mary recalled:

I try to slow myself… I wanna work, you know, and some times I feel like I can work but people still around me are telling me, go home, slow down, which I’m not sure if that’s good or bad [sic]. Sometimes I don’t like that at all. Or maybe I’ll want to work 6 days in a row instead of 5 and even the cardiologist is telling me I can’t do that. I can’t do that. And people around me are saying no, you can’t come in tomorrow. Slow down. Slow down. So I’ve heard that since my heart attack a lot.
Mary remembered discussing her concerns about her fear of death with her cardiologist. She also discussed the “good relationship” she had with her cardiologist and that she felt she could openly talk with him about her feelings. Mary recalled one office visit when she became “teary eyed” while discussing her fear with the cardiologist. Mary experienced feelings of anger when the cardiologist told her he was starting her on an antidepressant. Mary recalled:

I’m a little teary eyed and he said I think I’m going to put you on an antidepressant. And I told him, no, you’re not going to put me on an antidepressant. Okay I don’t need an antidepressant. I am probably one of the most upbeat, trying, you know, I don’t sit around and cry, I don’t have time for that, you know what I mean, but I do think about things, you know, and the fear and the time line, you know, and he thought that he should put me on an antidepressant. I said that’s not happening.

The relationship Mary had with her cardiologist provided an environment of comfort where she could openly reject his plan to start her on an antidepressant. Mary was fully aware of her disease process and she exercised her autonomy in making the decision not to start on an antidepressant.

Jean had been experiencing atypical heart pain symptoms that included lip numbness that radiated into her chin. Jean was an experienced cardiac nurse who knew about the atypical heart pain symptoms. Jean experienced a lack of acceptance because she could not believe or accept that she had an MI. She also had been treated for syncope over the past 6 months and rationalized that her symptoms were related to her syncope rather than an MI. Jean experienced denial because she was not able to accept that she was having an MI. Jean said:

Well, surprising. I had been having facial symptoms, like my lip had started feeling numb and then it went down into my chin area, and the day it started was going to, pressing into
the chin area...Shocking and disbelief. I said okay, how can that be when I never had any
of the typical symptoms or all that stuff...I just figured the cardiac cath was gonna come
back totally negative and somewhere a mistake was made and it was not my blood work.

Jean expressed that she thought the symptoms she was experiencing could be related to
the syncope she had over the past 6 months. Jean had decided to wait to seek immediate
healthcare attention. She stated, “And so I decided not to get, immediately go to the ER or
anything.” Multiple times throughout the study she expressed anger that a cardiologist who was
caring for her syncope symptoms had missed the symptoms of her MI. Jean recalled feelings of
anger:

How can you like truly be so focused on just syncope, I mean, he was a cardiologist and I
felt, especially after later when I found out that I had had the MI, that how could you have
not listened to me? And yes, your specialty is [sic].

Multiple times throughout the interview Jean expressed feelings of anger about the care
she did not receive. Jean said she was “disheartened” with nursing and medical staff and “very
discouraged with healthcare in general.” When discussing her feelings Jean said, “you know,
you’re just a number and they don’t really care.” Jean had expectations about her care that were
not met. Jean remembers feeling anger because the cardiologist “never did an assessment...never
listened to my heart or lungs or never, any part of an assessment.” Jean recalled:

You still have to look at the whole cardiac picture, the whole person, and at no time did
anyone try to look at the whole person and see everything that was going on...I was more
than willing to share with someone if they would just listen or even ask me...being a nurse
you always expect that you’re gonna be treated as if you were treating, you know,
someone, and overall, it just didn’t compare. And I would hope that no one ever felt like that I didn’t care for them like I felt these people, you know, the nursing staff didn’t care.

After multiple negative experiences with one specific cardiologist Jean experienced feelings of fear of going back to the hospital to receive care by the cardiologist and his cardiology group. Jean recalled:

I am fearful of an admission or you have to go back to the group again… I probably would never have had the cath and probably would never have had anything done because the symptoms were so atypical that I don’t think everyone in the group would have picked it up… you know, am hesitant to have to go to the hospital and see Dr. (name) because I, you know, they only have what’s in front of them, like it comes out of the CDR or whatever that, you know, from someone’s dictation, they don’t have, they don’t know the whole story [sic].

Jean later admitted that if she had recurrent chest pain she would rather “wait” to see the one cardiologist who she felt cared about her and knew her story. Jean also realized she “could be dead” if she waited to respond to chest pain.

After the MI Jean was scheduled for a transesophageal echocardiogram (TEE) and a cardiac catheterization. She was sedated for the TEE and woke up on the cardiac catheterization table. Denial helped Jean when she could not accept when the cardiologist told her he had just placed a stent in her circumflex and she said, “And I’m like me?” Denial continued as Jean, an experienced cardiac nurse, expressed uncertainty about which symptoms she should regard as important enough to seek healthcare attention. She said, “So, still don’t know truly what I should take serious and what I shouldn’t. So if it’s, it’s severe then I’ll go for help.” Denial helped Jean
cope while she grieved the loss of her old self and was trying to create the new self. Jean needed to take the time to grieve her loss.

Jean experienced feelings of guilt because, as a cardiac nurse, she knew what behaviors were needed to be heart healthy and she should have taken better care of herself and maybe she would not have had an MI. Particularly, she was sensitive to the issue of being overweight. She experienced guilt over what she could have done or should have done to avoid having an MI. Jean shared feelings of guilt:

I think, you know, hell everyone’s going to say she's so overweight or she's so this and what does she expect? Nothing. Where Dr. (name) never made me feel that way which, you know, again at the (name) Hospital ER, the cardiologist really made me feel like, you know, you’ve brought all this on yourself, you know, cause you’re overweight.

Jean continued to experience denial and feelings of anger when she started the cardiac rehabilitation program. Jean recalled:

I started rehab, and um felt like I shouldn’t be there…I felt very, um, out of shape and very hard on myself that, you know, why is it that I can’t do as much as they are and I should be able to do more and I should be able to, this shouldn’t happen to me, pretty much. Why did this happen to me?

Jean expressed her decision not to complete the cardiac rehabilitation program because she did not feel comfortable in that setting. She recalls feeling uncomfortable being one of the youngest in the group among many seniors citizens at the cardiac rehabilitation program. She experienced feelings of guilt and anger towards herself. She shared that she “should be” able to outperform the others at cardiac rehabilitation because she “was the youngest” one there. Instead,
she had feelings of guilt and anger because she was “not able” to perform at the same levels the seniors were working at in the cardiac rehabilitation program. Jean did not continue in the cardiac program because she was in denial and still grieving the loss of her old self. When she was at the cardiac rehabilitation program she saw the old Jean not the new Jean and her expectations were unrealistic.

This theme illustrated the grief process that helped the women cope with the loss of the old self after an MI. Denial, bargaining and feelings of anger, guilt, and fear helped the women grieve the traumatic loss of the old self and health status of the old self. Denial helped the women deal with what could not be faced or accepted as a changed life and a new self was created after the myocardial infarction.

Theme Two:

The women experienced the process of change throughout their recovery as they began to integrate the experience of an MI into the old self and create the new self or changed self. The women began to integrate the change to help them move towards new levels of personal growth as they engaged in behaviors that promoted recovery. Change occurred for the women in the valuing of self, family and others, activity level and responses to recurrent chest pain.

The participants repeatedly reflected openly about changes that occurred during their experience of having an MI. Change was part of every participants’ experience as they went through their own recovery. Change is essential to the process of creating a new self, which occurs by integrating the old self with the changed self. The participants experienced change in the valuing of self, family and others, activity level and responses to recurrent chest pain.
When Ann experienced her first chest pains she did not seek healthcare attention immediately. She developed chest pain in the morning and evening of the day she was providing a dinner for her family and friends. She did not want to impose on her family and friends with her need to go to the hospital. She recalls:

We were having out of town company to spend the night and come for dinner and sitting at the dinner table around 10 o’clock I felt the pain in my arm and my chest and my back shoulder and I was like, this can’t be. All right God if this is, let it come back tomorrow morning, after I get these people out of here, I don’t want to say thanks for coming to our house I’m going to the hospital, so we went up to bed.

Also, she had her husband “drive” her to the hospital because she did not want to inconvenience the neighbors by waking them with the sound of an emergency vehicle siren. On the day of her chest pain she was valuing family and friends more than herself and she delayed her care. She later admitted that she made a “mistake” by insisting her husband drive her to the hospital. After suffering from an MI and having a coronary stent placed Ann returned home from the hospital. Chest pain reoccurred while at home after discharge from the hospital. Ann reflects about changes in valuing of self, others and her response to recurrent chest pain:

Yeah, and I did wait. I mean, and don’t want to put anybody out. Don’t want to wake the neighbors. So I’ll go by car and well the next two times I woke the neighbors… You’re first reaction is this can’t be because they put the stent in. And I’m okay. But then they give you all the signs, you know, and I’m like, I’m not going to be stupid this time. So I said to (husband name) and my daughter had driven back in from (city name), and I said we’re going to call 911.
Ann advocated that women should “trust your pain” and listen to what their body is telling them if they are having pain. She wanted women to know that their life is more important than inconveniencing the neighbors. Ann said, “You’re more important than don’t wake the neighbors, you know, don’t draw attention to yourself. Go in and have it checked out and so if it wasn’t a heart attack, who cares.” Ann recalled that if she had listened to her body maybe she would not have had a heart attack. She said, “Had I gone in when I first felt pain Monday morning maybe I wouldn’t have had the heart attack.” Ann truly integrated her experience into her changed self as she responded to her chest pain in a way that afforded her immediate healthcare attention. She wanted to share what she had learned with other women and advocated that all women should learn from her experience and respond quickly. She said, “got the pain”...“get to the hospital. Call the ambulance. Don’t wait. Something’s causing that.”

Ann experienced a major change in how she valued others and God. She shared her feelings that “God changed my heart as he changed my heart.” She repeatedly shared her feelings that God showed her how much she is loved by Him, family, friends and healthcare providers. Ann changed her perception and value for the love that other people gave her and found an increased appreciation for their love. Ann recalled how much more she felt loved by other people. She recalled:

But it was a gift from God to show me how much He loved me and how much everybody else loved me. And I knew they did before. But it was like huge! Just, just huge. It was a big love fest. With me in the middle [sic].

Ann recalls a change in valuing family and others, particularly in valuing one male nurse
who provided her with care while in the “coronary care” unit. She stated, “I would have never thought I would have had a man nurse and been comforted like that.” She reiterated that we “take for granted” our relationship with “God”, “family and friends” and that she has a renewed love of God, family, friends and everyone. She recalled:

Then I think of rebuilding of, I think that we go through life like this with our appreciation of everything in life…Yes, and of our health, of our family, of the things that God’s given us and I know that I have a close relationship with God. But sometimes we just take it for granted. I know I have a great relationship with my family but sometimes you just take it for granted, you know!

Ann experienced change in the valuing of family, friends, and others as she integrated having an MI and new self-knowledge about her own vulnerability which created a renewed appreciation of life and those around her. Ann recalled spiritual feelings of the presence of God during her entire experience. She felt that she was “blessed” to have had the experience. She felt “love” and “peace” during her experience. Ann expressed people “need to let others know we are thinking of them” at any given time, not just when they are ill or dying. She said, “Send them a note say I love you, sick or without them being anything.” Ann spoke of her increased confidence to get better by “reclaiming” and “rebuilding” that had taken place in her life. Rebuilding relationships with God, family, self and others was a part of “getting better” and healing. Ann integrated her experiences to create behaviors of increased appreciation for and increased value of self, family, and others in health and illness.

Ann experienced a change in her activity level after the myocardial infarction. Ann had always “exercised” and had been “very health conscious” before the MI. She had been very active
in community events for those who were less fortunate than herself. After the myocardial infarction she realized she needed to change so that she was “not going beyond” what was expected during her recovery. To accomplish this Ann allowed others to help her with household duty of cooking for the family. Since her MI she has integrated her experience into her new self and accepted help from others while she is recovering. Ann spoke of all the help she had received from family and others and discussed that she has allowed brother-in-law to bring meals. She said:

I mean I can’t tell you the people who have just, my brother in law, I’m telling you, I think he’s cooked 20 meals. He shows up here morning about 6:45 and knocks on the door, and in he comes with another meal…Oh, I just feel so loved and special.

She shared that friends, family and neighbors “check on” her throughout the week. This was a major change for Ann to allow others to help her when she had been the one taking care of others all her life. This change occurred as Ann integrated her experience into valuing herself and family and her need to change her activity level during her recovery.

Mary experienced changes in the valuing of self, family and others after the MI. Mary recalled the change in valuing herself and her existence because of the constant threat that her coronary artery stent may occlude and cause another MI or death. She recalls being told that she may have up to “5 years” to live before the stent may close and cause another “heart attack or death.” The threat to her existence has helped her reevaluate what she wants to do with her life and brought an increased awareness about her increased vulnerability.

Mary expressed that she cherished the time she had on this earth and she wanted to make the most of it. She valued herself and decisions to make her own choices about how she was going to live her life without regrets. Mary recalls, “I don’t want to get sick then and then look back
and say, you should have taken advantage of this time you had.” Mary valued herself and knew she deserved to enjoy her life with full awareness. Mary recalls discussing her feelings about the limited timeline with her physician and making choices for herself:

I’m a little teary eyed and he said I think I’m going to put you on an antidepressant. And I told him, no, you’re not going to put me on an antidepressant. Okay I don’t need an antidepressant. I am probably one of the most upbeat, trying, you know, I don’t sit around and cry, I don’t have time for that, you know what I mean, but I do think about things, you know, and the fear and the timeline, you know, and he thought that he should put me on an antidepressant. I said that’s not happening.

Mary recalls taking pride in her inner strength to “fight” the battle against heart disease to stay as healthy as possible because she was “not ready to go yet.” Not ready to give up the “fight.” Mary said, “You have to go within I think yourself and bring it out.” Mary’s inner strength helped her make life style changes to maintain her health and helped her exert some control over her disease process at a time when her life was so vulnerable.

Mary experienced change in valuing her family and the time she had left to spend with them. Particularly she valued the time she had with her grandson who is just over 2 years of age. She said, “I’m glad I’m here to see him. I’m glad I was, you know, I lived through this heart attack, like I said, they told me it was very major, and it could have been different.” Because Mary’s life is threatened with her disease process she insists on spending what time she has with her grandson. In order to spend more time with him while she is alive she drives out of town to pick him up and takes him to her home every summer.
Mary experienced change in valuing others and their ability to relate to what she was going through and her real life experience after having an MI. Mary recalls diminished valuing of others who cannot understand her experience. Mary said, “Like you can only talk to your very very very close people and they still don’t even understand because they didn’t experience what I’ve experienced, you know [sic]. They listen, but you can’t share a lot with your friends.” Mary shared that she highly valued others with similar experiences as she was seeking networking with others to explore their lived experiences and provide validation of her experience. Mary recalls:

I keep reading, and I read other people’s, and other women’s stories [sic]. And it’s kind of nice to know there’s other people out there feeling that way too…the magazines are out there trying to promote the good health and everything, but, you know, it’s not like a network [sic]. I’d like to have a network that I could actually talk to other people about their experiences, you know…actual true-life stories of like it happened to me too, and felt like this that would be nice you know.

When Mary had chest pain on the day of her heart attack she delayed her care. Mary recalls changes in activity level and responses to recurrent chest pain:

I think this hit me worse than the bypass surgery…I still have a lot of things I want to do and things that I won’t do now. I won’t fly in a plane. I used to fly in a plane and I don’t, I won’t now. My children live in Virginia which is quite far from me so I do the driving instead because I can’t have a physician place a stent on an airplane and they can’t make an emergency landing I don’t think that quick.

Mary shared her experience of change in activity level. Mary related that “slowing” her pace had been a great challenge to her since she was used to working “at a fast pace.” Although
this change in activity was a challenge because she “did not want” to “slow down,” she realized that she “tired” more easily and it was “a struggle” for her to take care of her grandson because her endurance had decreased since the heart attack.

During the interview Jean spoke multiple times about how much she missed the presence of her husband during her hospitalization. Jean was very scared about having the infarction and needing a transesophageal echocardiogram. Jean remembers being transferred from hospital to hospital and having multiple tests without the presence of her husband. Jean shared her anger about the gap in communication that led her to going through much of the experience without her husband. Jean experienced a change in valuing of family during her crisis. Jean shared an increased value for family and her husband’s presence during this time of crisis in her life. Jean recalled:

I just started crying and could not stop and Ohhhh and my husband who knew that I had been transferred there was trying to locate me and I later found out they had told him that I never got transferred and so I was for him I was missing in action...oh my for half of the day and so he was extremely worried not knowing where I was at...even more scarier thinking I was going to die on this, having this procedure done [sic]. No family knows where I’m at and they can’t find me, and, I was very scared, and then the thought of that scope going down your throat was very scary [sic].

When Jean experienced her first-time MI she delayed her care. While at the hospital for her MI Jean obtained a coronary artery stent. She developed chest pain shortly after she was discharged to home. Jean recalls experiencing a change in her response to recurrent chest pain. Jean recalled that she had “midsternal chest pain” about 11/2 weeks after the hospital discharge.
During the recurrent chest pain she responded promptly to seek healthcare assistance. She stated, “We went to (name) Hospital ER.” But Jean recalls a negative experience of feeling “not listened” to when she responded promptly to the recurrent chest pain. She recalls being humiliated and degraded by a cardiologist in the emergency room, who insulted her intelligence and knowledge as a patient and an experienced cardiac nurse. Jean experienced change in valuing of self, others and response to recurrent chest pain which occurred after her negative experience with the cardiologist in the emergency room. She recalled:

Came to the ER to see me when I was there and said that I clearly didn’t understand what syncope was and that there’s no way that a stent can occlude that quickly and that I was wasting everyone’s time. So I have since not gone back for any kind of pressure in the chest or anything like that…since then I’ve had oh, half a dozen episodes where I have, you know, some mild pressure, chest pressure, chest pain, and I will say, okay, we’ll just sit down, or see if it goes away, and if it goes away then it was nothing. So, still don’t know truly what I should take serious and what I shouldn’t. So if it’s, it’s severe then I’ll go for help.

Although she was angry with the cardiologist about how she was treated, Jean began to see herself differently and she changed how she responded to recurrent chest pain. She doubted herself and her cardiac nursing knowledge about which signs and symptoms should have attention. Jean integrated change in the valuing of herself and the new experiences to create a new self, a changed self. Jean’s old self knew what symptoms to look for, but her new self had self-doubt because of negative experiences with a cardiologist. Jean recalls:
This other cardiologist came to the ER and you know, making me feel so stupid. I would never, I would never go back to the ER for that. If I could possibly wait until I could get in to see Dr. (name), I would wait until I seen him. Could be dead…I’d much rather look, you know, be dead than look like an idiot for going to see them, and having wasted their time. That’s how they made me feel, like I was wasting his time.

Jean spoke of changes in her activity level since the MI. During the interview she did mention that she had less endurance and she was more “tired” and “can’t do as much” since the MI.

Change was present and part of each participant’s recovery. The participants experienced change in their own unique way. Throughout recovery change occurred in the valuing of self, family and others, activity level and responses to recurrent chest pain. Participants’ openly told their stories of change after having an MI. Change is an important part of recovery as the experiences of women are integrated into the new self to create the changed self.

Theme Three:

The women experienced caring interactions with healthcare providers, such as nurses and physicians, that provided an environment which fostered the process of integration of change, recovery and healing and were crucial in promoting health-seeking behaviors. The women experienced caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery.

All participants reflected that they had experienced caring interactions with healthcare providers during recovery after the MI. The caring interactions with healthcare providers were unique to each of the women as they dealt with change throughout their own recovery. Caring
interactions occurred with healthcare providers and they provided relationships that promoted self-
knowledge and inner strength to make choices that enhance the recovery process.

While Ann was in the coronary care unit she recalled multiple caring interactions with the nurses. However, she spoke frequently about one specific nurse who cared for her during her first hospitalization and who “was there through the brunt” of her illness. His presence, touch, and communication were important to her comfort and recovery. She recalls:

I mean I think he was there every minute just...Yeah, just with this, put a towel on my head, and rubbing my back, and talking to me, and just so comforting. Just to know there's somebody who cares, you know...I've never been touched with nursing care like I was.

Ann shared that through her nurse’s caring interactions she gained confidence and decided to “rebuild” herself and the nurse provided her with confidence that she could get better and recover. Ann found the inner strength to “reclaim” what she could of her old self and heal during her recovery. She recalled:

Well, you know, it's the decision that, they all give you a confidence that you're going to get better...Oh, it's just a, it's a rebuilding thing. You know. And you feel a confidence in that.

And you want to get better.

Ann shared that when she was hospitalized for chest pain a second time, the same “phenomenal” nurse visited several times although he was not her nurse during that admission. Ann was comforted by his presence and intentions to care about her. Ann recalled another caring encounter with the same “phenomenal” nurse who showed respect and provided privacy. This encounter helped Ann maintain her dignity and wholeness as a person. Ann recalled:
He was incredible. He was incredible! I’m a very modest person and I was like, and he respected that through the whole thing, even like, getting on the bedpan and he would allow me to do everything that I wanted, you know, like cleaning myself up. He did a total respect of that… you feel like a real person.

Ann’s privacy was respected which helped to preserve her dignity as a human being and helped her to recognize that she is a whole “person” and she is not “meat package.” Multiple times throughout the interview, Ann spoke about the importance of feeling like a “person.” This was important to her during this time of loss of the old self and during a time when she was integrating her experience and creating the new self.

Ann recalled caring interactions with her nurses from the cardiac rehabilitation program. The caring interactions with her nurses demonstrated intention, kindness, and explaining information. These caring interactions helped Ann make decisions to choose behaviors that enhanced her recovery. Ann recalls the caring behaviors that helped her to “rebuild” and make decisions that enhanced her recovery:

Yeah, every one of them [sic]. All, they’re just are so nice and so kind and so gentle [sic]. Take the time to explain everything to you and help you through it, and I listen to them and they ‘re kind to everybody in that room. It’s like, these people are truly chose their field and their gift [sic]…Decisions, just now I’m in the Rehab and you know, doing that, get back to my exercise, get back to the life I had…decisions that I’m not going beyond what the doctor says I can do [sic]. I am going to do it their way and this is going to be complete and then I think of rebuilding of, I think that we go through life like this with our appreciation of everything in life.
During her recovery at home Ann experienced two more episodes of chest pain. She decided to respond to her repeated chest pain by seeking healthcare attention immediately both times. Additionally, she decided she would continue taking the “slow releasing nitroglycerine” which controlled her pain. Her choices have contributed to her safety during her recovery. Ann repeated multiple times throughout her interview how much she appreciated the nurses who cared for her and that it was important that the nurses were aware how much “their care meant” to her because “they did it with such love.” She recalled:

I think, for me, it’s important that they know what it meant to me…what you’re doing, that you just do automatically, was beautiful. It was, it was incredible…I don’t think people realize that their job is more than a job.

Mary recalls the caring interactions she had with the cardiac rehabilitation nurses. She shared that her care at the rehabilitation program “was wonderful.” The nurses “provided information” and “teaching” but most of all they helped her “enjoy” what she was doing. She began to see her own potential and gained confidence in herself and her recovery. She recalled: “Yes, I really, really enjoyed it and I can’t believe how quickly I think I bounced back from a major heart attack…Yeah, it was something. But cardiac rehab every week was better and better.” Acknowledging her progress Mary made the decision to be “faithful” to adhering to her exercise program and she converted her living room into a “health center” so she could continue her exercise regimen. She also realized her ability to educate herself and not depend on others. This also gave her a sense of control over her disease process. She recalled:
I eat healthy. I’ve always, I notice myself buying and picking up any kind of health book now. Not just for the heart, diet, exercise, every magazine made out there now I order. I’m trying to read more and more and more, educate myself.

Multiple times throughout the interview Mary recalled the caring interaction she had with the cardiologist when he had to tell her the painful truth about her high risk for another heart attack or death during the next 5 years. Although the caring encounter included truth and information that was devastating, she gained knowledge about herself and she found inner strength to survive as she decided to “fight” death. She said, “If I got sick I would be upset that I didn’t do what I wanted to do, not ready to go yet. Not ready to give up the fight.” Other decisions she made after having this knowledge was to try to limit her activity by “slowing down.” She discussed that it was very difficult for her to slow down and that she “copes” by deliberately keeping her “mind, body and soul” busy. As part of her recovery and healing she is staying busy as she takes the much-needed time to grieve the loss of the old self and integrate the MI and her survival timeline into her new self. Also, she is staying busy because if she slows down it means acceptance of the new self and the loss of the old self becomes more final.

Mary recalled another caring encounter with her cardiologist when he listened to her concern about the survival timeline. During that caring encounter she was able to be “teary eyed” and she spoke with him about her concerns regarding the timeline. She recalled:

I probably got a little teary eyed about it because, like I said, he was pretty direct with me and we really have a good relationship. I love him to death. I’m a little teary eyed and he said I think I’m going to put you on an antidepressant. And I told him, no, you’re not going to put me on an antidepressant. Okay I don’t need an antidepressant.
This caring interaction provided a trusting relationship and an environment that provided her comfort so that she could be honest and openly reject his plan to start an antidepressant. This caring encounter also helped her make a decision to exercise her autonomy to make her own decisions. Exercising her autonomy for decisions making helped her gain some control over her disease process.

Jean recalled a caring encounter she had with a nurse at the cardiologists’ office. After a negative interaction with the cardiologist during her first follow-up appointment she felt distraught about her unsuccessful efforts to find out more about her cardiac disease. After the negative encounter with the physician a caring interaction occurred with a nurse in the office. As Jean exited the office a nurse walked side by side with Jean and listened to her concerns and provided her with direction. Jean recalls the nurse saying, “Here’s what you need to do. You need to make an appointment with Dr. (name) and he’ll see you for all of it.” This caring encounter helped Jean at a time when she was feeling “discouraged” and she found inner strength, courage and confidence to made the decision to take control of who was going to be her cardiologist. Jean recalls her decision to terminate her relationship with the first cardiologist. Jean said, “I did the first follow-up with him after the admission and he said he wouldn’t see me for anything cardiac related other than the syncope, I told him I’d never seen him again.” Selecting a cardiologist who she thought would provide her the care she needed was important to her. She said, “I finally did follow up with Dr. (name).” Jean’s decision and health seeking behavior was critical progress for her during her recovery because she was in denial and had overriding feelings of guilt, anger, and fear.
It was during her first meeting with Dr. (name) that she had another caring encounter. When Jean met with this cardiologist he “took time” with her, “listened,” provided detailed information and explanation about her MI and insisted on being her cardiologist for all her cardiac needs. Her caring encounter with this cardiologist helped her understand more about her MI. Jean recalled the caring encounter with the cardiologist:

When I was in and had the high troponin and stuff, they said my EKG was quote normal, so I didn’t have changes on the EKG which Dr. (name) says, you know, because it was also, the location of, you know, the circumflex and all that, but, you know, it didn’t necessarily have the changes on there, so he didn’t know what everybody else was talking about and I’m to contact him if I had any more problems and stuff, anything bothersome, so, I’m seeing Dr. (name) for the syncope and for the other stuff…he took all the time I needed.

Jean continued to share that “Dr. (name)” was the only cardiologist she could go to and ask questions and he would “take the time” with her that she needed. Jean also stressed the point that as a cardiac nurse she was still a “patient” with many questions and she needed to feel like someone was going to give her “time” and the “information” she needed. She recalled:

And it’d be just nice to, to kind of know some of that information, even though you, as a nurse know it, as a patient you’ve got tons of questions and tons of what ifs and that you need someone to actually sit, you know, have the time to take a few minutes and answer and I felt like the whole experience before, during and after Dr. (name) was the only one that didn’t act like he was rushed and felt like, you know, I really could ask him things and something no one else seemed that way.
Other health seeking behaviors that evolved from her caring encounter included “taking the Plavix and the Aspirin” as well as the “Lipitor and Niaspan.”

All the women experienced caring interactions with healthcare providers during their experience of an MI. Caring interactions with healthcare providers included caring behaviors such as providing information, communicating, teaching, touching, respecting, listening, intention, presence, and providing time to be with the client. Caring interactions with healthcare providers provided an environment that helped women integrate change as they created the new self during their recovery. Nurses and physicians had caring client interactions that enhanced health-seeking behaviors of the women. Caring client interactions and relationships helped the women as they found inner strength, courage, and confidence to make decisions and choices that enhanced their recovery.

**Exhaustive Formalized Description of Phenomenon**

An exhaustive description is a statement that reflects the synthesis of the study themes. Loss and disharmony of the old self or pre-myocardial infarction elicited the process of grief as a coping response. Integration of experiences promotes change and restoration of harmony as a new integrated self is developed and sustained. Intentional caring transactions foster the integration of experience, change, and self-healing that promotes self-knowledge and inner strength to make choices in health-illness decisions.

**Summary**

In this chapter the findings of the phenomenological study of the lived experiences of women with first-time MI were presented. Van Manen’s (1990) method of phenomenology was used to analyze the data. The data presented in this chapter were taken from the verbatim from the
transcribed interviews of the three participants. Phenomenological reflection, writing, and rewriting led to the discovery of three themes that revealed the lived experience of women with first-time MI. Three themes emerged from the data and were identified as: (a) the lived experience of an MI elicited the process of grief to help the women cope with the stress of the loss. Following the sudden traumatic loss of the health status of the old self or pre-myocardial infarction, the women experienced denial, bargaining and feelings of anger, guilt, and fear as they explored the expectations and meaning of this new self after the MI; (b) the women experienced the process of change throughout their recovery as they began to integrate the experience of an MI into the old self and create the new self or changed self. The women began to integrate the change to help them move towards new levels of personal growth as they engaged in behaviors that promoted recovery. Change occurred for the women in the valuing of self, family and others, activity level and how they responded to recurrent chest pain; (c) the women experienced caring interactions with healthcare providers, such as nurses and physicians, that provided an environment which fostered the process of integration of change, recovery and healing and were crucial in promoting health-seeking behaviors. The caring interactions with healthcare providers provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery. Each of the three themes was discussed using excerpts from the verbatim descriptions provided by participants.
CHAPTER V

Discussion

The purpose of this study was to explore the lived experience of women with first-time myocardial infarction (MI). Three women were interviewed regarding what the experience of having a first-time MI has meant for them. Selection of a nursing theory was guided by the results of the study. The rationale for delaying the selection of a nursing conceptual model was based on the underlying philosophy of phenomenology as discussed in Chapter I. Watson’s (1979, 1985, 1988, 1999) nursing theory was selected as the conceptual framework because the study findings were congruent with Watson’s nursing theory. Watson’s nursing theory will be discussed in this chapter.

Van Manen’s (1990) Phenomenological Methodology was used for data collection and analysis of this study. Van Manen’s (1990) method includes four procedural steps: (a) turning to the nature of lived experience; (b) investigating experience as we live it; (c) phenomenological reflection; and (d) phenomenological writing. For a more in depth discussion of van Manen’s method, the researcher refers the reader to Chapter III. In this chapter, a discussion of the identified themes as they relate to Watson’s (1979, 1985, 1988, 1999) nursing theory and the research literature is presented. The study conclusions, limitations, implications for nursing and recommendations for further research are presented.

In this study, three themes are identified followed by an exhaustive description of the phenomenon of the lived experience of women with first-time MI. An exhaustive description is a statement that reflects the synthesis of the study themes. The themes included:
Theme One:
The lived experience of an MI elicited the process of grief to help the women cope with the stress of the loss. Following the sudden traumatic loss of the health status of the old self or pre-myocardial infarction, the women experienced denial, bargaining and feelings of anger, guilt, and fear as they explored the expectations and meaning of this new self after the MI.

Theme Two:
The women experienced the process of change throughout their recovery as they began to integrate the experience of an MI into the old self and create the new self or changed self. The women began to integrate the change to help them move towards new levels of personal growth as they engaged in behaviors that promoted recovery. Change occurred for the women in the valuing of self, family and others, activity level and responses to recurrent chest pain.

Theme Three:
The women experienced caring interactions with healthcare providers, such as nurses and physicians, that provided an environment which fostered the process of integration of change, recovery and healing and were crucial in promoting health-seeking behaviors. The caring interactions with healthcare providers provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery.

Exhaustive Formalized Description of Phenomenon

Loss and disharmony of the old self or pre-myocardial infarction elicited the process of grief as a coping response. Integration of experiences promotes change and restoration of harmony as a new integrated self is developed and sustained. Intentional caring transactions foster
the integration of experience, change, and self-healing that promotes self-knowledge and inner strength to make choices in health-illness decisions.

Identification of Conceptual Framework

The nursing framework used to conceptualize the results of this study was Watson’s (1979, 1985, 1988, 1999) nursing theory. Watson’s framework includes the concepts of human being, health, environment, and nursing. Watson (1979) formed the structure of her theory framework by proposing seven assumptions about the science of caring and 10 carative factors. The theory concepts, seven assumptions, and 10 carative factors will be discussed in this section.

Watson (1985,1988) viewed the human being as a “valued person in and of him or herself to be cared for, respected, nurtured, understood, and assisted; in general a philosophical view a person as a fully functional integrated self” (p. 14). According to Watson (1979), each person experiences crisis throughout his/her lifecycle that can elicit a stress reaction that requires a coping response. The coping response is an attempt by the individual to restore the whole self or the integrated self. Watson emphasized the importance of respect for each person’s autonomy and freedom of choice to make decisions that affect his/her health. Nurses need to understand each person during times of stress, illness, and wellness (Watson, 1979).

Watson (1979) viewed health as the “unity and harmony within the mind, body, and soul. Health is also associated with the degree of congruence between the self as perceived and the self as experienced” (p. 48). Watson viewed health and illness as a subjective state within the mind of each individual and defined by each person. Health is affected by stress or stressful type activities associated with social conditions, lifestyle, or environment and may result in disharmony. Disharmony between the mind, body and soul may lead to stress.
Watson (1979) viewed the environment as a social environment where each person has the need to belong to his or her culture or society. The environment in which we live provides a social environment that establishes values and determines acceptable roles, behaviors and goals. Values are affected by change throughout the life cycle and may lead to stress if the change affects the perception of the self. Additionally, each person has the need to give and receive love and affection. Stress and illness can interfere with meeting these needs and result in isolation or separation of the individuals from their society, family or group and create disharmony. It is during times of disharmony, stress, and illness that the nurse can help in meeting the needs of the person when caring is conveyed by listening, comforting, and allowing for unconditional freedom in expressing feeling (Watson, 1985, 1988).

Watson (1985, 1988) defines nursing as “...a human science of persons and human health-illness experiences that are mediated by professional, personal, scientific, esthetic, and ethical human care transactions” (p. 54). Through the caring process, nurses help individuals gain or regain harmony within the self to promote integration of their experiences, to develop meaning of their experiences, and promote self-knowledge and self-healing. According to Watson (1985, 1988), “nursing’s social, moral, and scientific contributions to humankind and society lie in its commitment to human care ideals in theory, practice, and research” (p. 33). Watson (1979) discussed the “trim” and “core” of nursing in the preface of her book. The “trim” of nursing is the focus on clinical procedures, settings, and changing times. In contrast, the “core” of nursing is the aspects of nursing, the nurse-client interaction, that potentates therapeutic results and healing. The core is grounded in science, philosophy, and the art of caring.
Watson (1979) proposed seven basic assumptions about the science of caring and 10 carative factors to form the framework of her theory. The following are the seven basic assumptions:

1. Caring can be effectively demonstrated and practiced only interpersonally.
2. Caring consists of carative factors that result in the satisfaction of certain human needs.
3. Effective caring promotes health and individual or family growth.
4. Caring responses accept a person not only as he or she is now but as what he or she may become.
5. A caring environment is one that offers the development of potential while allowing the person to choose the best action for himself or herself at a given point in time.
6. Caring is more “healthogenic” than is curing. The practice of caring integrates biophysical knowledge and knowledge of human behavior to generate or promote health and to provide ministrations to those who are ill. A science of caring is therefore complementary to the science of curing.
7. The practice of caring is central to nursing (pp. 8-9)

Watson (1979) viewed caring as the essence of nursing. Caring can increase self-knowledge, self-control, and promote health changes. Watson believes the main focus in nursing is on carative factors that are derived from a humanistic perspective combined with a scientific knowledge base. Watson’s (1979) carative factors serve as a guide for the “core” of nursing. The science of caring is built upon Watson’s (1979) 10 carative factors. The 10 carative factors are as follows:
1. The formation of humanistic-altruistic system and values
2. The instillation of faith-hope
3. The cultivation of sensitivity to self and to others
4. The development of a helping-trusting relationship
5. The promotion and acceptance of the expression of positive and negative feelings
6. The systematic use of the scientific problem-solving method for decision making
7. The promotion of interpersonal teaching-learning
8. The provision for a supportive, protective, and (or) corrective mental, physical, sociocultural, and spiritual environment
9. Assistance with gratification of human needs
10. The allowance for existential-phenomenological forces (pp. 9-10)

According to Watson’s (1985, 1988, 1999) theory caring words, actions, feelings, behaviors, genuine presence, intentionality, being centered in the moment, and conscious choice of action are key elements of each caring moment. The commitment to caring is communicated through the nurse-client relationship. According to Watson caring science is not limited to the discipline of nursing as she explained, “caring science is rapidly becoming an interdisciplinary or transdisciplinary field of study. It has relevance to all the health, education, and human service fields and professions” (Watson, 2006, para. 3).

Watson (1999) suggested that transpersonal caring and caring moments provided limitless possible outcomes for healing. Watson (1988) referred to the caring transaction as being transpersonal in that both the nurse and the patient “bring with them to the relationship a unique life
history and phenomenal field" which leads to "protection, enhancement, and preservation of the person’s humanity, which helps to restore inner harmony and potential healing" (p. 58).

Watson’s (1979, 1985, 1988, 1999) theory was selected because the study results are congruent with the major concepts of the theory. Watson’s theory is compatible with the study results as it relates to: (a) stress and coping responses; (b) integration of life experiences and change that promotes harmony and self-healing; and (c) caring transactions that help each person find “meaning in their existence, disharmony, turmoil, and promotes self-control, choice, and self-determination with the health-illness decisions” (Watson, 1988, p. 49). Figure 1 is a conceptualization of some of the major concepts in Watson’s Theory.
Figure 1. Conceptualization of Watson’s Theory

Discussion of Findings Related to Literature and Theory

The 3 participants described unique individual experiences of what it was like for them to experience a first-time MI. All of the participants provided valuable data that led the researcher to discover three themes that became apparent after a thorough analysis of the data. Each theme represents a commonality that existed among the participants’ descriptions of their experiences. Each theme will be discussed here as it relates to Watson’s (1979, 1985, 1988, 1990) nursing theory and the research literature. Figure 2 includes a conceptualization of Watson’s Theory as it relates to the findings of this study.

Theme One:

The lived experience of an MI elicited the process of grief to help the women cope with the stress of the loss. Following the sudden traumatic loss of the health status of the old self or pre-myocardial infarction, the women experienced denial, bargaining and feelings of anger, guilt, and fear as they explored the expectations and meaning of this new self after the MI.

Findings related to theory

According to Watson (1979) “nursing is concerned with promoting health, preventing illness, caring for the sick, and restoring health” (p. 7). At that time, she viewed nursing as needing to increase knowledge and education in the area of stress and developmental conflicts. That is, the nurse must understand human beings in wellness, sickness or when they are experiencing stress. By conceptualizing the study results within Watson’s theory, it becomes apparent that nursing must gain knowledge about human stress and coping responses in order to better understand human experiences.
Figure 2. The Lived Experience of Women with First-Time Myocardial Infarction

Conceptualization within Watson’s Theory

Watson (1985, 1988) viewed health as the “unity and harmony within the mind, body and soul. Health is also associated with the degree of congruence between the self as perceived and the self as experienced” (p. 48). Watson viewed the human being as “a... valued person in and of him or herself to be cared for, respected, nurtured, understood and assisted; in general a philosophical view of a person as a fully functional integrated self” (p. 14). Watson viewed illness as the disharmony between the mind, body and soul. Disharmony is a stress, which results in a stress reaction that necessitates a coping response. A coping response is elicited as a means to cope with the stress. Loss, as a stress, creates disharmony in the three spheres of body, mind and spirit (Watson, 1985, 1988).

Applied to the findings of this study, all 3 participants in this study experienced the sudden traumatic loss of the health status of the old self or pre-myocardial infarction self. The participants' loss created a disharmony resulting in stress for which a coping response was elicited. The coping response elicited by the participants in this study was the grief response. The participants' grief response included denial, bargaining and feelings of anger, guilt, and fear. The participants' were attempting to bring harmony within the self to help gain insight into the meaning of their experience as they integrated the experience of having an MI into the old self to create the new self.

Findings related to literature

Common to all of the participants was the experience of the process of grief to help cope with the stress of loss after the MI. The participants' grief process included experiences of denial, bargaining and feelings of anger, guilt and fear. All the participants experienced denial and feelings of anger, guilt, and fear. Two of the 3 participants experienced bargaining as part of their grief process. After the traumatic loss of health status of the old self, the participants experienced the
grief process, denial, bargaining, and feelings of anger, guilt and fear as they explored the experience of the MI and the meaning of the new self.

These findings were supported in the literature. The process of grief to help cope with loss has been supported in the literature (Bergman & Bertero, 2001; Hentz, 2002; Medich et al., 1997). The research study by Bergman and Bertero (2001) supported the process of grief to cope with loss. Bergman and Bertero explored the real life situation, opportunities and obstacles encountered in making lifestyle changes after being afflicted with coronary artery disease. Similar to the findings of this study, Bergman and Bertero’s findings indicated that grief was experienced in response to loss of health status. Their study findings also indicated that reorientation to the self and change that occurred was needed so that changes could be incorporated into creating a new life.

Hentz (2002) explored the experience of grief and body memory following a significant loss. Similar to the findings of this study, Hentz’s findings indicated that women experienced grief as a means of coping with loss. Hentz’s findings suggested that grief was a way of holding onto the memory to reinforce that the loss was a new part of them and their lived experience. Results of Hentz’s study showed that over time the body remembers grief and that the body experiences grief of the loss long after the loss occurs. The participants of Hentz’s study commonly experienced becoming silent and keeping grief hidden because of the fear that others would not understand because our “social world has been unwilling to accept a grieving process that extends out of the boundaries of the expected norm” (p. 161). Hentz suggested further studies to explore how integration of the integrity of body memory assists in helping women find personal meaning and healing. The findings of Hentz’s study supported this study’s findings of the process of grief to cope with loss.
An earlier study by Medich et al., (1997) also supported the process of grief to cope with loss. In their study, they explored the basic life processes, transitions, and meanings experienced after MI. Similar to the findings of this study, Medich et al.'s case study findings indicated grief was experienced to cope with loss. Their findings indicated that, “through integration, Mary clarified her core values, grieved losses, assigned meaning to her illness experience, and chose a direction for repatterning that was consistent with what was important and meaningful to her” (p. 77). Similarly in this study, participants grieved their loss as a way of coping after the MI.

The experiences of denial, bargaining and feelings of anger, guilt, and fear were supported in the literature. A study by O’Carroll, Smith, Grubb, Fox and Masterston (2001) supported the experience of denial. O’Carroll et al. studied the possible psychological factors that may be implicated in delayed presentation to the hospital following an MI. The findings in O’Carroll et al.’s study indicated that the two best predictors of treatment delay are denial and those who believe that health is largely based on chance. Similarly in this study, all the participants experienced denial and delayed seeking healthcare assistance while having the MI.

An earlier study by Sarantidis et al. (1997) supported the experience of denial. Sarantidis et al. investigated the changes in anxiety, depression and denial from admission to discharge following an acute MI. Findings of Sarantidis et al.’s study indicated that during the time from admission to discharge the levels of denial decreased while levels of anxiety and depression increased. In addition, those patients who have a positive family history of heart disease showed a lower level of denial at admission and higher at discharge. Sarantidis et al. explained, “It appears that patients with positive family history were in greater ‘need ‘ to sustain denial…they belong to a higher risk group, a fact over which they have no control” (p. 150). Similarly in this study, all the
participants experienced denial while having the MI. Unlike Sarantidis et al.'s findings, 1 participant in this study continued to experience denial throughout her recovery.

An earlier study by Thomas, Smucker and Dropleman (1998) provided support for the experience of feelings of anger. Thomas et al.'s study was one of the most comprehensive studies that explored the meaning of the anger experience of women. The findings of Thomas indicated that woman's anger involved feelings of frustration, hurt, and disillusionment and two-thirds of the anger situations involved powerlessness. Thomas et al.'s study findings indicated that most anger was stored inside the women in an effort to maintain harmony and connectedness within relationships. Thomas et al.'s findings also indicated that women wondered how to unload their stored anger since releasing the anger may hurt the feelings of others and could jeopardize relationships. Thomas et al.'s finding indicated that women's anger is rational in that “the spark igniting the flame of anger was an incident that violated the woman's core values, morals, or principles” (p. 317). The findings of Thomas et al.'s study indicated that women felt a sense of power when anger was “used to restore justice, respect, and relationship reciprocity...Anger motivated them to take action” (p. 319). Thomas et al.'s study finding indicated that participants felt a diminishing self when anger was kept inside or when anger was expressed while losing control.

Similarly, participants of this study expressed feelings of anger. One of the participant's expressed anger related to lack of respect, not providing her with information during a procedure and lack of acknowledgment of her presence. Another participant express anger for the persistent and repetitive nature in which others told her that she needed to slow down her activity level. That same participant expressed anger when a cardiologist tried to control her treatment plan. Another participant expressed anger related to lack of care provided by nurses and physicians. That same
participant also experienced anger about not being able to perform at a higher level during her first visit at cardiac rehabilitation.

A study by Svedlund et al. (2001) provided support for the experience of guilt. Svedlund et al. studied the experiences of women during the acute phase of an acute MI. Svedlund et al.'s study findings revealed the phenomena of guilt and shame. There indicated that the women experienced feelings of guilt and shame related their “vulnerability” as a sick person and distancing which occurred as they experienced “finding oneself” in an unreal situation (p. 204). Svedlund et al.'s findings indicated that women experienced guilt related to the change in the caregiver role and the women struggled to preserve their sense of self. Additionally, Svedlund et al.'s findings indicated that when women withheld communication from family and healthcare professionals it was their way of not allowing others to share their burden of suffering from an MI. Similarly, all the participants of this study experienced feelings of guilt. One participant shared guilt feelings because she did not listen to her body and delayed going to the hospital when she was having chest pain. Another participant experienced guilt about not being able to spend enough time with her grandson because of she may not be alive. Another participant experienced guilt about being overweight and her inability to perform in the cardiac rehabilitation program.

A study by Jackson et al. (2000) provided support for the experience of fear. Jackson et al. explored the recovery experiences of women survivors of first-time MI during the initial period following discharge. The findings of Jackson et al.'s study indicated, “recovery is a complex process, initially characterized by fear and uncertainty” (p. 1404). Jackson et al found that over the 7, 14 and 21 days following discharge from the hospital the women replaced feelings of fear and uncertainty with confidence, energy and a more optimistic outlook. The participants of Jackson et
al.’s study experienced fear of death, future, recurrence of infarction, taking part in the usual, and implications for their role as caretaker. Additionally, Jackson et al.’s study findings indicated that the “emotional and physical crisis precipitated by the MI and resultant inner disorder that was experienced by the women could well affect comprehension and recall” (p.1409). Jackson et al. suggested that this finding may explain that the women did not recall being provided with information and were unable to recall the information. Similarly, participants in this study experienced feelings of fear. One participant shared feelings of fear of death and reinfarction related to the high rate of occlusion of her coronary stents. One participant experienced fear of severe pain during a procedure at the hospital. Another participant had several negative care encounters with a cardiologist and she experienced fear of being cared for by this particular physician.

A study by Walton (2002) provided support for the experiences of denial, bargaining and fear. Walton explored spirituality in patients recovering from an acute MI. Findings from Walton’s study indicated that participants experienced five phases that included facing mortality, letting go of fear and turmoil, identifying and making life style change, seeking God’s purpose and finding meaning and purpose in everyday life. Walton found that when participants were facing their own morality they experienced feelings of fear for family, disability, finances, loss of dignity, pain and death. Similar to the findings of this study, Walton’s study findings indicated denial; bargaining and fear helped the participants cope through their recovery process. Similarly, 2 participants in this study experienced bargaining. Two of the 3 participants experienced bargaining for time after the MI. One participant bargained with God that she would do everything he wanted her to do if God
would let her live to attend her daughter’s wedding. Another participant bargained that is she remaining loyal to her exercise, eating and self-education her reward would be longevity.

Sutherland and Jensen’s (2000) study provided support for the experiences of bargaining, anger and guilt. Sutherland and Jensen explored and described elderly women’s perception of having an MI. Similar to the findings of this study, Sutherland and Jensen’s study findings indicated women experienced anger and bargaining as a response to dealing with loss and the acceptance of the change that had taken place. Sutherland and Jensen’s study findings indicated that the women experienced guilt when they reassessed their prior lifestyles in search of possible causes for the MI and what they could have or should have done differently. Similarly, all the participants in this study experienced bargaining and feelings of anger and guilt to deal with loss of self after the MI.

A study by Stewart, Davidson, Meade, Hirth, and Makrides, (2000) supported the experience of denial, anger and fear. Stewart et al. explored stress, coping strategies and social support experienced by survivors of MI and their spouses. The findings identified in Stewart et al.’s study indicated that the emotional impact of the heart disease ranged from “denial and confusion at the outset, to persistent fear, frustration and irritability” (p. 1351). Anger was related to physical loss and frustration with life adjustments and fear emerged from the perceived loss of control. Similarly in this study, the participants experienced denial at the outset of the MI and feelings of fear and anger. Unlike Stewart et al.’s findings about anger, the current study findings did not support anger related to physical loss.

The Bergman and Bertero’s (2001) study provided support for the experiences of anger and fear. Bergman and Bertero explored the real life situation, opportunities and obstacles
encountered in making lifestyle changes. Similar to the findings of this study, Bergman and Bertero’s study findings indicated that fear and anger were experienced by the participants. The fear experienced was related to everyday life and trying to understand the connection between rest, work and recreation. Anger was experienced in response to excessive demands made by self, family and employers and the lack of time and energy to do everything. The results in Bergman and Bertero’s study findings suggested that if feelings of anger and fear persisted or were unresolved this could result in disrupted relationships and isolation. The participants in Bergman and Bertero’s study expressed feelings of fear in relation to starting each day, being forgotten, relapse and death. The participants of Bergman and Bertero’s study experienced feelings of anger because of the overload of demands they experienced. Similarly, participants in this study expressed feelings of fear and anger. One of the participant’s experienced anger related to unrealistic expectations of herself and the lack of energy to perform at the cardiac rehabilitation program.

Theme Two:

The women experienced the process of change throughout their recovery as they began to integrate the experience of an MI into the old self and create the new self or changed self. The women began to integrate the change to help them move towards new levels of personal growth as they engaged in behaviors that promoted recovery. Change occurred for the women in the valuing of self, family and others, activity level and responses to recurrent chest pain.

Findings related to theory

As individuals reevaluate their life experiences and try to find meaning they attempt to become an integrated whole self through integrating their experiences and changes into their life to
create a new self and a new life. According to Watson (1985, 1988), “The nurse helps individuals find meaning in their existence, disharmony, suffering, and turmoil, and promotes self-control, choice, and self-determination with the health-illness decisions” (p. 4). Watson’s caring-healing model helps redefine and refocus nursing practice to focus on the lived experiences of each person’s health situation and what is important and meaningful to each person. Applying Watson’s theory (1985, 1988), nurses acknowledge the uniqueness of each person and that each person integrates their past, present, and future in their own unique way as they create change to restore unity of the self. Through caring nurses acknowledge each person’s uniqueness and support them during the integration of their experience and changes while they move toward higher degrees of harmony within the mind, body and soul to promote self-healing.

**Findings related to literature**

Common to all participants was the experience of change in valuing of self, family and others, activity level and responses to recurrent chest pain. All participants experienced change in valuing of self, family and others. All participants experienced a change in activity level. All the participants experienced a change in response to recurrent chest pain after the MI. All 3 participants responded by seeking healthcare assistance without delay.

The follow literature provided support for change in valuing of self, family and others, activity level and responses to recurrent chest pain. The research by Fleury, Sedikides and Lunsford (2001) supported the experience of change in valuing self, family and others and activity level. Fleury et al. explored the role of self in the experience of women living with cardiovascular disease. Findings of Fleury et al.’s study indicated that change existed in the definition and meaning of self during illness as women explored and “learned to accept and value the changing
self" (p. 77). As the participants in Fleury et al.’s study accepted the changed self they openly invited alternatives to managing and living their new life and self-integrity was restored. Similar to the findings of this study, participants of this study experienced change in valuing self. One participant valued herself and her life more because of the constant threat of reinfarction and death. One participant valued her self more as she learned to accept the new self and the limitations that it brought to her life. Another participant valued herself less after several negative care interactions with a cardiologist.

Fleury et al.’s (2001) study findings indicated that value of family lessened as value of others, outside of the family, grew as the women sought connectedness with others who could understand and validate their experiences of the new self. Unlike the findings of Fleury et al.’s study, in this study there was no decrease in valuing of family when 1 participant experienced an increased in valuing others, outside the family, who could understand her experiences. This same participant experienced a decrease in value for others who could not understand her experience. One participant valued family, others, and God more after integrating her experience and acknowledging her vulnerability. Fleury et al.’s study indicated that the participants experienced less activity because of the decreased ability to endure household chores and that the family members had unrealistic expectations about the household duties. Fleury et al.’s study findings indicated that focusing on the changed self and reprioritizing expectations based on “changed abilities” fostered women’s healing during recovery (p. 79). Similarly in this study, all the participants experienced decreased activity as they acknowledged their changed abilities.

A study by Crane and McSweeney (2003) provided support for the experience of change in valuing of self, family and activity level. Crane and McSweeney explored women’s lifestyle
changes after MI. Crane and McSweeney’s study supported change in valuing self. Findings of Crane and McSweeney’s study indicated that women changed their views of themselves and their world as they reprioritized and made their self and their life a priority. Participants in Crane and McSweeney’s’ study reported a focus on self and reprioritizing to accommodate change. Similarly in this study, all the participants experienced change in valuing of self. Two of the 3 participants integrated their experienced and reprioritized to make their self and their life a priority. One participant slowly changed the value of her self. Over time the participant started to value herself as a priority and she started making choices about selecting a cardiologist who she felt genuinely cared about her.

Findings of Crane and McSweeney’s (2003) study indicated a decrease in activity level was related to insecurity about the availability of healthcare resources and physiological symptoms that affected the pattern and the type of activities women could tolerate. Participants in Crane and McSweeney’s study reported stopping, sitting or slowing down in order to complete activities such as walking and household chores. Similarly in this study, all the participants experienced change in activity level. One participant decreased her activity because she did not want go beyond what was expected and she allowed her family members cook meals for the household. Two participants decreased activity and slowed down due to decreased endurance. Crane and McSweeney’s study supported the change in valuing of family. Findings in Crane and McSweeney’s study indicated women valued the family members more, during this time when the women could do less, and the women allowed other family members to cook meals for the family. Similarly in this study, all the participants increased valuing of family during this time in their life. Only one of the 3 participants in
this study discussed allowing other family members to cook for the family. Two of the 3 participants did not discuss whether or not other family members were allowed to cook family meals.

The study findings of Johansson, Dahlberg and Ekebergh (2003) supported the experience of change in valuing of self and activity level. Johansson et al. explored women's experiences following an MI. Findings from Johansson et al.'s study indicated the participants valued themselves and their lives more because of the increase recognition of "how short and vulnerable life is" (p. 232). Similarly in this study, all the participants valued themselves more. Two of the 3 participants experienced increased in valuing themselves and their life as they recognized how short and vulnerable life is. Johansson et al.'s study indicated a decrease in activity level and endurance because of loss of strength and vitality. Johansson et al.'s finding indicated that usual household chores and short walks became challenging and difficult to manage and the women felt they had no other choice but to adjust to the new activity level during their recovery. Similarly in this study, participants experienced change in activity level. Two of the 3 participants experienced decreased activity due to decreased endurance. One of the 3 participants decreased her actively because she did not want go beyond what was expected.

A study by Rankin (2002) supported the experience of change in activity level. Rankin studied the recovery trajectories of women after acute MI. Findings indicated that women had decreased activity levels and that African American women had a greater level of inactivity than white women. Similarly in this study, all the participants experienced decreased activity level. A study by Gregory, Bostock and Backett-Milburn (2006) also provided support for change in activity level. Gregory et al. studied the experiences and views of people recovering from MI. Findings in Gregory et al.'s study indicated women had less activity with household tasks chores and they
were uncomfortable relying on family members to help. Similarly in this study, all participants experience decreased activity level.

An earlier study by Medich et al. (1997) supported the experience of change in valuing of self and others. In their study Medich et al. explored the basic life processes, transitions, and meanings experienced after MI. Similar to the current study findings, Medich et al.’s case study findings indicated the participant experienced change in valuing her self and others as she integrated change and searched for meaning of her experience. The participant in Medich et al.’s case study reevaluated her health status and reprioritized her values of self and others and she focused more on caring for herself. The participant in Medich et al.’s case study had increased value for others who participated in her cardiac rehabilitation because they could relate to her illness experience. Similarly in this study, all the participants experienced change in valuing of self. All the participants of this study increased value for self and others as they integrated their experience and focused on caring for self. One of the 3 participants increased value for those who could relate to her illness experience.

The study findings of Johansson et al. (2003) supported the experience of change in responses to recurrent chest pain. Johansson et al. explored experiences of women following an MI. Johansson et al.’s study finding indicated that women changed how they viewed their body as they could not trust their body because the “unreliable body” could have a repeated MI at any time (p. 233). Thus, the women planned ahead and created ways to be prepared for recurrent pain and situations that could occur in the future. Similarly in this study, participants experienced change in response to recurrent chest pain. All the participants responded to recurrent chest pain by seeking
immediate healthcare assistance. One of the 3 participants planned to avoid traveling by airplane because it would be difficult to obtain a coronary artery stent while being airborne.

Theme Three:

The women experienced caring interactions with healthcare providers, such as nurses and physicians, that provided an environment which fostered the process of integration of change, recovery and healing and were crucial in promoting health-seeking behaviors. The caring interactions with healthcare providers provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery.

Findings related to theory

According to Watson’s (1985, 1988, 1999) theory, caring words, actions, feelings, behaviors, genuine presence, intentionality, being centered in the moment, and conscious choice of action are key elements of each caring moment. Watson (1999) suggested that transpersonal caring and caring moments provided limitless possible outcomes for healing. Watson (1988) referred to the caring transaction as being transpersonal in that both the nurse and the patient “bring with them to the relationship a unique life history and phenomenal field” which leads to “protection, enhancement, and preservation of the person’s humanity, which helps to restore inner harmony and potential healing” (p. 58). According to Watson (1988) “The nurse helps individuals find meaning in their existence, disharmony, suffering, and turmoil, and promotes self-control, choice, and self-determination with the health-illness decisions” (p. 49). Applied to this study, caring transactions from nurses and physicians helped foster healing by helping individuals find meaning in their experience and promoted self-knowledge and confidence to make health-seeking choices that enhanced their recovery.
Findings related to literature

Common to all participants was the experience of caring interactions with healthcare providers, such as nurses and physicians, that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery. All the participants experienced caring interactions with healthcare providers that included behaviors such as listening, touch, presence, respect, talking, intention, kindness, truthfulness, and providing teaching, explanation, and information. Through caring interactions all the participants found self-knowledge and inner strength to make choices that enhanced their recovery.

The follow literature supported caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices to enhance recovery (Johansson et al., 2003; Medich et al., 1997; Mullaney, 2000; Walton, 1999, 2002). A study by Johansson et al. (2003) supported the experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices to enhance recovery. Johansson et al.'s findings indicated that healthcare professionals provided women with caring interactions that included listening, support, and guidance that facilitated the women's “reconciliation” or a reestablishing of the “natural relationship with their bodies and lifeworlds” (p. 235). Johansson et al.'s findings indicated as the women chose to engage in the reconciliation process inner balance and harmony were restored which was critical for health and well-being. Johansson et al. suggested, “in the caring relationship there is a force that can empower these women in their health process” (p. 235). Similarly in this study, all the participants experienced caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery.
One of the 3 participants experienced a caring interaction with a nurse that included listening, support, and guidance that helped her find inner strength, courage and confidence to make the decision to take control of choosing a cardiologist to care for her.

An earlier study by Medich et al. (1997) supported the experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices to enhance recovery. Medich et al. explored the basic life processes, transitions, and meanings experienced after MI. The findings in Medich et al.’s case study indicated caring interactions by the nurses promoted an environment that increased self-knowledge and self-directed “health enhancing” behavioral choices for management of the disease process and risk modification (p. 73). The participant in Medich et al.’s study experienced caring interactions from healthcare professionals that included “giving and /or receiving information, feedback, encouragement; and or demonstrations of caring” that helped her rediscover her inner strength, gave her “confidence” to confront her illness and manage her recovery and heal (p. 74). Medich et al.’s findings suggested that when healthcare providers provide consistent feedback and recognition of the patients’ health behaviors a strengthening of the patients’ recognition of the benefits of the new behaviors and healing will be enhanced. Similarly in this study’s theme three, all the participants’ experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery. One of the 3 participants experienced a caring interaction with a physician that included listening, taking time, explaining and providing information about her disease process which promoted an environment to foster self-knowledge to make the choice to continue with the cardiologist for follow-up care.
A study by Mullaney (2000) supported the experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices to enhance recovery. Mullaney studied the lived experiences of depressed women who enter therapy and experience Watson’s actual caring occasion with in the transpersonal caring relationship. Findings of Mullaney’s study indicated connectedness and unconditional acceptance by the therapist caused all the participants to adhere to their therapy even though the therapy was emotionally painful. Mullaney’s findings indicated that participants felt an alignment with their therapist that “directly facilitated their active participation in prescribed treatment modalities/activities that led to healthier lifestyles” (p. 139). Mullaney suggested that Watson’s theory can be integrated into nursing practice to help facilitate clients energies towards wholeness and healing” (p. 139). Similarly in this study’s theme three, all the participants’ experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery. One of the 3 participants experienced a caring interaction with a physician that included trust and unconditional acceptance that provide an environment of comfort. This promoted self-knowledge of her inner strength and courage to make a decision to reject the physicians plan to initiate antidepressant therapy.

An earlier study by Walton (1999) supported the experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices to enhance recovery. Walton studied what spirituality meant to patients recovering from an acute MI and how spirituality influenced recovery. Findings in Walton’s study indicated that caring interactions with healthcare providers had outcomes of decreased fear, turmoil, anxiety and chest pain and “enhanced coping, hope for recovery, encouragement, and positivity” (p. 44). In
Walton’s study caring interactions included presence, reassurance, caring attitude, teaching, providing education, and words of concern and encouragement. Walton’s study findings indicated, “caring connections between the nurse and the participant assisted the participants to have faith in treatment decisions and the physical healing of the heart muscle itself” (p. 44). Participants in Walton’s study found “inner strength and courage” as they listened to their inner self to help restore balance, health, healing, and wholeness to their life through identification of self initiated healthy lifestyle changes (p. 46). Similarly in this study’s theme three, all the participants’ experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery. One of the 3 participants experienced a caring interaction with a nurse that included presence, touch, talking, comforting, and reassurance which provided confidence and inner-strength that promoted the decision to rebuild and heal.

A study by Walton (2002) supported the experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices to enhance recovery. Walton explored spirituality in patients recovering from acute MI. Findings of the Walton’s study indicated caring interactions occurred with nurses who demonstrated their concern through listening, touching, humor and caring. Walton’s study findings indicated that the nurses’ presence provided enhanced coping, comfort and inner strength to the participants and facilitated identifying and integrating healthy lifestyle changes into daily life. Similarly in this study, all the participants’ experience of caring interactions with healthcare providers that provided relationships that promoted self-knowledge and inner strength to make choices that enhanced their recovery. One of the 3 participants experienced caring interactions
with nurses from the cardiac rehabilitation program that included providing information and teaching of the joy of learning which promoted courage, self-confidence and inner strength to make the choice to integrate and adhere to her diet and exercise program.

Conclusion

This study explored the lived experience of women with first-time MI. The lived experience was revealed through verbatim responses of the 3 participants. Suffering from a first-time MI brought unexpected loss and change. The process of grief provided the women a way to cope with the loss of self and prior health status after the MI. All the women dealt with change and integration of their experience throughout the recovery process. Caring interactions with healthcare providers provided relationships that promoted inner-strength that promoted health-seeking behaviors that enhanced their recovery.

Though findings of this study were supported by the literature, many of the studies were international. Though few studies supported the process of grief to cope with loss (Hentz, 2002; Bergman & Bertero, 2001; Medich, et al., 1997), no studies were found that focused solely on the grief process of women throughout recovery after an MI. Instead, common components of the process of grief (O’Carroll et al., 2001; Sarantidis et al., 1997; Stewart, et al., 2000; Bergman & Bertero, 2001; Jackson et al., 2000; Thomas et al., 1998; Svedlund, et al., 2001; Sutherland & Jensen, 2001; Walton, 2002), such as denial, bargaining, and feelings of anger, guilt and fear, were found throughout the literature reviewed. In addition, many studies of the literature reviewed had focused on change (Fleury et al., 2001; Crane and McSweeney, 2003; Johansson et al., 2003; Rankin, 2002; Gregory et al., 2006; Medich et al., 1997; Johansson et al., 2003) that occurs after the myocardial infarction. A recurrent theme found within the literature supported that women
experience change in valuing self, family and others and activity level. Only one study could be found that supported the theme of change in responses to recurrent chest pain (Johansson et al., 2003) during recovery after the MI. Most studies about change focused on the acute phase of recovery rather than months or years after the MI. An important similarity between the findings in the literature and the current study were the participants experienced caring interactions that promoted self-knowledge and inner strength to make choices that enhanced recovery. Several studies were found that supported the theme of caring interactions that provided relationships that promoted self-knowledge and inner strength to make choices that enhance recovery (Johansson et al., 2003; Medich et al., 1997; Walton, 1999, 2002; Mullaney, 2000). Understanding caring interactions in caring for women after the MI could impact the women’s understanding of her experience, which could impact the integration of change and making choices that enhance healing and recovery. Findings of this study led to important implications for nurses and other healthcare providers who care for women with MI.

Limitations

Limitations of this study can be identified. The researcher was not able to reach saturation due to size of the sample and limited timeframe for the study. Additional findings may have been obtained if true saturation had been obtained. A second limitation was the inexperience of the researcher in doing qualitative research. The third limitation was all the participants were from the same large cardiology practice group. This could have created a bias in terms of perception of the healthcare providers providing caring interactions. The fourth limitation is that all the women were Caucasian and married. This could create a bias related to change that occurs after the infarction and available resources and support systems during recovery. The fifth limitation, which
contributes to rigor in qualitative research is credibility (Speziale & Carpenter, 2003). It would have been preferable to have a second contact with the participant to validate the reported findings.

Implications for Nursing

The findings in this study and literature provided support that the process of grief, denial, bargaining, and feelings of guilt, anger, and fear assisted women to cope with loss and the importance of understanding their experience. Understanding the lived experience of women with MI should be a priority for cardiac nurses in the care of patients and their families. It is important for nurses to understand the feelings of women as they grieve their losses better assessment, planning, implementation and evaluation of care occurs which could result in the optimal care women need. Each woman has her own unique grief process that needs to be evaluated by nurses so that support can be provided which could enhance the grief process to provide optimal outcomes during recovery. Women may be silent about their grief because of fear of being misunderstood and their silence may be misunderstood and could lead to gaps in treatment and much needed care. It is important for nurses to assess women for grief to acknowledge individualized responses to grief and plan for providing education, teaching, and resources to support women and families. Assessing women for grief, providing education, teaching and resources could prepare patients and families about what to expect and could enhance coping and recovery. Denial exists when women are not ready to accept their experience of having an MI. Understanding denial is important because misunderstanding and misinterpretation of denial could lead to possible labeling of the patient, gaps in care and less than optimal recovery. When women do not attend cardiac rehabilitation programs or take part with other parts of their treatment plan it is important not to label the patient as “non-compliant” because it may be related to denial. It is
important for nurses to assess women’s coping mechanisms and provide support and education to patients and family members, which could provide a positive influence on recovery outcomes.

Women’s anger may produce silence and feelings of powerlessness and hesitancy to express anger for fear of distancing relationships. Distancing could result in disruption of relationships and isolation. It is important for nurses to understand that women’s anger is usually rational and employed when their morals, principles or core values have been violated. It is important for nurses to provide teaching, support, and education to patients and family members about the usefulness of anger in empowering women to accept and express anger. Providing teaching, support and education could have a positive influence on fostering maintenance of relationships, avoidance of isolation, and enhance optimal outcomes.

Women’s guilt and possible reasons for guilt should be understood because guilt could result in decreased communication with family members and healthcare providers. Decreasing communication allows women to not share the burden of illness and to protect relationships and roles. It is important for nurses to assess for guilt and communication patterns in addition to providing support and education to patients and family members. Assessing, providing support, and education could increase understanding about guilt and could encourage family engagement in the recovery process, which could have a positive influence on outcomes. Women’s fear may be related to threat of death, recurrence of infarction, caretaker role changes, pain, and loss of dignity. Nurses should understand that women’s fear along with physical crisis could affect recall and comprehension and may explain women not being able to recall information or recall being provided information. Nurses should assess fear and acknowledge that fear and provide women with support to discuss the meaning of their fear and provide resources, which could have a
positive influence on recovery outcomes. Nurses should provide women with education, teaching, information, and support repeatedly throughout the recovery process. Additionally, an assessment of the women’s understanding of the information could have a positive influence on establishing ongoing unmet needs that should be addressed.

The findings in this study and literature provided support that change in the valuing of self, family and others, activity level and responses to recurrent chest pain occurred and the importance of understanding these experiences. Change occurred as women integrated their experience and they reprioritized to make themselves a higher priority. Women found an increased value in connecting with others who had similar experiences while the women searched for validation of experience. It is important that nurses provide women with education about opportunities that allow for the connecting with others with similar experiences, which should provide for connectedness and validation of experience. It is important that nurses educate patient and family members about the need for validation of experience, which could provide increased understanding of the change of valuing others.

Changes in activity levels may be related to decreased physical endurance and result in decreased ability to continue with prior established activities and household chores. It is important that nurses provide teaching and education to patients and family members about the expected changes in endurance, strategies for energy conservation and symptoms that should be reported to healthcare providers. Providing for teaching and education about changes in endurance could provide an environment that allows for safety, healing and optimal recovery.

The findings in this study and literature provided support for caring interactions with healthcare providers provided relationships that promoted self-knowledge and inner strength to
make choices that enhanced their recovery. It is important that nurses understand the power of
caring interactions on empowering women to find inner strength, confidence and courage to make
choices that are health seeking and improve recovery outcomes. Caring interactions provide a
powerful intervention to enhance patient wholeness, caring and healing. It is important that nurses
and other healthcare providers have knowledge and understanding of caring interactions that
provides patients with opportunities for caring and healing.

It is important that nurses to provide education to healthcare providers regarding caring
interactions and the impact to health outcomes and encourage incorporation into daily practice.
Providing education about caring interactions to healthcare workers could have an influence on
patient outcomes and the recovery process. Nurses have a unique role in facilitating change of
behaviors and healing. It is important that nurses include narrative descriptions from the patients
about the meaning of their experiences, as a part of assessing and setting meaningful rehabilitation
goals and creating strategies for recovery. Listening to the stories of women as part of the
assessment assists in learning about unmet needs and what resources are needed to enhance
recovery.

The Advanced Practice Nurse’s role in the cardiac health of women could have a profound
impact on women’s cardiac healthcare outcomes by implementing such things as providing caring
interactions, education, teaching and support. It is important that nurses and other healthcare
providers understand the experience of women and their individual journey with grief, integration of
change, and caring interactions of healthcare providers. This research provided valuable
knowledge about the lived experience of women with MI that can be applied to nursing practice.
The nurse can provide education, teaching and caring presence in providing support for patients
and family members. The nurse can provide education to nurses and other healthcare providers regarding the power that caring interactions have on empowering women to find inner strength, courage and confidence to make choices that facilitate healing. As indicated, the findings of this study demonstrated important implications for nurses that could potentially influence future care of those women who suffer from MI.

**Recommendations for Further Research**

The findings of this study provided valuable knowledge for nursing and other healthcare providers. Despite the data obtained, a more in depth understanding regarding the lived experience of women with MI is needed, especially within the discipline of nursing in the United States. The literature reviewed provided evidence of the lack of current nursing studies on this phenomenon in the United States. Though research had indicated that women grieve after MI, further research focused on the grief process of women throughout recovery would provide valuable data. Literature reviewed provided evidence of the lack of nursing studies on women’s responses to recurrent chest pain after MI. Research on women’s responses to recurrent chest pain after MI would provide additional valuable data that could potentially be useful in evaluating current teaching strategies and developing teaching strategies that enhance recovery outcomes. Women experienced caring interactions yet there were not many studies to explore this topic. Research on the short-term and long-term outcomes of caring interactions would provide valuable data. Research on women who are from various age groups, ethnic background, and marital status would provide increased data from a more diverse group of women who have suffered from MI.
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APPENDIX A

Principle Investigator: Joanne Ehrmin Ph.D., RN
Co-Investigators: Diane French Ph.D., RN, CNP
Joan van der Blij MSN, RN, CNS, BC
Sheila Olson BSN, RN

The Lived Experience of Women with a First-Time Myocardial Infarction (heart attack)
Information Sheet

You are being asked to take part in a research study to learn about the experiences of women who have had a heart attack for the first time over the past 12 months. Your cardiologist gave you this information sheet to provide information about the study and a phone number for you to call if you are interested in taking part. Taking part in this study is voluntary.

The goal of this study is to learn more about the experiences of women who have had a "heart attack" for the first time. A heart attack occurs when there is not enough oxygen to feed the heart muscle and damage occurs. Learning more about this experience may be useful to nurses caring for women who have had a heart attack.

If you choose to take part in this study you will need to call me and let me know that you want to be in the study. My phone will not be able to identify your phone number. During that phone call you and I will set up a date to meet. We will meet at a private room in the Medical University of Ohio at Toledo hospital library or a private meeting room at your doctor's office. You and I will be the only people in the meeting.

When we meet you and I will review this information sheet to cover any questions you may have. It is important that your questions are answered so that you have all the information you need to make a choice about being in this study or not. After you have made your choice to be in the study we will begin the private audiotaped interview. I will ask you a few questions before beginning the audiotaped interview. I will ask you questions to make sure you are freely choosing to take part in the study and that you are a woman who is allowed to be in the study.

During the first part of the interview I will ask you to complete a short form to obtain personal information about you. Your name will not be put on this form. I will be there for any questions you may have. If there are questions you do not want to answer you do not have to complete those questions. Then we will begin a private audiotaped interview that will last from 30 - 60 minutes. During the interview you will be asked if you are voluntarily participating in the study. Then you will be asked about your experience of having a heart attack.

Page 1 of 2
(Please read both sides of this information sheet)
APPENDIX A

The Lived Experience of Women with a First-Time Myocardial Infarction (heart attack)

Information Sheet

If there is a second interview it will occur by phone. During our meeting we will set up a date when you would talk to me by phone. This gives us time to discuss any thing you want me to understand about your experience. It is your choice if you want to call me.

Any information obtained in this study will not have your name on it. Only data from all the women as a group will be discussed in the final report of this study. No information that identifies you personally will be used. Every effort will be made to keep your information confidential. If you decide to be in the study, or not, your decision will not be known by your cardiologist and other health care providers. If you decide to be in the study or not, your care will not be affected.

If you agree to take part in the study you are not required to answer any question that may make you uncomfortable. There are no consent forms to sign. You may stop the interview at anytime without explaining why. And, you may stop taking part in the study at any time. Taking part in this study will provide no personal benefits to you. The information you share may be useful to nurses who care for women who have had a heart attack. The information you give, your name or any identifying information will not appear on the short form (questionnaire), the tapes, or my study notes. A professional stenographer will create documents (transcripts) of the audiotaped interview without any identifying information about you. Audiotapes, transcripts and questionnaires will be stored and destroyed by policy of the Institutional Review Board at Medical University of Ohio at Toledo. Any publication or presentation of the information from this study will not identify you.

The only cost to you for taking part in this study is that you will need to have your own transportation to the interview. During the interview you may have feelings of anxiety as you share your experiences of having a heart attack. If you feel you need help with your anxiety you may call Rescue Mental Health Services at (419) 255-9585.

If you have read this information sheet and plan to voluntarily take part in the study please call Sheila Olson at (419) 346-8927.

Page 2 of 2
(Please read both sides of this Information sheet)

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MUOT IRB #105283
APPENDIX B

The Lived Experience of Women with a First-Time Myocardial Infarction: A Phenomenological Study

Template for conduction of interviews

Introduction of researcher to participant
Explain what the participant can expect, the course of the interview, and participation may stop at any time during the process.
Review information sheet and answer any questions participants may have
Ask questions to confirm:
Understanding of the study → Do you understand the study information sheet?
Voluntarism of participant
Are you volunteering for this study of your own free will?
Non-pregnant status (by self report)
To the best of your knowledge—Are you pregnant?
Non-terminal illness status (by self report)
To the best of your knowledge—Are you free of any terminal illness?
Continue interview only if understanding of the study, voluntary participation of own free will, non-pregnancy and non-terminal illness status exists.

Begin the non-audiotaped portion of the interview
Provide and explain the brief study questionnaire (see questionnaire) and the option of not answer all questions on the form
Reinforce avoiding placing participant name on the form
Be available to answer questions
Collect the completed questionnaire

Forewarned of the potential for feelings of anxiety while sharing their experiences of having a first-time MI and provide support resource phone number of Rescue Mental Health Services at 419-255-9885.

Begin the audiotaped Interview
At the beginning of the audiotaped interview confirm that the participant is volunteering for the study of her own free will.
Open-ended prompts and van Manen’s unstructured dialogue will occur
Main question: Tell me about your experience of having a heart attack for the first time?
Example of possible open-ended probes:
1. How does it feel to ___?
2. What’s it like to be ______?
3. What does that mean?
4. In what way?
5. Tell me more about ______?
6. Give me an example.

Set up a date when the participant may contact the researcher, by phone, if they feel the need to
Contact the researcher for questions or to clarify experiences
Emphasize that the phone contact is at the discretion of the participant
Provide the phone number to the participant
Reinforce the phone has no caller identification
Thank the participant for taking part in the study and adjourn the meeting/interview

APPROVED BY MEDICAL UNIVERSITY OF OHIO AT TOLEDO IRB
APPENDIX C

Principle Investigator: Joanne Ehmin Ph.D., RN
Co-Investigators: Diana French Ph.D., RN, CNP
Joan van der Bijl MSN, RN, CNS, BC
Sheila Olson BSN, RN

The Lived Experience of Women with a First-Time Myocardial Infarction (Heart Attack)

Study Questionnaire Form

Please complete the form below. Do not put your name or signature on this form. Mark an X in the area for your answer. Return this form to the researcher when you have finished. Please see the researcher if you have any questions about this form.

1. Your Age is: _____ (years)

2. Gender: Male_____ Female_____

3. What is your race or ethnic background?

   Black_____ Hispanic____ White_____ Other: _______________________

4. What is your Marital Status?

   Married____ Single____ Widowed____ Divorced____ Other: ____________

5. How many weeks were you in the hospital for your heart attack?
   a. Less than 1 week _____
   b. 1 – 2 weeks _____
   c. 3 – 4 weeks _____
   d. Greater than 4 weeks _____

6. How many weeks has it been since you were discharged from the hospital?
   a. Less than 1 week _____
   b. 1 – 2 weeks _____
   c. 3 – 4 weeks _____
   d. Greater than 4 weeks _____

Thank you for completing this form. When you are finished please give this form to the researcher.

Page 1 of 1

MUO IRB # ______

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OF OHIO AT TOLEDO IRB

MUOT IRB #105283
APPENDIX D

Examples of possible open-ended probes

1. How does it feel to be_________?
2. What's it like to be_________?
3. What does that mean?
4. In what way?
5. Tell me more about_________
6. Give me an example
APPENDIX E

Medical University of Ohio at Toledo
INSTITUTIONAL REVIEW BOARD
Department for Human Research Protections
Center for Creative Education Building – Room 0106
3025 Arlington Avenue, Toledo, Ohio 43614-2570
Phone: 419-383-6796 Fax: 419-383-3248
(PW 6890977952)

TO: Joanne Ehrlme, Ph.D., R.N., C.N.S.
MUOT College of Nursing
FROM: Roland Skeel, M.D., Chair
Gregory Siegel, R.Ph., J.D., Chair Designee
MUOT Institutional Review Board

DATE OF ACTION: June 21, 2006

SUBJECT: IRB # 105283 – The Lived Experience of Women with First-time Myocardial Infarction: A Phenomenological Study

The Chair and Chair Designee of the Medical University of Ohio at Toledo Institutional Review Board determined that this project be designated as expedited research (category #6 & 7). The requirement to obtain a signed consent/authorization for use and disclosure of protected health information form has been waived as this research is determined to be minimal risk and a signed consent/authorization document would be the only record linking the subject to the data. It was determined that this waiver for signed consent/authorization for use and disclosure of protected health information form will not adversely affect the rights or welfare of the participants. The full board will be notified of this action at its meeting on 07/20/2006.

Items Reviewed:
- IRB Application requesting Initial Review for Expedited Status Designation of Research
- Protocol (assigned version date 06/21/2006)
- Request for Waiver of Individual Authorization For Use and Disclosure of Protected Health Information (PHI) for Purposes of Research

APPROVAL DATE: 06/21/2006 EXPIRATION DATE: 06/20/2007

It is the Principal Investigator’s (P.I.’s) responsibility to:
1. Abide by all federal, state, and local laws and regulations; the MUOT federal assurance and institutional policies for human subject research and protection of individually identifiable health information including those related to record keeping and be sure that all members of your research team have completed the required education in these areas.
2. Promptly notify the MUOT IRB at (419) 383-6796 of any untoward incidents or unanticipated adverse events that develop in the course of your research. Please complete and submit RGA Form 317 for ALL SUCH REPORTS for this protocol. The Principal Investigator is also responsible for submitting to the MUOT IRB reports of adverse events that occur at other sites conducting this study and for maintaining an up-to-date cumulative table of adverse events (RGA Form 316) and submitting it to the MUOT IRB for each research project. The Principal Investigator is responsible for reporting adverse events to the appropriate federal agencies and the sponsor (when one exists).
3. Report promptly to the MUOT IRB any deviations or violations from the MUOT IRB approved protocol in accordance with the procedures outlined in RGA Form 309. In your report include the protocol number and title, the subject’s initials/specimen identifier (as appropriate) and study I.D. number, date of the event, a brief description of the occurrence and a description of any corrective actions taken. The Principal Investigator is responsible for reporting deviations, violations and participant non-compliance to the appropriate federal agencies and the sponsor (when one exists) in accordance with federal regulations, institutional policy and any other legal agreements with these organizations.
4. Obtain prior MUOT IRB review and approval for changes in study personnel and for any and all changes/new information that may require additional information be provided to participants.
APPENDIX E

5. Report **promptly** to the MUOT IRB, sponsor (if this research is sponsored) and all other required federal and state agencies all new information affecting the risk/benefit ratio and obtain **prior MUOT IRB approval** for any changes in the study documents that may be required by the new information.

6. Obtain **prior MUOT IRB review and approval** for all modified and/or added incentives going to the P.I., study coordinator, other study personnel, and/or the institution. These incentives may be in the form of money or other items of value, including, but not limited to, equipment, such as computers, and intangibles, such as frequent flyer miles.

7. **Promptly** notify the MUOT IRB, other required MUOT committees, departments or individuals; the sponsor (if this research is sponsored); and all other required federal and state agencies of all potential conflicts of interest before beginning this research and, during the course of this research report to these committees, individuals and agencies any changes that may affect conflicts of interest for any of the study personnel. **Prior MUOT IRB approval** must be obtained for any changes in the study documents that may be required by information related to conflict of interest or any changes in this information during the course of the research.

8. **Promptly** notify the MUOT IRB of any changes in contracts, budgets, grants or other agreements with sponsors, agencies or individuals regarding the conduct of this research before initiating these changes. The IRB reserves the right to review these study related documents and changes to them to verify accuracy and consistency with regard to the research protocol in order to protect the rights and welfare of the study subjects. Changes in these documents that have the potential to affect the rights, welfare or willingness of the study subjects to participate in or continue to participate in this research and changes in subject documents (such as informed consent, assent or authorization for use and disclosure of protected health information forms, etc.) that are a result of these changes **must** be reviewed and approved by the MUOT IRB **prior** to being instituted.

**Additional Information:**

- **Other Required Review(s) or Approvals(s):** Review or approval by the MUOT Institutional Review Board does not take the place of any other review or approval required by the Medical University of Ohio at Toledo, non-MUOT performance sites, the government and/or the study sponsor.

- **Required Procedure to Request Review and Approval for Changes/Updates to MUOT IRB Approved Research:** Please complete and submit the Request for Amendment/Changes/Updates (RGA Form 314 found at <http://www.medohio.edu/research/rga_frm/rga314.doc>) with a copy of all materials relevant to the requested change (including consent/assent/authorization for use and disclosure of protected health information forms if applicable) with the changes underlined. If you are requesting review and approval of consent/assent/authorization for use and disclosure of protected health information forms, please attach a clean copy of the revised forms for the MUOT IRB to stample. Please remember that all changes and correspondence submitted to the MUOT IRB (regardless if they are generated by a sponsor, the P.I. or requested by the MUOT IRB) must be in writing, signed and dated by the Principal Investigator.

- **Federally Mandated Continuing Review:** MUOT IRB protocols must be reviewed and reapproved not less than once per year. The Institutional Review Board will try to remind you when reapproval is due. However, it is the responsibility of the Principal Investigator to have his/her own reminder system in place to initiate the re-approval process at least a month prior to the expiration date shown above. Please note that Federal Regulations prohibit the extension of this expiration date. Please see the Application for Continuing Review (RGA Form 319 found at <http://www.medohio.edu/research/rga_frm/rga319.doc>) for items required for continuing review.

- **Required Final Report Upon Termination of Research:** When you decide to stop this research, you are responsible for completing and submitting a Final Report (RGA Form 320 found at <http://www.medohio.edu/research/rga_frm/rga320.doc>) to the MUOT IRB for review.

Please contact the IRB at (419) 383-6796 if you have any questions or need assistance.
ABSTRACT

The purpose of this study was to discover the lived experience of women with first-time myocardial infarction. Van Manen’s (1990) phenomenological method of human science guided the data collection and analysis. Watson’s (1979, 1985, 1988, 1999) nursing theory was the conceptual framework. Three themes emerged and are synthesized in an exhaustive description of the phenomenon.

Exhaustive Formalized Description of Phenomenon

Loss and disharmony of the old self or pre-myocardial infarction elicited the process of grief as a coping response. Integration of experiences promotes change and restoration of harmony as a new integrated self is developed and sustained. Intentional caring transactions foster the integration of experience, change, and self-healing that promotes self-knowledge and inner strength to make choices in health-illness decisions.