10

The lived experiences of wives of first time myocardial infarction survivors during the convalescent period

This thesis is presented for the degree Master of Science (Nursing)

March 2001

Wendy McLeod

Department of Nursing
Faculty of Health Sciences
University of Cape Town

The copyright of this thesis vests in the author. No quotation from it or information derived from it is to be published without full acknowledgement of the source. The thesis is to be used for private study or non-commercial research purposes only.

Published by the University of Cape Town (UCT) in terms of the non-exclusive license granted to UCT by the author.

University of Cape Town

DECLARATION

I, ___________________, hereby declare that the work on which this thesis is based is my original work (except where acknowledgements indicate otherwise), and that neither the whole work nor any part of it has been, is being, or is to be submitted for another degree in this or any other university.

I empower the University of Cape Town to reproduce for the purpose of research either the whole or any portion of the contents in any manner whatsoever.

signature removed

Signature

15 March 2001

Date

ACKNOWLEDGEMENTS

I would like to extend my sincere thanks to:

Erik, my husband and "research assistant", for his keen eyes and endless patience as well as his loving support over the last three years. It has meant a lot to me.

My parents who have always had the greatest confidence in me and to whom I dedicate all my achievements.

My supervisor Professor Rosalie Thompson who instructed, supported and inspired me from the time I took the first few tentative steps of my research journey and who encouraged me to find my creative spirit and to make use of it.

My second supervisor Mrs. Edelgard le Roux for her enthusiasm, encouragement and valuable practical advice.

ABSTRACT

There is evidence that wives of first time myocardial infarction survivors play a crucial role during the convalescent period. A knowledge deficit exists however, regarding the significance of their experiences during this time. The aim of this study therefore, was to investigate and illuminate the lived experiences of wives of first time myocardial infarction survivors during the first six to eight weeks of their husbands' convalescent period.

The inquiry paradigm chosen for this study was the qualitative approach and the research strategy used was hermeneutic phenomenology. Max van Manen's six procedural research activities guided the methodological processes of this study. A pilot interview was conducted using the Free Attitude Interview Technique, following which four study interviews were done with participants who met the inclusion criteria. Qualitative analysis revealed eight central themes that described the lived experiences of the participants. They were: 1) being a protective shield; 2) life changes; 3) facets of the relationship change; 4) meeting additional role responsibilities; 5) living with fear; 6) drawing from the support fund; 7) causal explanations for the myocardial infarction and 8) the need for knowledge. The study findings are discussed in relation to the available literature and recommendations are made for nursing research, practice and education.

The knowledge gained from this study will enable nurses to plan and implement nursing interventions that will better prepare, support and equip wives during the convalescent period. This in turn will assist the wives to enhance family resources and promote their husbands' readjustment during the convalescent period.

TABLE OF CONTENTS

DECLARATION i
ACKNOWLEDGEMENTS ii
ABSTRACT iii
TABLE OF CONTENTS iv
LIST OF TABLES vii

CHAPTER 1:
THE BACKGROUND TO THE RESEARCH JOURNEY 1
The background to the research question 2
The aim of the study 3
An overview of the research process 3
The context of this study 5
A brief overview of the literature related to the research question 7
An overview of this thesis 10

CHAPTER 2:
FINDING MY WAY THROUGH INQUIRY PARADIGMS AND RESEARCH STRATEGIES 11
Inquiry paradigms: which path to follow? 12
Exploring the different inquiry paradigms 12
Quantitative and qualitative inquiry paradigms: which one to choose for this study? 14
The philosophical assumptions of the qualitative researcher 15
Phenomenology 16
Comparison of Husserlian Phenomenology and Heideggerian Phenomenology 16
Hermeneutic phenomenology 18
The philosophical underpinnings of hermeneutic phenomenology 19
World 19
Interpretation and pre-understanding 20
Prejudice 20
Temporality 21
Horizons 21

The hermeneutic circle 21
Hermeneutic phenomenology and qualitative nursing research 22
Conclusion 22

CHAPTER 3:
THE ITINERARY 24
van Manen's hermeneutic phenomenology 25
van Manen's six procedural research activities 26
Turning to the nature of lived experience 27
The nature of lived experience 27
Orienting to the phenomenon and formulating the research question 28
Explicating assumptions and pre-understandings 28
Investigating experience as we live it 30
Participant criteria 30
Participant identification 31
Consent 32
The hermeneutic phenomenology interview 32
Pilot interviews 33
Sample size 33
Ethical issues in interviewing 34
Intervention by the researcher 34
Data collection 34
Power differential in the participant/researcher relationship 35
Context within which the interviews were performed 35
The researcher as the data collection instrument 36
Interviewing techniques 36
Audiotaping and transcription 39
Reflecting on essential themes 40
Working with the text 40
The hermeneutic circle in thematic analysis 41
van Manen's line-by-line approach to thematic analysis 41
Phenomenological describing through the art of writing and rewriting 50
Maintaining a strong and oriented relation to the research question 51
Balancing the research context by considering parts and whole 52

Trustworthiness 52
Credibility 54
Transferability 56
Dependability 57
Confirmability 60
Conclusion 61

CHAPTER 4:
WHAT I LEARNT FROM THOSE I MET 62
The themes 63
Theme: Being a protective shield 63
Theme: Life changes 68
Theme: Facets of the relationship change 74
Theme: Meeting additional role responsibilities 77
Theme: Living with fear 79
Theme: Drawing from the support fund 82
Theme: Causal explanations for a myocardial infarction 86
Theme: The need for knowledge 89
Conclusion 93

CHAPTER 5:
MY FINDINGS IN PERSPECTIVE 94
Discussion of findings and related literature 95
Being a protective shield 95
Life changes 98
Facets of the relationship change 102
Meeting additional role responsibilities 107
Living with fear 109
Drawing from the support fund 111
Causal explanations for a myocardial infarction 114
The need for knowledge 115
Limitations of the study 121
Recommendations for further research 122
Recommendations for nursing practice 123
Recommendations for nursing education 125
Conclusion 126

REFERENCES 127

APPENDICES 141

Appendix A: Letter of approval from the Dean of the Health Sciences Faculty of the University of Cape Town on behalf of the Postgraduate Programmes committee 141

Appendix B: Letter of approval by the Research Ethics Committee of the Health Sciences Faculty of the University of Cape Town 142

Appendix C: Letter of consent 143

Appendix D: Contract for the transcriber 145

LIST OF TABLES

Table 1: Basic beliefs of the inquiry paradigms 14

Table 2: Comparison of Husserlian phenomenology and hermeneutic Phenomenology 18

Table 3: The four basic concerns of trustworthiness and their quantitative and qualitative analogues 53

Chapter one: The background to the research journey

"In the hour of sorrow and sickness, a wife is a man's greatest blessing"
(Euripides 484-406 B.C. "Antigone", Fragment 164)

Coronary artery disease is the major cause of morbidity and mortality in most Western countries (Marik, Lipman, Eidelman and Erskine 1990: 179). According to the Heart Foundation of South Africa "one in three men and one in four women will suffer from coronary artery disease before they reach the age of 60 years" and they predict that by 2020 cardiac disease will be the most important cause of death and disease in South Africa (http://www.heartfoundation.co.za.htm). Most myocardial infarction survivors in South Africa are admitted to critical care units where they are closely monitored for approximately three days. If there are no complications they are transferred to a general ward where they stay for a couple of days and are then discharged from hospital into the care of their wives and families. The wife now assumes the role of primary care giver and provider of support during the convalescent period and plays an important role in enhancing both family resources and furthering her husband's readjustment. However unlike the nurse, she has little knowledge regarding symptom recognition and management (including how to deal with emergencies) and may also be unfamiliar with instituting and maintaining lifestyle changes. I wondered how a wife experienced her husband's convalescent period. Was it an enormous responsibility? Was it stressful? How did she cope? What impact did it have on family dynamics? I thought that she would probably find it stressful, frightening and bewildering and that family dynamics were probably altered, but these were my preconceptions, I wasn't really sure. When the time came for me to choose a research question for my thesis, I saw this as the ideal opportunity to find the answers to these questions.

- This chapter includes:

  - The background to the research question.
  - The aim of the study.
  - An overview of the research process.
  - The context of this study.
  - A brief overview of the literature related to the research question.
  - An overview of this thesis.

THE BACKGROUND TO THE RESEARCH QUESTION

I have been a critical care nurse for 10 years and during this time I have noticed that as critical care nurses, we often place great emphasis on the physiological aspects of coronary artery disease at the expense of other dimensions and consequences of this illness. In the critical care unit the patient, rather than the wife, is the focus of nursing attention as nursing interventions are primarily directed towards preventing further damage to the myocardium. Some critical care nurses may be so preoccupied with administering drugs, scrutinising rhythm strips and electrocardiograms and

analysing blood results that perhaps we forget about the wife waiting anxiously in the reception area. After the initial crisis little or no time is spent with the wife outlining the psychological and social challenges she faces during the convalescent period. I wondered why this was so and came to the realisation that I, and probably many other critical care nurses, really have no knowledge regarding the significance of the wife's experiences during the convalescent period. I believe that until nurses have a full understanding of the experiences of wives in the convalescent period we cannot plan nursing interventions that will better prepare, support and equip her during this time. It was from this realisation that the idea for this study grew. Little did I know that this idea would take me on a journey into the world of research, the greatest journey of my academic career thus far.

THE AIM OF THE STUDY

The aim of this study was to investigate and to ultimately understand more fully the lived experiences of wives of first time myocardial infarction survivors during the first six to eight weeks of their husbands' convalescent period.

AN OVERVIEW OF THE RESEARCH PROCESS

John Locke (1632-1704) said, "The improvement of the understanding is for two ends: first, for our own increase of knowledge; secondly to enable us to deliver and make out that knowledge to others" (cited by Stevenson 1967: 2006). My research destination was to improve my understanding of the experiences of wives of myocardial infarction survivors during the convalescent period and to use this knowledge to produce a thesis that would illuminate these experiences for those who read it. In the subsequent text I provide you with a brief overview of my research journey, a more thorough discussion of which is presented in the chapters that follow.

The inquiry paradigm chosen for this study was the qualitative paradigm, because I felt that the basic beliefs and worldviews that undergird it are congruent with those of nursing. The qualitative research strategy, or method used in the study was hermeneutic phenomenology. Phenomenology is described by van Manen (1990: 38) as "the descriptive study of lived experience (phenomena) in the attempt to enrich lived experience by mining its meaning". Hermeneutics he described as "the interpretive study of the expressions and objectifications (texts) of lived experience in the attempt to determine the meaning embodied in them" van Manen (1990: 38).

My research process was guided by six procedural research activities suggested by van Manen (1990: 31), which are:

- Turning to the nature of the lived experience
- Investigating experience as we live it
- Reflecting on essential themes
- Phenomenological describing through the art of writing and rewriting
- Maintaining a strong and oriented relation to the research question
- Balancing the research context by considering parts and whole

Five participants who met the selection criteria were identified in the critical care unit in which I worked. They were contacted telephonically and invited to take part in the study after their husbands had been discharged from hospital. I met each of them six to eight weeks following their husbands' discharge from hospital and once consent had been negotiated, an interview was conducted using the Free Attitude Interview Technique (Meulenberg-Buskens 1997: 1). The interview I did with the first participant was considered to be the pilot interview and the interviews with the other four participants were used in the study. Each interview was tape-recorded and these audiotapes were then sent for transcription. The transcripts became my data, which were subjected to an exhaustive analysis process, until eight themes were identified. These are:

- Being a protective shield
- Life changes
- Facets of the relationship change
- Meeting additional role responsibilities
- Living with fear
- Drawing from the support fund
- Causal explanations for the myocardial infarction
- The need for knowledge

A literature review followed and each theme discussed in the light of the available literature. On the basis of the findings recommendations are made for further nursing research, nursing practice and education.

THE CONTEXT OF THIS STUDY

I have spent some time describing the context of the study so that you may have a clear idea of the background to and circumstances in which the study took place. This also allows you to judge the transferability, a criterion of trustworthiness, of this study. The study was carried out in a critical care unit at a private hospital in Cape Town in the Republic of South Africa. I have worked in critical care units as a registered nurse for the past ten years and in this particular unit for the last six years, the most recent two as the unit manager. The hospital does not have a dedicated coronary care unit; instead patients are admitted to our seven bedded medical and surgical critical care unit. Cardiac patients are referred to this unit via the hospital's emergency unit and via general practitioners who refer their patients to the cardiologist and physicians who practice at the hospital. The majority of myocardial infarction survivors seen in our critical care unit are male; this is probably because the incidence of myocardial infarction is higher amongst men than amongst women in the less than 50 years age group (Jacobs and Sherwood 1996, cited by Stewart, Davidson, Meade, Hirth and Makrides 2000: 1357).

Patients are cared for in the unit by registered nurses. A number of the experienced registered nurses working in the unit have completed either a six-month certificate course or a one-year diploma or honours degree in critical care nursing, at a post-registration level. Caring for the critically ill cardiac patient forms part of the syllabus in all these courses. Our hospital does not have a cardiac catheterisation laboratory nor facilities for coronary bypass surgery, so patients requiring invasive cardiology are referred to nearby hospitals that offer these facilities.

As mentioned earlier, the study took place in a private hospital, one of many owned by a large corporation in South Africa, which is run as a business concern. For this reason two categories of patients are seen at this hospital, those on medical aid schemes or hospital insurance plans and those who have personal financial means to pay for medical treatment. Those patients falling outside these two categories are forced to seek medical attention at state hospitals. Due to the escalating costs of medical care we receive a great deal of pressure from the administrators of the medical aid funds to reduce costs and this has resulted in shorter hospital stays. This impacts negatively on the time available for educating and counselling the couple.

All patients with a suspected or diagnosed myocardial infarction are admitted to the critical care unit where they stay for two to three days. If there are no complications they are transferred to the ward where they are usually discharged from hospital after two to three days.

All our cardiac patients are given an informational booklet called "Heart attack, what now?" At the time of compilation the authors Bennett, Griffiths, de Beer, Prinsloo and Steinmetz (1993), were all members of the multidisciplinary health care team associated to the coronary care unit of the Pretoria Academic Hospital and the Faculty of Medicine at the University of Pretoria. A pharmaceutical company prints and distributes the booklet, which is printed in two of the thirteen official languages in South Africa namely English and Afrikaans. Most of the patients we admit to our unit speak either English or Afrikaans. It is a comprehensive booklet written for laypersons with pictures to facilitate understanding.

A dietician affiliated with the catering company that services the hospital sees all cardiac patients together with their wives before discharge from hospital. She discusses the dietary principles they have to follow and gives them written information, which they can use later as a reference source.

The first six to eight weeks following discharge from hospital is considered to be the convalescent period during which time the patient recovers physically and psychologically and hopefully resumes his premorbid level of functioning. There are three cardiac rehabilitation centres situated in Cape Town all offering chronic disease risk reduction and reversal programmes for cardiac patients. They all charge for their services, the costs of which are covered by some medical aid schemes. The physician refers the patient to a rehabilitation centre once the patient has been assessed at the follow up visit, which is usually four weeks after the myocardial infarction. One of the rehabilitation centres however informed me that they encouraged the physicians to refer their patients as soon as two to three weeks after the myocardial infarction. It would seem that referral to a cardiac rehabilitation centre does not happen routinely as only one patient in this study was referred for rehabilitation. The majority of the patients seen at these centres are male which is probably in keeping with the gender bias of this disease. Only one rehabilitation centre offered a multidisciplinary team approach i.e. doctors, biokineticians, dieticians and psychologists as part of their programme. At the other centres patients requiring these services had to be referred and of course pay the fee for service in addition to the cost of the rehabilitation programme. I was pleased to hear that all the rehabilitation centres offered some kind of educational lectures.

None of these rehabilitation programmes offer any kind of service or support specifically geared towards meeting the needs of the wives of myocardial infarction survivors. At one rehabilitation centre the wife could join her husband's rehabilitation programme but had to pay half the price of his programme, the cost of which is not covered by the medical aid scheme. At the other two rehabilitation centres the wife was free to accompany her husband at no extra cost. All three rehabilitation centres reported that this did not happen very often and in this study the patient that did

attend a rehabilitation centre was not joined by his wife. One of the rehabilitation centres runs a diet help line which patients and families can make use of and is free of charge.

A BRIEF OVERVIEW OF THE LITERATURE RELATED TO THE RESEARCH QUESTION

I conducted a brief literature review so that I could substantiate the feasibility of my research journey before I embarked on it.According to Rolland's (1987: 204-205) conceptual perspective of the chronic illness lifecycle, the onset of a myocardial infarction is acute and requires the family to quickly mobilize skills required for managing a crisis. The illness then assumes a "constant course" or "chronic phase" characterized by a stabilization in the course of the illness, during which time the family have to learn to live with the changes imposed on them by coronary artery disease. The main task of the family during this time is to try and maintain an impression of normal life in the "abnormal" presence of the illness, the unpredictability of which may have significant effects on the family. The psychosocial effects of a myocardial infarction are as significant for the patient's family as they are for the patient in particular his wife who assumes the task of primary care giver and the provider of support during the convalescent period. The wife, who is generally the closest family member to the myocardial infarction survivor, plays an important role in enhancing both family resources and furthering her husband's readjustment during this time.

Numerous studies have demonstrated the significant role the wife plays in her husband's adjustment following a myocardial infarction (Mayou, Foster and Williamson 1978a: 699; Ben-Sira and Eliezer 1990: 530; Beach, Maloney, Plocica, Sherry, Weaver, Luthringer and Utz 1992: 36; Stewart, Hirth, Klassen, Makrides and Wolf 1997: 158; Kettunen, Solovieva, Laamanen and Santavirta 1999: 486). Mayou et al (1978a: 699) state that there are two important factors which determine the patient's rate and extent of recovery. Firstly, the wife's attitude and behaviour towards her husband and secondly, the general quality of family life which is usually determined by her.

The benefits of a marital relationship have been found to be valid up to ten years following the myocardial infarction. Chandra, Szklo, Goldberg and Tonascia (1983: 322) found that married patients have a significantly better survival prospect both during hospitalisation and ten years after discharge following a myocardial infarction, than those patients who were single. These findings were confirmed by Mayou (1984: 24) when he reported that eighteen months following myocardial infarction, the married patients in his sample were found to have recovered faster and more completely than those who lived alone. More recently Case, Moss, Case, McDermott and Eberly (1992: 519) demonstrated that living alone was an important "independent risk factor for the

recurrence of a major cardiac event", the major effects of which were evident within the first six months after the initial myocardial infarction.

The wife provides her husband with tangible and emotional support, the value and importance of which is highlighted by Waltz (1986: 802) who concluded that an intimate marital relationship determines whether the patient will cope effectively with, and adapt to, the consequences of his illness. Similarly Ben-Sira and Eliezer (1990: 530) found that the wife plays a vital role specifically in enhancing the patient's self-esteem, mastery of the convalescent period and conditions his cognitive readjustment. Cognitive adjustment is described by Dimond (1983, cited by Ben-Sira and Eliezer 1990: 524) as the "individual's realistic assessment and understanding of their condition, acceptance of their life as meaningful and purposeful despite limitations imposed by the disease". These studies further highlight the significant role played by the wife within this group of patients and confirm the words of Euripides (484-406 B.C) when he said, "In the hour of sorrow and sickness, a wife is a man's greatest blessing" (cited by Strauss 1968: 656).

I now turned to literature that gave me some insight into the issues that surround the wife during the convalescent period much of which originates from quantitative studies. It would seem that this can be a time of appreciable psychological difficulty for the wife, which manifests as anxiety, depression, fatigue, irritability, poor concentration as well as insomnia and, as a result her quality of life may deteriorate (Skelton and Dominian 1973: 101; Mayou et al 1978a: 699; Dhooper 1983: 18; Thompson and Cordle 1988: 224; Arefjord, Hallaraker, Havik and Maeland 1998: 1213; Kettunen et al 1999: 483; O'Farrell, Murray and Hotz 2000: 101). A Finnish study done in 1980 by Hentinen, Hentunen, Hyvarinen, Karppinen and Manninen, found that the wife showed more problems coping with her husband's convalescence after a myocardial infarction than did any other member of the family (cited by Hentinen 1983: 521). Some wives may still show considerable psychological distress as much as a year after their husbands' myocardial infarction (Skelton and Dominian 1973: 102, Mayou et al 1978a: 699, Schott and Badura 1988: 125).

I could only find four qualitative studies that investigated the experiences of the wife during the convalescent period (Thompson, Esser and Webster 1995: 707; Theobald 1997: 595; Daly, Jackson, Davidson, Wade, Chin and Brimelow 1998: 1199; Stewart et al 2000: 1351).

A British study done by Thompson et al (1995: 707) investigated the experiences of patients and their wives a month after a myocardial infarction. Semi-structured interviews were conducted with 20 couples; all the survivors of the myocardial infarction were male. Their data revealed six categories which they felt described the experiences of patients and their wives. These were: "expectations about advice and information; feelings about the future; reactions to the partner;

playing down the significance of the heart attack; wanting to get back to normal; and the effect on the couple's relationship". A limitation of this study is that firstly the data was collected from the couple and is therefore of both their experiences rather than the experiences of the wife only. Secondly the wife was interviewed at the same time as her husband, which may have caused her to suppress her true experiences.

A qualitative study was conducted in Australia by Theobald (1997: 595) who investigated the experiences of spouses one month after their partners had suffered a myocardial infarction. In-depth interviews were conducted with three participants, two female and one male and analysis revealed five major themes. They were, "crushing uncertainty; overwhelming emotional turmoil; the need for support; the lack of information which heightened anxiety; and the acceptance of lifestyle changes". A limitation of these findings may be that one of the participants was male and it is possible that his experiences are different to those of female spouses.

The results of an Australian pilot study conducted by Daly et al (1998: 1199) the following year investigated the experiences of seven Lebanese-born women living in south-western Sydney, whose husbands were myocardial infarction survivors. Semi-structured interviews were conducted two to four weeks post-patient discharge and qualitative analysis revealed four themes. These were: "struggle to resolve distress; intensive monitoring of the acute myocardial infarction survivor; searching for avenues of support; and reflecting on the future". This study lacked diversity in that it focused on a distinct cultural group and more specifically an "elite" subgroup within this group i.e. English speaking, which could be considered to be a limitation of the study.

Most recently a Canadian study carried out by Stewart et al (2000: 1351) sought to "describe the stress, coping strategies and social support experienced" by fourteen survivors and their spouses over a period of twelve weeks, following a myocardial infarction. The study appears to have used a qualitative research approach but this fact, as well as the research strategy used to guide the study is not described. Their aim however, was to describe and they have used qualitative techniques to collect and analyse data. The research findings were limited because the research questions focused only on aspects of the experience predetermined by the researchers, rather than on the participant's whole experience. Once again data was collected from both the spouse and the survivor simultaneously and one of the fourteen spouses was male, which may have influenced the findings.

In contrast to the four studies most recently cited, this study will focus only on wives, data will be collected using unstructured interviews which will be carried out on an individual basis and the participants will not be limited to a specific cultural group.

AN OVERVIEW OF THIS THESIS

Chapter one describes the background to the journey, the research route that was followed, and the context within which the journey was undertaken as well as a brief overview of the literature related to the research question. **Chapter two** details my exploration of the different inquiry paradigms and their suitability for this study. I explore phenomenology as an enquiry strategy, comparing Husserlian phenomenology and Heideggerian phenomenology. I also investigate hermeneutic phenomenology and related philosophy and its suitability for the research question. **Chapter three** describes my research journey in detail, in terms of the six procedural research activities that were used to guide the methodological process of this study, as well as the way in which the issues of trustworthiness were attended to. **Chapter four** describes the findings of my research journey. I describe the eight themes that emerged from my analysis of the stories I collected from the wives of myocardial infarction survivors that I met on my journey. In **Chapter five** I discuss my research discoveries in relation to discoveries chronicled by other travellers who had journeyed along similar routes. I note the limitations of my study, make recommendations for further research journeys and discuss the implications of my discoveries for nursing practice and education. The list of **references** used in this study and the **appendices** follow chapter five.

Mention should be made of the writing style used in this study. As you will have noticed I have written this thesis in the first person. I have done so because the role of the researcher in qualitative research is an integral part of the study and therefore I believe her presence should be maintained. Wolcott (1990: 19) states that in qualitative research "the more critical the observer's role and subjective assessment, the more important to have the role and presence acknowledged in the reporting". For this reason I have also shared personal reflections of my experiences of "doing" research and "being" the researcher, throughout the text. You should note that when I refer to the female gender of the researcher it could equally refer to the male gender. Join me in the next four chapters as I share with you an account of my research journey.

Chapter two: Finding my way through inquiry paradigms and research strategies

"One does not discover new lands without
consenting to lose sight of the shore for a very long time".
(French novelist Andre Gide, 1869-1951)

During my academic career I had been exposed to research on two occasions, once at undergraduate level and again at postgraduate level five years later. On both occasions my exposure was to quantitative research. I knew that qualitative research was an alternative approach that could be used and that it did not involve statistics or mathematics, which appealed to me. I also knew that quantitative research is viewed by some as the only truly scientific approach whereas qualitative research is seen as the soft option. This was the sum total of my knowledge.

When I registered for my Masters degree I embarked on the greatest journey of my academic career. My destination was a thesis that I hoped would illuminate the experiences of wives of myocardial infarction survivors, so that they could be understood and used to guide nursing practice and education. As I began my research journey, however, I came face to face with a maze of research terminology, paradigms and philosophies that were unfamiliar and bewildering. I soon learnt, in the words of French novelist Andre Gide (1869-1951) that "One does not discover new lands without consenting to lose sight of the shore for a very long time" (cited by Daintith and Isaacs 1989: 173). With these words in mind I ventured forth turning to the writings of seasoned travellers to show me the way. In the chapter that follows I describe my research journey through previously unexplored territories.

- This chapter includes:
  - An exploration of the different inquiry paradigms and deciding which would be most suitable for this study.
  - Investigating phenomenology as an enquiry paradigm.
  - A discussion regarding hermeneutic phenomenology and qualitative nursing research.

INQUIRY PARADIGMS: WHICH PATH TO FOLLOW?

Exploring the different inquiry paradigms

Guba and Lincoln (1994: 105) define an "inquiry paradigm" as "the basic belief system or worldview that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways". They describe four inquiry paradigms, they are: positivism, postpositivism, critical theory and related ideological positions, and constructivism. The basic beliefs that define each of these inquiry paradigms "can be summarised by the responses given by proponents of any given paradigm to three fundamental questions, which are interconnected

in such a way that the answer given to any question, taken in any order, constrains how the others may be answered" (Guba and Lincoln 1994: 108). These three fundamental questions are the questions of ontology, epistemology and methodology. Ontology asks questions about the nature of knowledge, epistemology about the nature of the relationship between the researcher and knowledge, and methodology addresses how the researcher can go about acquiring knowledge.

I discuss the basic beliefs of each inquiry paradigm in Table 1, under the headings ontology, epistemology and methodology drawing from the writings of Carter (1985: 30); Duffy (1985: 226-227); Leininger (1985: 5); Lincoln (1992: 379-380); Guba and Lincoln (1994: 109-111) and Bailey (1997: 19).

It should be understood from the outset that several terms are used interchangeably in research, something which as a neophyte researcher I found to be extremely confusing. Some authors interchange the terms positivism with quantitative research and postpositivism, critical theory and its related ideological positions, and constructivism with qualitative research. In this study I chose to use terminology that I was familiar with and which is still used extensively by nursing researchers, that of quantitative and qualitative research. Positivism is referred to in this study as the quantitative paradigm and constructivism as the qualitative paradigm.

Authors agree that there is a place for both the quantitative and qualitative paradigms. However, since each has a different world view, serves a different purpose and uncovers different knowledge, it is important to consider what would be most suitable for research in nursing as well as for the specific research question (Leininger 1985: 13; Munhall 1989: 21; Lincoln 1992: 384).

ITEM	POSITIVISM	POSTPOSITIVISM	CRITICAL THEORY	CONSTRUCTIVISM
Ontology	Reality is driven by fixed laws and context-free generalizations that are used to predict and therefore control phenomena.	Reality is subjected to the widest possible critical examination so that it can be known as perfectly as possible, but never perfectly.	Reality is historical, shaped by social, cultural, political, economic, ethnic and gender factors, crystallised into a series of structures.	Realities are the mental constructions of participants as they interact within their social environment and are therefore dependent for their form and content on those who hold them.
Epistemology	The researcher and the object of investigation are seen as independent entities, preventing the influencing of one another, so research results will be free of bias.	Dualism is seen as not possible and objectivity as crucial. The "guardians" of objectivity are, pre-existing knowledge and the critical community, e.g. peers.	The researcher and the object of investigation are influenced by one another; therefore the research is unavoidably influenced too.	The researcher and the object of investigation are seen as an interactive entity and the research results are literally created by this interaction.
Methodology	Hypotheses are stated and tested experimentally conditions are controlled to prevent biases. Data is presented in numerical form.	The aim is to attempt to falsify the hypothesis. The enquiry is done in a way that tries to address the critique levelled at positivism.	Dialogue must take place between the researcher and the object of investigation so that ignorance can be transformed to "informed consciousness".	Constructs are obtained and advanced by interaction between the researcher and the object of investigation. The result is a greater understanding of the construct.

Table 1: Basic beliefs of the inquiry paradigms (Carter 1985: 30; Duffy 1985: 226-227; Leininger 1985: 5; Lincoln 1992: 379-380; Guba and Lincoln 1994: 109-111; Bailey 1997: 19).

Quantitative and qualitative inquiry paradigms: which one to choose for this study?

In the past the quantitative paradigm was viewed by some as the only truly scientific and reliable inquiry paradigm that could be used to approach knowledge and understand people (Duffy 1985: 225; Leininger 1985: 2; Lincoln 1992: 389). Nursing recognizes that people are cultural beings with differing views of life and experience, and is concerned with fundamental questions about the nature of human beings, the nature of the environment and the interaction

between the two (Munhall 1989: 21). For this reason some researchers have challenged the quantitative paradigm saying that it is inadequate to investigate complex human behaviours, since it reduces human beings to objects and does not consider environmental influences (Leininger 1985: 3; Munhall 1989: 23; Guba and Lincoln 1994: 106). The qualitative paradigm would therefore be more appropriate for nursing research because it recognizes the multiple meanings that people attach to their care, behaviours, practices and attitudes (Lincoln 1992: 378).

Denzin and Lincoln (1994: 2) define qualitative research as being "multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative research involves the studied use and collection of a variety of empirical materials – case study, personal experience, introspective, life story, interview, observational, historical, interactional and visual texts – that describe routine and problematic moments and meaning in individuals' lives". I considered their definition in relation to my research destination and found that there was a congruency between the two. I was convinced that the qualitative inquiry paradigm was the appropriate path to follow, however I had learnt from the work of seasoned travellers that before I could be absolutely certain, I had to consider my philosophical assumptions as a researcher in relation to the nature of human behaviour.

The philosophical assumptions of the qualitative researcher

Is it enough to follow the path of an inquiry paradigm that best suits the research question? What of the philosophical assumptions of the researcher? Benoliel (1985: 4) and Munhall (1989: 22) suggest that the qualitative researcher should have some of the following philosophical assumptions about the nature of human behaviour, in order to be a qualitative researcher:

- "The world is not an external force independent of mankind and objectively identifiable; rather there are multiple realities and multiple frameworks for viewing the world in its many dimensions and complexities" (Benoliel 1985: 4).
- "Social life is the shared creativity of individuals such that the sharedness produces a reality perceived by the particular participants to be objective, extant and knowable" (Benoliel 1985: 4).
- "Human beings are viewed as active agents who construct and make sense out of the realities they encounter" (Benoliel 1985: 4).
- "Experience is imbued with meaning, with linguistic, social and cultural patterning" (Munhall 1989: 23).

- "The subjective experience of the individual and/or groups is valued and described. Meaning comes from the source and is not presumed, assigned or assumed" (Munhall 1989: 23).

Those researchers who share these philosophical assumptions will remain faithful to the research process and produce research findings born in the true spirit of qualitative research, which will ultimately reveal the true nature of humankind.

PHENOMENOLOGY

As I ventured down the path of the qualitative paradigm I found that it branched. These branches are termed "research strategies" by Morse (1994: 223) and are used when referring to the tools or approaches, methods and techniques that a researcher uses to conduct her study. Some of the major types of qualitative research strategies include phenomenology, ethnography and grounded theory (Bailey 1997: 20). According to Morse (1994: 223) the research question largely determines the qualitative research strategy used in the study because it "illuminates certain aspects of reality more easily than others and produces a type of results more suited for some applications than others". I wished to understand the experiences of wives of myocardial infarction survivors and according to Morse (1994: 224) a research question that plans to elicit the "meaning or essence of an experience" is best answered by phenomenology. van Manen (1990: 9) states that phenomenology "aims at gaining a deeper understanding of the nature or meaning of our everyday experiences". With these words in mind I chose to set off down the phenomenological branch of the qualitative paradigm only to find that this path branched into two. It was here that I met two gentlemen who showed me the way.

Comparison of Husserlian Phenomenology and Heideggerian Phenomenology

The modern phenomenological tradition was founded by Edmund Husserl (1859-1938) (Walters 1995: 792) in Germany prior to World War 1. Husserl was concerned with the epistemological questions of knowing and was interested with finding the essence or the ultimate structures of consciousness (Drauker 1999: 361). He believed that experiences are inaccessible because they are taken for granted and only re-examination of these experiences would reveal the essence or perception of the human world (Koch 1995: 828). Conscious awareness is seen as the starting point of knowledge building and experience the basis on which it is built (Drauker 1999: 361). According to Koch (1995: 828), Husserlian phenomenology, also referred to as transcendental phenomenology, can be seen as the "culmination of the Cartesian tradition". The

Cartesian notion of self is described by Leonard (1989: 41) as a view of self as subject, uninvolved with and passively contemplating the external world of objects via representations held in the mind. A key feature of Husserlian phenomenology is the notion of bracketing. Bracketing involves suspending all preconceived ideas, disconnecting from the realities of the outside world, as well as those in the individual consciousness. This act, also known as phenomenological reduction, is thought to protect the validity of the interpretation from the bias of the researcher (Koch 1995: 829).

Martin Heidegger (1889-1976) a scholar of Husserl rejected the Cartesian tradition and its notions of subject and object as well as phenomenological reduction. Instead he extended Husserl's philosophy to one with a primary ontological focus, rather than epistemological focus (Leonard 1989: 42; Cohen and Omery 1994:136; Annells 1996: 706). Heidegger was concerned with the question: "What does it mean to be a person?" rather than, "How do we know what we know?". He saw human beings as self-interpreting, 'being' in and of the world, and human existence was referred to as 'being-there' (Koch 1995: 832). He believed that experience could only be understood in terms of background, history and social context and therefore presuppositions cannot be suspended (Walters 1995: 792; Draucker 1999: 361). For this reason Heidegger rejected the notion of phenomenological reduction. Heideggerian phenomenology is also referred to as existential phenomenology, philosophical hermeneutics or hermeneutic phenomenology. In this study I will refer to Heideggerian phenomenology as hermeneutic phenomenology.

Koch (1995: 823) provides a very informative comparison between Husserlian phenomenology and hermeneutic phenomenology, parts of which are presented in Table 2. From this comparison it becomes evident that there are clear distinctions between hermeneutic phenomenology, and Husserlian phenomenology. It is therefore important that researchers state which perspective they are using, as each has implications for the way in which a study is conducted. I rejected Husserlian phenomenology as the research strategy for this study as it seemed to be incongruent with the way in which qualitative research and nursing saw people and their interaction with the world. Koch (1995: 834) goes so far as to say, "Husserlian phenomenologists take on a subject-object dualism in their research, and consequently have become unwitting positivists". For these reasons I chose to follow the path of hermeneutic phenomenology.

HUSSERLIAN PHENOMENOLOGY	HERMENEUTIC PHENOMENOLOGY
Asks "epistemological questions of knowing".	Asks "questions of experiencing and understanding".
"How do we know what we know?"	"What does it mean to be a person?"
"A mechanistic view of the person".	Person is seen as "self-interpreting being".
"Mind-body person who lives in a world of objects".	"Person exists as a 'being' in and of the world".
"Unit of analysis is the meaning giving subject".	"Unit of analysis is the transaction between the situation and the person".
The "essence of the conscious mind" is shared.	"Culture, history, practice and language" are shared.
"Meaning is unsullied by the interpreter's own normative goals or view of the world".	"Interpreters participate in making data".
The meanings of the participants are "reconstituted in interpretive work by insisting that data speak for themselves".	"Within the fore-structure of understanding, interpretation can only make explicit what is already understood".
"Adequate techniques and procedures guarantee validity of interpretation".	"Establish own criteria for trustworthiness of research".
"Bracketing defends the validity or objectivity of the interpretation against self-interest".	The hermeneutic circle allows the researcher to bring her "background, co-constitution and pre-understanding" to the research process.

Table 2: Comparison of Husserlian phenomenology and hermeneutic phenomenology (Koch 1995: 823).

Hermeneutic phenomenology

The word "hermeneutics" is derived from the Greek verb "hermeneueuen" which means to interpret, and from the noun "hermeneia" meaning interpretation, both being derived from Hermes, the messenger of God (Pascoe 1996: 1309). The word "phenomenology" is derived from two Greek words, "phainomenon meaning appearance" and "logos meaning reason" (Walters 1995: 791). Hermeneutics is described by van Manen (1990: 38) as "the interpretive study of the expressions and objectifications (texts) of lived experience in the attempt to determine the meaning embodied in them". He describes phenomenology as the "the descriptive

study of lived experience (phenomena) in the attempt to enrich lived experience by mining its meaning" (van Manen 1990: 38).

The emphasis of modern hermeneutic phenomenology is on the human experience of understanding and interpretation (Thompson 1990, cited by Pascoe 1996: 1310). Hans-Georg Gadamer, a student of Heidegger, is recognised as being central to the evolution of modern hermeneutic phenomenology. Gadamer followed Heidegger's lead by extending Heidegger's existential ontological exploration of understanding by providing an emphasis on language.

Hermeneutic phenomenology is rooted in philosophy (Munhall 1989: 24; van Manen 1990: 7). van Manen states that it is important for a researcher to have some knowledge of the philosophies upon which this inquiry paradigm is based, this sentiment is echoed by Koch (1996: 175). It was the mists of philosophy however that obscured my chosen path, never the less I inched forward, reading along the way and after a while found that the mist began to lift.

The philosophical underpinnings of hermeneutic phenomenology

World

In Heideggerian philosophy every person is seen to have a world. Leonard (1989: 43) states that "world" can be interpreted as "the meaningful set of relationships, practices and language that we have by virtue of being born into a culture". Our skills, practices and the way in which we relate to others "is all part of our understanding of being in our world of shared background practices and familiarity" (Plager 1994: 69). Thus it can be said, "human existence and the world co-constitute each other" (Koch 1995: 831).

Heidegger described three distinct and inter-related modes in which individuals interact with their world on a day-to-day basis, he referred to these modes as the "ready-to-hand"; the "unready-to-hand"; and the "present-to-hand" modes (Plager 1994: 72, 73; Walters 1995: 793). In the ready-to-hand mode everything runs smoothly and transparently, for example, the family is healthy and life is going along smoothly. In the unready-to-hand mode some sort of breakdown occurs and things no longer run smoothly and are no longer transparent, for example, a husband may have a myocardial infarction and usual family functioning becomes disrupted. Practical everyday activity ceases in the present-to-hand mode and individuals detach themselves from the situation and view everything objectively. Qualitative research focuses on the ready-to-hand and the unready-to-hand modes whilst quantitative research focuses on the 'present-to-hand' mode (Plager 1994: 73).

Differences in people's worlds, such as individual situations, culture and language means that the significance and value of encounters differs from person to person. Context can change the significance and value of an encounter to reveal a different understanding (Leonard 1989: 45, 46). In order to understand people's behaviour, they should be studied within their own context, in their own worlds and against a background that is significant for them. This will allow for a more appropriate interpretation of the significance that experiences have for them.

Interpretation and pre-understanding

Meaning and understanding are interconnected elements and in order to interpret the text a person must have some pre-understanding of the subject and situation. According to Koch (1995: 831) Heidegger uses the term pre-understanding to "describe the meaning and organisation of a culture (including language and practices) which are already in the world before we understand". People are seen as self-interpreting, able to understand and interpret events because of a background of shared human practices (Leonard 1989: 4; Plager 1994: 70). Heidegger explicated a threefold structure of pre-understanding upon which all interpretation is grounded (Plager 1994: 71,72).

- A "fore-having": an individual comes to a situation with a practical familiarity, that is, with background practices from his/her world that make interpretation possible.
- A "fore-sight": because of this background individuals have a point of view from which to make an interpretation.
- A "fore-conception": because of one's background individuals have some expectations of what they might anticipate in an interpretation.

In the research situation all understanding comes from these fore-structures, which can be corrected and modified, but never eliminated or bracketed (Koch 1995: 831).

Prejudice

Prejudice is a term used by Gadamer to described Heidegger's fore-structures of knowledge that determines what we may find intelligible in a situation and is seen as a positive concept (Koch 1996: 177). Gadamer agreed with Heidegger in saying that "to try and eliminate one's own concepts in interpretation is not only impossible, but manifestly absurd" (Gadamer 1975, cited by Annells 1996: 707).

Temporality

A strong theme in Heidegger's phenomenology is that of the notion of 'temporality' and extends the concept of context. According to Leonard (1989: 48) the Western notion of time is linear and "now" so that one gets the feeling that things are motionless, "atemporal" and that past and future cannot be related. Phenomenologists view time differently. They see time as being connected rather than linear (Annells 1996: 706), thus everything we have been is an essential determination of our existence. Therefore, a person should only be studied "within the context of having-beenness and being-expectant, or its past and future, by which it is constituted" (Leonard: 1989: 49).

Horizons

Gadamer (1975: 269-273) states that every person has a horizon. The concept of 'horizon' expresses the wide, superior vision of a person seeking to understand, and is acquired by looking beyond what is close at hand to see in a larger and truer proportion. This means that a person is not limited to what is nearest, but can see beyond it. Alfred, Lord Tennyson (1809-1892) wrote this about horizons in his poem "Ulysses" (cited by Stevenson 1967: 592):

"I am part of all that I have met;
Yet all experience is an arch wherethro'
Gleams that untravell'd world whose margin fades
For ever and ever when I move."

In the process of understanding our experiences, the historical horizon fuses with the new horizon, so that it is simultaneously removed as it is overtaken by the present horizon of understanding. In hermeneutic phenomenological inquiry the horizon of the researcher is constantly fading and moving as her horizons fuse with that of the participants as she gains a deeper understanding of their experiences.

The hermeneutic circle

Heidegger believed that all human beings live in a circle of understanding, known as the hermeneutic circle (Allen and Jensen 1990: 244; Plager 1994: 72; Koch 1995: 831-832). Interpretation starts with prior understanding and understanding works through interpretation therefore "as the part unravels the whole, the whole takes on a new meaning. Understanding then is an unfolding process which rotates on itself" (Allen and Jensen 1990: 245). According to Thompson (1990: 243) the hermeneutic circle is a "metaphor used to describe the experience of moving dialectically between part and whole". The process of understanding can never achieve finality because we are always understanding in the light of our pre-understandings and because

our horizons cannot be fixed. Thus the interpretive process has no clear end, but moves forward and backward starting at the present (Allen and Jensen 1990: 245) and that is why it is called the hermeneutic circle. The hermeneutic circle is a central notion of Heideggerian phenomenology in contrast to bracketing, which is a central notion of Husserlian phenomenology. This is one of the reasons why it is so important for the researcher to state the approach she is using, and to demonstrate how she "gets into" the circle.

HERMENEUTIC PHENOMENOLOGY AND QUALITATIVE NURSING RESEARCH

Nursing research using hermeneutic phenomenology has proliferated in the past ten years (Draucker 1999: 371). Some authors promote the phenomenological method as essential to theory development in nursing. This is because descriptive data is generated that can be used to guide larger studies, such as theory development, which can be used to enhance nursing's knowledge base and in turn guide nursing practice (Oiler Boyd 1989: 17; Smith 1989: 16; Jasper 1994: 313). Hermeneutic phenomenology is a research strategy that can "meet the needs of nurse researchers who wish to focus their research to a greater degree on aesthetics, on personal ways of knowing, on questions of being, and on multiple realities" (van der Zalm and Bergum 2000: 217). The goal of hermeneutic phenomenology is achieved when the researcher gains meaning from the lived experiences of the participant, whilst still retaining the context of the experience, and is able to show the reader what it really means to be involved in that particular experience (Robertson-Malt 1999: 292). In this way, everyday situations encountered by nurses caring for patients acquire meaning and are better understood, with the result that practice is changed on the basis of this new understanding (van der Zalm and Bergum 2000: 217). This is the desired destination of my research journey.

CONCLUSION

As I arrived at the end of this chapter, having made my way through inquiry paradigms and research strategies, the words from a poem written by Christina Rossetti (1830-1882) titled "Up-Hill" (cited by The Oxford Dictionary of Quotations 1985: 409), encapsulated my research journey thus far:

"Does the road wind up-hill all the way?
Yes, to the very end.
Will the day's journey take the whole long day?
From morn to night, my friend".

Chapter 2

The road had wound up-hill, little had been straightforward, as I had to grapple with the twists and turns presented by research terminology, paradigms and philosophies that I had not heard of. It took self-discipline and sheer hard work, often from morning to night to acquire the knowledge I now have and to write this chapter. I couldn't help feeling an enormous sense of achievement and even a little excited as I closed this chapter of my journey and opened a new one. I was under no illusions, the road would continue to wind up-hill, however armed with my newfound knowledge I could continue my research journey with new confidence.

Chapter three: The itinerary

"The use of travelling is to regulate imagination by reality,
and instead of thinking how things may be,
to see them as they are".
Samuel Johnson (1709-1784)

The research proposal can be compared to the itinerary of a journey. In the same way that an itinerary provides the traveller with a plan of what her journey is going to entail, so the research proposal provides the researcher with an outline of the research activities that will guide her study. I looked to the writings of van Manen (1990), a seasoned hermeneutic phenomenologist to guide the development of my proposed itinerary. He proposed six procedural research activities that a researcher should follow and which I have used in this study. As an idealistic novice researcher I had no idea at the time of writing the research proposal what the itinerary represented in reality. I soon found that the journey from research question to answer is an arduous one, which demands that the researcher be reflective, accurate, rigorous and personally involved. In this chapter I describe the reality of "doing" research and "being" the researcher using the proposed itinerary as a guideline. With the aid of documentation made as I travelled I have been able to describe the people I met, how I collected their stories and the context within which they were told. I have detailed the process that gave birth to the eight central themes in this study, as well as the process of writing and rewriting in pursuit of a meaningful phenomenological text.

- This chapter includes:
  - A brief overview of van Manen's (1990: 8-13) hermeneutic phenomenology.
  - A description of van Manen's (1990: 31) six procedural research activities i.e.
    - Turning to the nature of lived experience
    - Investigating experience as we live it
    - Reflecting on essential themes
    - Phenomenological describing through the art of writing and rewriting
    - Maintaining a strong and oriented relation to the research question
    - Balancing the research context by considering parts and whole

    and how they were used to guide this study
  - A discussion of the way in which issues of trustworthiness were attended to.

VAN MANEN'S HERMENEUTIC PHENOMENOLOGY

Max van Manen, a contemporary hermeneutic phenomenologist, studied Pedagogy in the Netherlands in the 1960's. There he was exposed to the German tradition of "human science pedagogy" which employed an interpretive or hermeneutic methodology and the Dutch "phenomenological pedagogy" which employed a descriptive or phenomenological tradition (van Manen 1990: ix). van Manen's hermeneutic phenomenology is a modem extension of the hermeneutic phenomenological tradition found in Germany (1900-1965) and the Netherlands (1945-

1970). van Manen later moved to Canada where he is currently a Professor of Education at the University of Alberta.

It is my belief that since this study has been guided by the six research activities proposed by van Manen it is important that you understand how he conceptualises hermeneutic phenomenology as a human science. According to van Manen (1990: 8-13):

- "Phenomenological research is the study of lived experience". Phenomenology aims to create a deeper understanding of everyday experiences.
- "Phenomenological research is the explication of phenomena as they present themselves to the consciousness". The only access that human beings have to the world is through consciousness and in order to know something it must first present itself to consciousness.
- "Phenomenological research is the study of essences". Phenomenology tries to discover and describe the structures, or essences, that constitute a lived experience.
- "Phenomenological research is the description of the experiential meanings we live as we live them". Hermeneutic phenomenology "attempts to describe and interpret these meanings to a certain degree of depth and richness".
- "Phenomenological research is the human scientific study of phenomena". "Phenomenology claims to be scientific in a broad sense, since it is a systematic, explicit, self critical, and intersubjective study of its subject matter, our lived experience".
- "Phenomenological research is the attentive practice of thoughtfulness". The phenomenological researcher pays thought to the meaning of living a life.
- "Phenomenological research is a search for what it means to be human". The discovery of the essences of lived experiences creates a more comprehensive understanding of what it means to be in the world as a human being.
- "Phenomenological research is a poetising activity". In the same way that a poem cannot be summarised without losing the result, since the poem is the result, phenomenological research cannot break its links with its results, the researcher must always return to where the result emanated from.

VAN MANEN'S SIX PROCEDURAL RESEARCH ACTIVITIES

It should be understood from the outset that there is no single standardised method identified for hermeneutic phenomenology (Robertson-Malt 1999: 292), however there is a philosophical tradition that should be adhered to. van Manen wrote in a monograph in 1984 that the methodology of phenomenology "is more a carefully cultivated thoughtfulness than a technique. Phenomenology has

been called a method without techniques. The 'procedures' of this methodology have been recognised as a project of various kinds of questioning, orientated to allow a rigorous interrogation of the phenomenon as identified at first and then cast in the formulation of the question. The methodology of phenomenology requires a dialectical going back and forth among these various levels of questioning" (van Manen 1984a: 27).

van Manen (1990: 31) identifies six procedural activities, which provide the researcher with a "methodological" structure that can be used to guide hermeneutic phenomenological research and which I have used to guide this study. They are:

- Turning to the nature of lived experience
- Investigating experience as we live it
- Reflecting on essential themes
- Phenomenological describing through the art of writing and rewriting
- Maintaining a strong and oriented relation to the research question
- Balancing the research context by considering parts and whole

He points out that hermeneutic phenomenological research should be seen as a dynamic interplay among these six procedural activities, rather than six mechanistic sets of procedures.

Turning to the nature of lived experience

The nature of lived experience

William Shippen Jr. (1736-1808) once said, "Experience is the mother of truth; and by experience we learn wisdom" (cited by Strauss 1968). It would seem that the value of experience has long been acknowledged as a means of understanding our world. Hermeneutic phenomenology is the study of lived experiences, which are the experiences of people that arise from their everyday interactions with other people and situations (van Manen 1990: 37; Plager 1994: 75). Munhall (1994: 44) states that the study of lived experience is always the study of "being" and according to van Manen (1990: 175) "to ask for the Being of something is to enquire into the nature or meaning of that phenomenon". One could say that the researcher tries to capture "the meaning of being human" (Munhall 1994: 45), through a process of interpretation, reflection and understanding.

Orienting to the phenomenon and formulating the research question.

The researcher starts a hermeneutic phenomenological study by identifying or orienting to a phenomenon that interests her. In chapter one and later in this chapter I detail my reasons for choosing to investigate the lived experiences of wives of myocardial infarction survivors during the convalescent period. Essentially I want to know what the nature (the essence) of this lived experience is. My research question in this study is: what are the lived experiences of wives of first time myocardial infarction survivors during the convalescent period?

Explicating assumptions and pre-understandings

The beliefs of the hermeneutic phenomenological researcher are an important part of the research process. Understanding, in the hermeneutic sense, means that the researcher "must bridge the gap between the intellectual operations of oneself and one's subject in order to see the phenomenon, or object of interpretation, in larger context" (Hagemaster 1992: 1122). The hermeneutic circle, as outlined in chapter two, allows the researcher to bring her experience and understanding into the research, as she is also involved in the world. The researcher should undergo self-reflection to enable her to locate her preconceptions, biases, past experiences, theories, and perhaps research hypotheses, before interviewing the participants (Polkinghorne 1989: 46). In order to contribute to the credibility of the study she should make these known so that you can judge how they may have affected her interpretation (Hycner 1985: 281; Hagemaster 1992: 1122; Plager 1994: 72).

Early in the research process I explored with my supervisor Professor R. Thompson my reasons for wanting to investigate the lived experiences of wives of first time myocardial infarction survivors during the convalescent period. She encouraged me to be interviewed and to have the interview recorded on video tape and suggested that my second supervisor Mrs E. le Roux, whom I knew less well, do the interview. This discussion was documented on video and revealed some interesting insights into my past experiences, preconceptions and motivations behind my choice of research topic. In the true spirit of hermeneutic phenomenology I shall share these insights in the text that follows. It should be noted that this is not verbatim text from the interview, but rather an attempt to share the general substance of the interview with you.

> *My earliest recollection of a critically ill person was of my uncle who had suffered a myocardial infarction, I was fifteen at the time. We received a phone call from my aunt (my mother's sister) informing us that he lay critically ill in a Johannesburg hospital and my aunt asked my mother to fly to Johannesburg immediately because she needed her support. My mother left later that day. Thus my first impression of a myocardial infarction was that it was a serious,*

life threatening disease that happened to the best of people. When I was older my aunt shared her experiences of that time with me and my impression was that it had been an extremely difficult time for her, both while he was hospitalised, and during the convalescent period.

My earliest recollection of a critical care unit was the same one in which my uncle was cared for when he had his myocardial infarction. Before I began my training as a nurse, I visited my aunt in Johannesburg. She did volunteer work for the unit and had to go there on business, so she took me with her. Although our visit was extremely brief I clearly remember what the unit looked like as well as the nurses who cared for my uncle. I admired them since they looked so professional, my aunt spoke very highly of them and above all they had saved my uncle's life. It is possible that in some way these experiences have shaped my choice of profession as well as the field of nursing in which I chose to specialise and continued to exert their influence when I chose the research question.

My choice of research question may have also been influenced by my father who suffers from hypercholesterolaemia. The presence of this risk factor makes me acutely aware of his risk for a myocardial infarction, although I may be overreacting, since my father has always been extremely healthy. I am concerned about the impact that a myocardial infarction would have on my parents; particularly my mother, and I can definitely see a link between my concerns and my choice of research question. If my father were to have a myocardial infarction my mother would naturally turn to me for advice and support, firstly because we have a close relationship, and secondly because as a nurse she would expected me to be knowledgeable about such things. The truth is I really had very little knowledge of what she may experience during the convalescent period. I often see the look of shock and disbelief on the face of a wife of a myocardial infarction survivor as she comes to realise that her husband has a life threatening disease. I sometimes wonder to myself: what is going through her mind? Is she concerned about what lies ahead, is she rethinking their future together or is she just living from day-to-day? As the patient begins to recover my thoughts turn to the convalescent period and more questions come to mind: is the convalescent period one of enormous responsibility? Is it stressful? How did she cope during this time? I thought that she would probably find it stressful, frightening and bewildering, but these were my preconceptions probably shaped by my aunt's stories of her experiences. I knew that a study such as this would provide the answers I was looking for and this is perhaps what motivated my choice of research question. On a personal level I could use this knowledge to help me to help my mother and on a professional level to help nurses help wives of first time myocardial infarction survivors during the convalescent period.

Investigating experience as we live it

According to van Manen (1990: 62) "we gather other people's experiences because they allow us to become more experienced ourselves" and we gather them by means of interviews, participant observation and written responses such as diaries in order to answer questions about the nature of the phenomenon. In the current study I have made use of interviewing to gather the experiences of wives of first time myocardial infarction survivors during the convalescent period.

Participant criteria

Phenomenological inquiry only has one legitimate source of data and that is participants who have lived the reality being investigated and who are able to articulate these experiences (Colazzi 1978: 58; Baker, Wuest and Stern 1992: 1357). I used the following criteria to select participants for this study:

- The research participant should be 50 years or younger, since Skelton and Dominian (1973: 101) state that younger wives experience more severe grief reactions post myocardial infarction. In addition O'Farrell et al (2000: 103) found that younger women (51.99 + 9.94 years) were more likely to be distressed than were older women (55.74 + 10.54 years).
- It should be her husband's first myocardial infarction since the wife's experience of her husband's second myocardial infarction may be different.
- She should be currently living with her husband and therefore 'lived' the experience under investigation.
- She should have the capacity to provide full, sensitive descriptions of the experience in English.

van Kaam (1969 cited by Polkinghorne 1989: 47) recommends certain requirements that participants involved in phenomenological research should meet and these were used in addition to those mentioned above:

- They should be able to express themselves linguistically with ease.
- They should be able to express feelings without embarrassment.
- They should have recently experienced the experience under investigation.
- They should have an interest in their experience.

Participant identification

Quantitative researchers go to great lengths to randomly select participants by means of statistical sampling so that statistical generalisations can be made. Polkinghorne (1989: 48) states that the point of participant selection in qualitative research however is to not to describe the "mean and standard deviation of a group as it relates to an experience" but to "obtain richly varied descriptions". For this reason no effort was made to control or randomise the participants in this study, instead theoretical or purposeful sampling was used which is when the researcher selects participants based on the information she requires (Polit and Hungler 1999: 297). I identified participants who met the criteria as their husbands were sequentially admitted to the critical care unit of a private hospital in Cape Town. They were contacted telephonically approximately six weeks after their husbands had been discharged from hospital and invited to take part in the study. Six potential participants were contacted, five agreed to participate in the study and one declined stating that she did not have the time to do the interview.

All the participants were English-speaking, female South Africans under the age of fifty years. Three were white and two were of mixed race. I state this to indicate the diversity of the sample as well as to alert you to subtle verbal cultural differences that may be noted in excerpts from the transcripts. Most of the male survivors that we see in our critical care unit are either white or of mixed race. This may be because the hospital is situated in a predominantly white and mixed race area. Asians are seldom seen despite the fact that in 1983 they were reported to have the highest mortality rate from coronary heart disease in South Africa (110.6/100 000), second only to the white population's mortality rate which was higher (189.7/100 000) (Statistics from the Department of National Health and Population Development 1986/1987, cited by Steyn, Rossouw and Joubert 1990: 62). Another reason may be that the Asiatic community is in the minority in Cape Town. We almost never see black patients with coronary heart disease in our critical care unit. This may be due to two reasons, the first being that coronary heart disease is relatively uncommon in this population group, however with the adoption of western lifestyles this may begin to change (Seedat, Mayet, Latiff and Joubert 1992: 251). Secondly this population group was most affected by the apartheid policies of the previous government of South Africa, which resulted in poverty and unemployment and therefore some do not have medical aid.

Three of the participants were employed and two were self-employed. The participants appeared to be of middle class income, however this was not discussed. All of the participants were married to men who had survived their first myocardial infarction, confirmed by means of a positive electrocardiogram and raised cardiac enzymes, for which they received thrombolytic therapy. Each couple had at least two children.

Consent

Consent to do this research was granted by the Dean of the Health Sciences Faculty of the University of Cape Town, on behalf of the Postgraduate Programmes Committee (See Appendix A). The study was also approved by the Research Ethics Committee of the Health Sciences Faculty of the University of Cape Town (see appendix B). Written consent was obtained from the participants, which included consent for the tape recording of all interviews (see appendix C). It is important to obtain voluntary and informed consent from all participants, which means they should be free from coercion and have full knowledge and understanding of the research project. Seaman (1987: 23) suggests that in order to provide informed consent the researcher should afford the participants with a full description of:

- The purpose and value of the research.
- All the procedures used in the research, as well as the reasons why.
- The participant's role in the research and the amount of time required of each participant.
- Possible discomforts, stress or loss of dignity.
- How their privacy, confidentiality and autonomy will be protected.
- How the data will be used.

I used these suggestions as a guide when writing the consent form used in the current study. According to Miles and Huberman (1994: 291) weak consent leads to a relationship of mistrust, which usually leads to poorer data because the participants try to protect themselves. It is clearly stated in my consent form that the participants have the right to refuse to participate or withdraw from the study at any time without fear of recrimination. Although it was impossible for me to promise them confidentiality, as quotations from the interviews would be used in the research report, I was able to assure them that anonymity would be maintained throughout the study. To this end I assigned each participant a number and these numbers were used when referring to the participants or when quotes were used from the interviews in the research report. The participants had the choice of having their audiotapes returned to them at the conclusion of the study, however I received no requests for this so I shall destroy the tapes at the conclusion of this study. I did warn the participants that the transcriber would have to listen to the audiotapes, but that she had signed a contract (see appendix D) agreeing to keep all information concerning what she heard confidential.

The hermeneutic phenomenological interview

The purpose of the phenomenological interview is to "understand shared meanings by drawing from the respondent a vivid picture of the lived experience, complete with the richness of detail and context that shape the experience" (Sorrell and Redmond 1995: 1120). The researcher

encourages the participant to describe her unique perspective of the experience being investigated. You should know that the descriptions provided during the interview by the research participants of their lived experiences, are interpretations of these experiences, and are not identical to the experience itself (Oiler 1982: 179). This is because the reality of an experience is subjective and therefore cannot be known apart from the participant's experience and interpretation of it (Burns and Grove 1987: 81; Smith 1989: 14; Rose, Beeby, Parker 1995: 1126). The goal of the researcher during the interview is to discover meaning and to achieve an understanding of the way the experience forms part of the participant's everyday life, so that she can describe the experience as accurately as possible (Wilson and Hutchinson 1991: 266; Sorrell and Redmond 1995: 1120).

The advantage of interviews over written descriptions is that the researcher is provided with verbal as well as non-verbal data and is able to use her interpersonal skills to encourage the participant's efforts to articulate the experience. In this study I chose to use the "Free Attitude Interview Technique also described as a non-directive controlled depth interview" (Meulenberg-Buskens 1997: 1).

Pilot interviews

I planned to do two pilot interviews, the purpose of which was to assist me in the acquisition of the interview skills I required to generate quality data. The first pilot interview highlighted the fact that I needed to refine my interviewing skills. Shortly thereafter I attended a three-day interviewing course at the University of Cape Town's Nursing Department, which taught novices like myself the skills essential to the art of the Free Attitude Interview Technique (Meulenberg-Buskens 1997: 1). I then did my second pilot interview and the data that emerged from this interview was so valuable that I decided to use the interview as the first in the study rather than as a pilot.

Sample size

Polit and Hungler (1999: 299) state that in qualitative research a sample size of less than ten will usually suffice. Sample sizes in qualitative studies are usually small because of the large amount of data that must be analysed and because contacts with participants are usually prolonged and intensive (Sandelowski 1986: 31). "An adequate sample size in qualitative research is one that permits - by virtue of not being too large - the deep, case orientated analysis that is the hallmark of all qualitative inquiry, and that results in - by virtue of not being too small - a new and richly textured understanding of experience" says Sandelowski (1995: 183). In this study I did one pilot interview and four study interviews each lasting approximately an hour long. I continued to conduct interviews with new participants until "data saturation" (Polit and Hungler 1999: 299) occurred. Polit and Hungler (1999: 299) describe "data saturation" as "sampling to the point at which no new information is obtained and redundancy is achieved".

Ethical issues in interviewing

Intervention by the researcher

The researcher's role is to investigate; not counsel, educate, organise or sympathise. I found it difficult to separate my roles as nurse and researcher during the interviews. Smith (1992: 101) is of the viewpoint that it could be viewed as morally incorrect for the interviewer to withhold information which she might possess, which would benefit the participant. I knew that any intervention during the interview might have changed the knowledge base of the participant or altered her response and therefore the research data. Despite this I found it particularly difficult not to intervene during the interview process especially when I could tell that the participants required, or would benefit from, my input as a nurse. I made a decision to maintain a neutral stance during the interview and only to offer ideas or information at the end of the interview if I thought that it was essential or I was actively requested to do so.

Data Collection

During the research interview the participant reflects on a phenomenon and may offer highly personal and emotionally charged information and while this may be beneficial to them, there may also be some risks. The participant's reflections may increase her awareness of the negative aspects of the situation, resulting in a change in attitude towards a phenomenon that may have far-reaching consequences. According to Polkinghorne (1989: 58) participation in the phenomenological research process can be useful for subjects, as they are provided with an opportunity to talk about their experiences and this acts as a kind of catharsis. I informed my participants of the risks and benefits of partaking in the study when I obtained consent. One participant did cry during the interview when she spoke about how she conducted cardiopulmonary resuscitation on her husband, however she recovered quickly once we had moved onto a different topic and did not appear to be emotionally traumatised. The rest of the participants found the interview to be cathartic and were grateful to have the opportunity to talk freely of their experiences.

I believe I had an ethical responsibility to handle personal and emotionally charged information with sensitivity and judgement. I was careful during my interviews not to probe in a way that would produce or encourage unnecessary emotional pain in my participants, in order to benefit my study. Arrangements were in place for those participants who required emotional counselling as a result of the interview, to be referred to Mrs. E. le Roux, one of my supervisors, an Advanced Psychiatric Nurse Practitioner.

Power differential in the participant/researcher relationship

I was reluctant to approach the participants whilst their husbands were still in the critical care unit, as I was concerned that they might feel that their refusal to take part in the study would jeopardise the care their husbands received. I therefore waited until the patients were discharged before contacting the wife telephonically. I wore my nursing uniform to three of the interviews. In two instances this was because the interview was held at the hospital shortly after I went off duty. In the third case this was because I had no time to go home and change between leaving work and meeting my appointment with the participant, since I stay a long way from where she lives. It is possible that the participants may have found my uniform intimidating or that they related to me more as a nurse than as a researcher because of it. On the other hand the uniform may have advanced the trust relationship, since it reminded them that I was the competent nurse they knew and perhaps this made them feel more comfortable with sharing their experiences with me. It is possible that the participants did not criticise their husband's care since they were aware that I was the Unit Manger or because they would have had to see me again should their husbands be readmitted.

Context within which the interviews were performed.

Five interviews were conducted including the pilot interview at a time and venue of the participant's choice. Two participants requested that the interviews be done in their homes, two wished to be interviewed at the hospital and one at her place of employment. Time may have been a problem for the participant who chose to be interviewed at her place of employment, because she had set aside her lunch hour in which to do the interview. Fortunately I was a little early and she was able to join me as soon as I arrived so that we had more than enough time to complete the interview. All the locations were private, quiet and provided a relaxed milieu. It is essential that an atmosphere be provided in which the participant can relax to enable her to put sufficient time and orderly thought into the reporting. I tried to put the participants at ease by spending some time chatting informally, and then by giving a short explanation about the study and gaining consent before the interview began. I have to admit that this also gave me a chance to relax and get my thoughts in order. Providing information about the study at the beginning of the interview serves a second purpose; it ensures that the researcher does not have to do so later in the interview thereby interrupting the participant's train of thought and the overall structure of the interview (Meulenberg-Buskens 1997: 1). I felt that it was important to reassure my participants about the presence of the tape recorder, because most people, including myself, are usually acutely aware of a tape recorder and are not able to relax and talk naturally. The interviews lasted approximately an hour and were concluded when the participants had nothing further to tell me.

The researcher as the data collection instrument

The researcher uses herself as a data collection instrument as she conducts interviews with participants to elicit descriptions of their experiences. During the data gathering process she learns and obtains notions about the structure of the experience, therefore it is considered essential for her to participate directly in data gathering (Polkinghorne 1989: 50). As the manager of the critical care unit and in some cases the nurse that cared for the participant's husband I was concerned firstly that the participants would relate to me as a practitioner rather than a researcher. Secondly I was concerned about how I would react to criticism about nursing care. I wrote about these concerns in my personal research notes on 20-10-1998 before my first interview:

> *What if I omitted to do something whilst caring for her husband while he was in the critical care unit and she mentions it as "poor nursing care" during the interview? How would I react to this? What about the nurse/researcher differentiation? Will she see me as a nurse during the interview or as a researcher? Things to think about!*

All the participants mentioned that the health care team had inadequately prepared them for the convalescent period, apart from this there were no other references to omissions in care. It is possible that there were other issues but that they identified with me more as a nurse, than as a researcher, which made them feel uncomfortable to talk openly with me about them.

During interviews the researcher should guard against becoming too close or over-identifying with the participants, known as 'going native' (Duffy 1985: 229; Field and Morse 1985: 93). If this happens, perception is distorted and effectiveness is lost (Field and Morse 1985: 93).

Interviewing techniques

The idea of the hermeneutic circle (discussed in chapter two and again later in this chapter) includes keeping the dialogue open, therefore the interview approach should be non-directive, allowing the participant to take the researcher with them in their narration. For this reason I started each interview with this opening request: "I would like you to share your experiences from the time that your husband came home from hospital after his heart attack, until now".

According to Gadamer (1975: 238) a question is always related to the answer that is expected in the text, therefore to facilitate true understanding the researcher should surrender to directing the course of interviews by asking set questions. I attempted to evoke natural responses from the participants rather than have the participants fit responses to my preconceived ideas and

interpretations, and to this end I employed a few useful techniques suggested by Meulenberg-Buskens (1997: 5). These are:

- Using reflective summary throughout
- Asking clarifying questions
- Pause or silence

When the interviewer performs a reflective summary she "gives back the interviewee's opinions and feelings" in her own words and this serves to structure the interviewee's information Meulenberg-Buskens (1997: 5). I have included excerpts from my interviews to illustrate how I did this. Please note when reading excerpts from the transcripts that bold text has been used to denote the interviewer and a series of dots have been used to denote pauses.

Ja [Yes], so I am hearing that anxiety has actually taken you to the doctor.

Yes.

Fear that is making you over protective, it's making him angry. Anger from your side and maybe a bit towards him and a bit towards your sons and your husband's family.

Family, yes.

A lot of uncertainty, a lot of questions that you still have. Um, and you're unhappy about your life style, your life that is no longer normal, as you describe it, it's a limited life style.

Excerpt from interview with Participant 2

So the things that I am hearing is that when he came out of hospital you had already decided that you were not going to baby him?

Yes.

You have a lot of support from the people around you, the community, and your family and you've made a conscious decision not to worry about what might happen, but you are .....

Ja ...subconsciously aware that he's got the problems, so ..

Yes, you are subconsciously aware.

Excerpt from interview with Participant 3

The interviewer uses a **clarifying question** to ensure that she really understands what the interviewee is saying. According to Meulenberg-Buskens (1997: 5) "a 'real' clarifying question will always remain within the information already given by [the] interviewee". Once again I have included excerpts from my interviews to illustrate how I did this.

What kind of anger is this ?
Excerpt from my interview with Participant 2

So you are not living a normal life?
No.
Tell me, what is normal?

Excerpt from interview with Participant 2

What do you mean by "see that things go smoothly"?
Excerpt from interview with Participant 3

You say that you felt you were under stress, what do you mean by stress?

Excerpt from my interview with Participant 4

Tell me more about the fear.

Excerpt from interview with Participant 4

The use of a pause or silence can be effective as it gives both parties a chance to think. According to Meulenberg-Buskens (1997: 6) "in 80% of the cases, the interviewee will resolve the silence within 10 seconds". I can tell you that for a novice interviewer such as myself, ten seconds can feel like ten minutes and initially I felt very uncomfortable with silences. Following my pilot interview I wrote this about silences in my field notes:

There was one silence during the interview in which I felt acutely uncomfortable, I wasn't sure what to say next. I realise that I do not handle silences very well and I am going to have to overcome this.

After I wrote this I attended a course that taught Free Attitude Interview Techniques. Here I had the opportunity to practice using pauses and silences in a "safe" and less pressurised interview situation and gained confidence in using them.

I was aware that the participants may exclude parts of the experience that are painful, or confidential, however I tried to overcome this problem by heeding the advice of experienced qualitative researchers. In my interactions with the participants I tried to establish and maintain rapport (Sorrell and Redmond 1995: 1118), portray an attitude of trust and acceptance (Jasper 1994: 312) and obtain truly informed consent (De Haan 1993, cited by Jasper 1994: 312).

Audiotaping and transcription

I made use of audiotapes during the interviews to facilitate analysis because it allows access to the nuances of the interactions during the interview. It also reduces the potential for interviewer error or cheating, thus validating the accuracy and completeness of the data (Barriball and While 1994: 332) and allows for audit-ability of data collection procedures (May 1991: 198). I listened to the tape recordings as soon after the interviews as possible. A copy was then made of the master tape so that it could be kept in a safe place and the chance of loosing valuable data was minimized. I then gave a copy of each audio taped interview to an experienced transcriber with instructions to record as faithfully as possible all linguistic and para-linguistic communications. Sandelowski (1994a: 311) points out that the researcher chooses, by means of instructions to the transcriber, and within the limits of what can be preserved in an audiotaped interview, what becomes preserved in print. I gained a lot of insight into transcription from Mishler's (1986) writings in his book *Research interviewing: context and narrative.* He reminds the researcher that any transcript is only a partial representation of speech and each representation is also a transformation in that some features of speech are included and others excluded (Mishler 1986: 48). Mishler states further that certain changes in speech such as pitch, stress, and rate are almost impossible to represent adequately and still retain the legibility of the

text. He warns the researcher that it is important that systematic transcription procedures concerning what is to be preserved in text are followed because this directly influences the interpretation of interview data and the validity of analysis (Mishler 1986: 50).

The transcriber saved each transcription onto a three-inch micro floppy disc and I later downloaded the file onto my computer. The transcriptions were typed in single-space with a blank line between speakers, pauses were denoted with a series of dots and all exclamations and laughter were included. I then spent many, many hours forwarding and rewinding the audiotape checking each transcript against the audiotape ensuring that it had been transcribed as faithfully as possible. Once the text had been corrected every sentence was assigned a line number and each page was numbered and coded with the participant's number. The participant with whom I did the pilot interview was assigned the number one and for the duration of the study was referred to as participant one, or P1. The next four participants were assigned the numbers two to five and for the duration of the study were referred to as participants two, three, four and five or P2, P3, P4, P5. The corrected text was then printed and each page was stuck onto the left hand side page of a blank book, the right hand side page was left blank so that I could record my comments during the analysis process.

Reflecting on essential themes

Phenomenological themes are the experiential structures that make up an experience and are found through a process of hermeneutic phenomenological reflection or thematic analysis (van Manen 1984b: 59). During thematic analysis each transcript is analysed in an attempt to identify the essential themes that make up the experience under investigation. Field and Morse (1985: 115) state that the depth of data analysis "will depend upon the researcher's sensitivity, perceptivity, informed value judgements, insight and knowledge". Before I describe how I did the thematic analysis I would first like to comment on the role of text and the hermeneutic circle in thematic analysis.

Working with the text

During the analysis process the researcher works with the text. Text is any conversion of speech transcribed into the written word and in this study refers to the transcriptions of the audio taped interviews with each participant. Lived experience is soaked in language and we are only able to recall and reflect on experience because of language. As a methodology, hermeneutical analysis of human experience seeks to provide an understanding of human behaviours and actions beyond the initial impressions of the text (Robertson-Malt 1999: 292). Gadamer (1975: 349) states that texts have to be understood and expressed through the interpreter, who changes the text into intelligible terms. The researcher enables the text 'to speak' and thus find expression.

The hermeneutic circle in thematic analysis

The hermeneutic phenomenological researcher uncovers the meaning of human experience by interpreting the participants' stories (Habermann-Little 1991: 188), which enables her to gain a greater understanding of a phenomenon (Allen and Jensen 1990: 244). Interpretation however is dependent upon a person's pre-understanding of a subject or situation and "each interpretation in a sequence yields a partial understanding of what has been interpreted" (Allen and Jensen 1990: 244). According to Thompson (1990: 243) understanding in the hermeneutic tradition is described "as a process of moving dialectically between a background of shared meaning and a more finite, focused experience within it. The hermeneutic circle is a metaphor used to describe the experience of moving dialectically between part and whole." (Thompson 1990: 243).

In practice the researcher brings her pre-understandings to the analysis process and uses them to gain a greater understanding of the text. According to Koch (1996: 178, 179) entering the hermeneutic circle properly includes using your own experience as data, being aware of preconceived ideas and how these may interact with the participants' stories. The researcher then attempts to gain the meaning of the whole text and in order to do this she begins to work back through the text looking at the parts to determine how the whole is construed. The basic structures of the text, the words, acquire meaning when seen in the context of the sentences, which acquire meaning when seen in the context of paragraphs and the text as a whole (Allen and Jensen 1990: 243). In other words, each interpretation provides some understanding of what has been interpreted and this interpretation then provides partial grounds for the understanding of the parts and the relation of the parts to one another and to the whole. As the circle is followed, understanding occurs, as a new reference begins to emerge from the text. In the text that follows I show how I "got into" the hermeneutic circle during the thematic analysis.

van Manen's line-by-line approach to thematic analysis

I used van Manen's (1990: 93) detailed or line-by-line approach to thematic analysis to isolate themes. In the detailed reading approach every single sentence or sentence cluster is examined and the question asked, "what does this sentence or sentence cluster reveal about the phenomenon or experience being described?" (van Manen 1990: 93). In order to "get into" the hermeneutic circle I started by reading through the transcript observing my reactions, pre-understandings, thoughts and emotions in relation to the text and wrote these down next to the text. This process enabled me to become aware of my pre-understandings of the text and how these could interact with the participants' stories and my interpretations thereof. I have included an excerpt from the data analysis of participant 4's transcript to illustrate this step.

Excerpt from transcript of participant 4	My reactions, pre-understandings, thoughts and emotions in relation to the text
Ja [yes], obviously, obviously as a mother you're keeping a business going, plus you are having to make sure that the family still runs and the home still gets seen to, you know, as far as cooking and cleaning and all that. I did have friends who were very good during that first week particularly, I had people cooking and helping with that sort of thing you know, so that I could see to my other commitments. But um otherwise, um, I think you have to get on with it, when you, if you are a woman and you have all those jobs on your shoulders, you just do it, you know, so it was not a big problem to do it. I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know.	*Extra role responsibilities of a woman, she has a career, she is a mother, wife, housewife and now she is a nurse too, and this must be very draining.* *Support from friends eases the demands of the role responsibilities. Good friends make a difference* *She doesn't have a choice. She has all these responsibilities on her shoulders and she just has to do it.* *She only realised the stress she was under once she began relinquishing some of her responsibilities, but not at the time. I suppose she was too preoccupied to even think about how she was feeling at the time. I think it is a bit like me when I go on leave, I only realise the stress that I have been under once I begin to relax. Before I never thought about it, I just got on with it.*
You say that you felt you were under stress, what do you mean by stress? How did you know that that was stress?	
Well you can just feel that you are coping with such a lot, you know, and you are having to, and also not wanting to let him get upset with things, so you try and hide... when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know, so I was just trying to cope with things there, and you do feel it, you feel that you're dizzy and you... there's a lot going on, a lot that you're trying to do but I think only afterwards you actually then think, well I was coping with a lot then. But you do it because you have to do it.	*She takes on all these extra responsibilities to protect him. She puts so much emphasis on the effect that stress may have on his health. She doesn't want him to have to deal with problems that will cause him any amount of stress. So she hides them from him, putting out fires before he sees the smoke.* *The stress made her feel dizzy, there are so many things going on in her mind. She is overloaded, her body is sending out warning signals.* *She feels that she has to do it, that she doesn't have a choice. Does this feeling stem from her love for her husband or from a sense of duty?*

I then read and re-read the text, reflecting and observing my reactions, thoughts and emotions until I felt I had grasped the meaning of the text as a whole and as experienced by the participants. On the computer each sentence or naturally occurring sentence cluster was separated and labelled with the participant's number as well as the line numbers it corresponded to in the original transcription e.g. participant two, line numbers 1-3 (P2: 1-3). This coding enabled me to refer back to the master transcript quickly and efficiently at any time during the analysis process. The same excerpt used

previously from participant 4's transcript has been used to illustrate this step of the data analysis process.

Excerpt from transcript of participant 4	**Separated and labelled sentences or naturally occurring sentence clusters**
Ja [yes], obviously, obviously as a mother you're keeping a business going, plus you are having to make sure that the family still runs and the home still gets seen to, you know, as far as cooking and cleaning and all that. I did have friends who were very good during that first week particularly, I had 2 people cooking and helping with that sort of thing you know, so that I could see to my other commitments. But um otherwise, um, I think you have to get on with it, when you, if you are a woman and you have all those jobs on your shoulders, you just do it, you know, so it was not a big problem to do it. I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know. **You say that you felt you were under stress, what do you mean by stress? How did you know that that was stress?** Well you can just feel that you are coping with such a lot, you know, and you are having to, and also not wanting to let him get upset with things, so you try and hide... when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know, so I was just trying to cope with things there, and you do feel it, you feel that you're dizzy and you... there's a lot going on, a lot that you're trying to do but I think only afterwards you actually then think, well I was coping with a lot then. But you do it because you have to do it.	Ja [yes], obviously, obviously as a mother you're keeping a business going, plus you are having to make sure that the family still runs and the home still gets seen to, you know, as far as cooking and cleaning and all that. P4: 47-49 I did have friends who were very good during that first week particularly, I had 2 people cooking and helping with that sort of thing you know, so that I could see to my other commitments. P4: 49-51 But um otherwise, um, I think you have to get on with it, when you, if you are a woman and you have all those jobs on your shoulders, you just do it, you know, so it was not a big problem to do it. P4: 51-53 I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know. P4: 53-57 **You say that you felt you were under stress, what do you mean by stress? How did you know that that was stress?** Well you can just feel that you are coping with such a lot, you know, and you are having to, and also not wanting to let him get upset with things, so you try and hide... when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know, so I was just trying to cope with things there, and you do feel it, you feel that you're dizzy and you... there's a lot going on, a lot that you're trying to do but I think only afterwards you actually then think, well I was coping with a lot then. But you do it because you have to do it. P4: 59-72

Once again I read and re-read the text, reflecting and observing my reactions, thoughts and emotions, this time scrutinising each sentence or sentence cluster to determine what it revealed about the experience being described. The words acquired meaning when seen in the context of the sentences, which acquired meaning when seen in the context of paragraphs and the text as a whole. Within each interview themes began to emerge and sentences or sentence clusters were allocated to these emerging themes based on their relationship to the theme. With the aid of my computer, I cut and pasted the corresponding sentences or sentence clusters, preserving my speech as well as the participant and line numbers together under each theme. The themes and their related data were then scrutinised, compared and contrasted, resulting in higher levels of interpretation. During this process changes were made until I felt certain that I had exhausted all the possible meanings of the text. If I was in doubt as to whether a sentence or sentence cluster revealed more about one theme than another, it was placed in both. The same excerpt used previously from participant 4's transcript has been used to illustrate this step of the data analysis process.

Separated and labelled sentences and sentence clusters	**Allocation of sentences and sentence clusters to emerging themes**
Ja [yes], obviously, obviously as a mother you're keeping a business going, plus you are having to make sure that the family still runs and the home still gets seen to, you know, as far as cooking and cleaning and all that. P4: 47-49 I did have friends who were very good during that first week particularly, I had 2 people cooking and helping with that sort of thing you know, so that I could see to my other commitments. P4: 49-51 But um otherwise, um, I think you have to get on with it, when you, if you are a woman and you have all those jobs on your shoulders, you just do it, you know, so it was not a big problem to do it. P4: 51-53 I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know. P4: 53-57	**STRESS OF EXTRA RESPONSIBILITY** Ja [yes], obviously, obviously as a mother you're keeping a business going, plus you are having to make sure that the family still runs and the home still gets seen to, you know, as far as cooking and cleaning and all that. P4: 47-49 But um otherwise, um, I think you have to get on with it, when you, if you are a woman and you have all those jobs on your shoulders, you just do it, you know, so it was not a big problem to do it. P4: 51-53 I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know. P4: 53-57 **You say that you felt you were under stress, what do you mean by stress? How did you know that that was stress?** Well you can just feel that you are coping with such a lot, you know, P4: 59-62

You say that you felt you were under stress, what do you mean by stress? How did you know that that was stress? Well you can just feel that you are coping with such a lot, you know, and you are having to, and also not wanting to let him get upset with things, so you try and hide... when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know, so I was just trying to cope with things there, and you do feel it, you feel that you're dizzy and you... there's a lot going on, a lot that you're trying to do but I think only afterwards you actually then think, well I was coping with a lot then. **Um** But you do it because you have to do it. P4: 59-72	So I was just trying to cope with things there, and you do feel it, you feel that you're dizzy and you... there's a lot going on, a lot that you're trying to do but I think only afterwards you actually then think, well I was coping with a lot then, but you do it because you have to do it. P4: 65-72 **SUPPORT** I did have friends who were very good during that first week particularly, I had 2 people cooking and helping with that sort of thing you know, so that I could see to my other commitments. P4: 49-51 **SHIELD AND PROTECT** And also not wanting to let him get upset with things, so you try and hide... when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know, P4: 63-65

As the analysis process continued I began to identify common themes amongst the interviews. I then grouped the data relating to a specific theme from each interview together by means of cutting and pasting. For example a theme common to all the interviews was "support", so I took the sentences or sentence clusters relating to support from each interview and grouped them together. I should add that not all the themes were necessarily common to all four interviews at this stage, their commonality however was found later in the analysis process when scrutinising the data for central themes. An excerpt from the data analysis process has been included to illustrate this step.

SUPPORT

Because there is not a lot that I know... this is the first time really that I could now sit and talk on how... of you know of the anger and that type of thing, but there was nobody that... even in my family that went through the same thing, that I could sit and talk and say, look, this is how I feel or this is how angry I am or... P2: 656-660

The support was very important I mean, for any woman I can tell you if there is, if they have got family around then it is good support then. It is good to know that you can turn to somebody and that the burden of this whole thing isn't on you alone, you know. That was the nicest part. P3: 162-165

To support you and take you through, you know, your moments when you needed them the most. P3: 290-291

And also, also just the support of friends and family as well, with what you're going through, you know, that they keep phoning and say "How things going?" and "Are you okay?" "are the children okay ?" you know "Is everybody coping?". P4: 248-251

I think the support from people around you is amazing, it's incredible, I think if you don't have that then you... it would be very difficult to cope. I've got all, my family are here and friends are here, you know, and I think it makes it all so much easier when people rally around you, you know, you do tend to cope. P4: 699-702

So you believe that that was all in the hands of God?
Oh definitely. Oh ja [yes]. Ja [yes], no definitely.
Was that your main support?
Yes P5: 491-497

A lot of phone calls from people. Um... lot of friends showed a lot of concern, and that as well. Ja a lot of... you're surprised at how many friends you actually have, you know. P5: 504-508

These files were then printed and worked on by hand so that each sentence or sentence cluster could be read, re-read and reflected upon and changes were made based on this further interpretation. At the end of this process I had 25 themes. They were: anger; attempting to reduce his stress levels; blame; caring role; closer relationship; communication; comparing experiences with peers; compliance; difficult for him to come to terms with his myocardial infarction; effect on the rest of the family; faced with the possibility of his death; fear manipulates her being; fear; feeling of loneliness; having a positive attitude; knowledge deficit; lifestyle changes; relationships are changed; sex; she says her say; shield and protect; stress of extra responsibility; support; the medical profession; the repercussions of his disease.

Each of the 25 theme files were printed and worked on by hand as I proceeded to interrogate these 25 themes in order to find the central or main themes. It became apparent that certain themes could merge with others to form a central theme, for example "faced with the possibility of his death", "fear", "fear manipulates her being", and "a positive attitude" described a central theme of "living with fear ". Below I have taken excerpts from each theme to illustrate how the themes merged to create a central theme.

THEME - FACED WITH THE POSSIBILITY OF HIS DEATH

And I would go to the shop once and get everything for the next day and that, because I wouldn't leave him! Because that fear was always like, you know, he might just have another heart attack and I am not there! P2: 101-103

It's just that the heart is one of your main organs and you're gone if you have a major attack, you know, so that's the worst part, I mean you're here today and tomorrow you're gone if you have a major heart attack, so that's the only bad thing about it. P3: 182-185

And as you say it changed your life too.
From that point of view, ja [yes]. I mean you think you take each other so for granted when you are married, we have been married for 25 years, so when you have been married for a long time you actually, you know, the other person is always there, you know, and I think you wake up to the fact that, you know, they are not always going to be there and he nearly didn't... and you sort of think about what could have happened if he wasn't, you know, if something had gone wrong, how would I have cope with it all? So it does make you think a bit, it makes you more appreciative of everything around you and of your partner as well, you know. P4: 483-495

THEME – FEAR

That it would really take over part of me, you know, that I am living in this fear all the time. P2: 508-509

I actually had somebody the other day who stopped me in the supermarket, a lady I know there, and she said to me "I just heard what happened to Geoff!" so I said "ja well, but he's alright, you know, don't worry about it" and said "but aren't you scared to have And said "but aren't you scared to have him around you?" and I said "no, why must I be scared?" you know, and said, "Ooh, I would be petrified in case something happened" and I said to her look, you know, there is that... I don't think it's fear with me, I think that now that, as he gets better and better, that the fear now... I'm positive that as long as he leads a good lifestyle we won't have a repeat of it. P4: 543-550 543-546

Tell me more about the fear
...(Long pause) I don't know um... was always, like, scared that he would overdo things, that he would be walking down a road and have another heart attack or... even now, sometimes when I know he is overdoing things, you know, then I sort of like watch him. P5: 79-85

THEME - A POSITIVE ATTITUDE

I mean it is horrible when you think about it, I mean your partners young, and you know, and your kids are still young and things like that. But I am not going to be negative about it because it is not good. It is not good for the kids and it's not good for you as a person. P3: 209-212

That's what we are trying to do, so then I think that you must be positive after that, you are over the worst and it won't repeat itself. P4: 569-570

I do believe he's going to be his old self within a short time, you know, I do believe he's going to get better, you know. I really do believe that, you know. As long as he doesn't do stupid things (laughter). P5: 406-415

CENTRAL THEME - LIVING WITH FEAR

And I would go to the shop once and get everything for the next day and that, because I wouldn't leave him! Because that fear was always like, you know, he might just have another heart attack and I am not there! P2: 101-103

You know, and I think that made it, the fear even worse because the fear was like gripping me so that, that I myself felt like getting... I used to get sweaty palms and I started perspiring, the doctor even gave me a tablet for the, for the sweat because I was, I couldn't... when I, during the night I would wake up and I was soaking wet from perspiring. And I had to, I had to get up and change my, my pyjamas and get something dry to put on because of this... and okay, at least I had the... the support I would say of my family doctor and she sat me down and she said, look, this, this... he is going to be okay again, you know, you don't have to worry about it, don't think of the negative because that is the fear that... that because of the negative thinking, it puts you into that... P2: 124-135

That it would really take over part of me, you know, that I am living in this fear all the time. P2: 508-509

It's just that the heart is one of your main organs and you're gone if you have a major attack, you know, so that's the worst part, I mean you're here today and tomorrow you're gone if you have a major heart attack, so that's the only bad thing about it. P3: 182-185

I mean it is horrible when you think about it, I mean your partners young, and you know, and your kids are still young and things like that. But I am not going to be negative about it because it is not good. It is not good for the kids and it's not good for you as a person. P3: 209-212

And as you say it changed your life too.
From that point of view, ja [yes]. I mean you think you take each other so for granted when you are married, we have been married for 25 years, so when you have been married for a long time you actually, you know, the other person is always there, you know, and I think you wake up to the fact that, you know, they are not always going to be there and he nearly didn't... and you sort of think about what could have happened if he wasn't, you know, if something had gone wrong, how would I have cope with it all? So it does make you think a bit, it makes you more appreciative of everything around you and of your partner as well, you know. P4: 483-495

That's what we are trying to do, so then I think that you must be positive after that, you are over the worst and it won't repeat itself. P4: 569-570

I actually had somebody the other day who stopped me in the supermarket, a lady I know there, and she said to me "I just heard what happened to Geoff!" so I said "ja well, but he's alright, you know, don't worry about it" and she said "but aren't you scared to have And said "but aren't you scared to have him around you?" and I said "no, why must I be scared?", you know, and said, "Ooh, I would be petrified in case something happened" and I said to her look, you know, there is that... I don't think it's fear with me, I think that now that, as he gets better and better, that the fear now... I'm positive that as long as he leads a good lifestyle we won't have a repeat of it. P4: 543-550

Tell me more about the fear.
... (long pause) I don't know um.... I was always, like, scared that he would overdo things, that he would be walking down a road and have another heart attack or... even now, sometimes when I know he is overdoing things, you know, then I sort of like watch him. P5: 79-85

I do believe he's going to be his old self within a short time, you know, I do believe he's going to get better, you know. I really do believe that, you know. As long as he doesn't do stupid things (laughter). P5: 406-415

At the end of this process I had uncovered eight central or main themes, which, I felt, described the experiences of wives of myocardial infarction survivors during the convalescent period. They were:

- Being a protective shield
- Life changes
- Facets of the relationship change
- Meeting additional role responsibilities
- Living with fear
- Drawing from the support fund
- Causal explanations for the myocardial infarction
- The need for knowledge

Throughout the analysis process my supervisor, Professor R. Thompson read and did her own analysis of my transcripts. We met frequently and spent many hours discussing the data. I found these discussions to be of great value as they provided me, a novice researcher, with much needed guidance and helped generate deeper insights and more complete interpretations. On one occasion I gave my transcript to a Hospice social worker to read. The discussion that ensued was enlightening as she interpreted the transcripts from a completely different perspective, which stimulated my thinking.

I attended two qualitative data analysis workshops presented by Mrs I. Meulenberg-Buskens, an experienced qualitative researcher, anthropologist and research consultant, both before and during the data analysis process. Apart from teaching the practical aspects of data analysis, Mrs Meulenberg-Buskens also spent time demonstrating how we could access our thoughts and feelings, valuable tools for any qualitative researcher.

Phenomenological describing through the art of writing and rewriting

According to van Manen (1990: 39) essence is the "linguistic construction" used to describe a phenomenon. The aim of phenomenology is to "transform lived experience into a textual expression of its essence" (van Manen 1990: 36). A "good description that constitutes the essence of something is construed so that the structure of a lived experience is revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way" (van Manen 1990: 36).

After the thematic analysis I had eight themes, each with their corresponding sentences or sentence clusters derived from the transcripts of the participants. My task was to create a phenomenological text that you will immediately recognise as meaningful and which would afford you a deeper understanding of the experience being studied. I used the themes as a framework around which the phenomenological descriptions of the participants' experiences were written (see chapter 4). Selected sentences or sentence clusters from each theme were used to provide evidence for my interpretations and to provoke a response from the audience of this research report.

The depth required of a phenomenological text cannot be achieved in one writing session as I soon found out. Wolcott (1990: 21) states that "writing is thinking" and I could not agree with him more. It was only through a process of writing, thinking and rewriting that I was able to begin to condense a pattern of meaningful relations into a discursive whole, with the necessary depth required of phenomenological writing. It was however a process that I found to be personally demanding since

I had to externalise something that was internal and initially I felt very self-conscious, which probably stilted my writing. Wolcott (1990: 12) points out that, "a few moments of ecstasy over something well written or favourably reviewed are meagre compensation for all the agony endured to achieve it". During the process of writing and rewriting however, I began to relax and became more reflective in my writing and thinking as I tried to write as deeply and as sensitively as I could about the experiences of my participants. Through the process of writing and rewriting I developed deeper insights into the themes and greater depth in my writing and just when I thought I had rewritten for a last time I would re-interpret or understand something differently and have to rewrite once again. It was difficult knowing when to stop.

As I wrote and rewrote, I submitted drafts frequently to both my supervisors as well as my husband. Receiving feedback of any manner is usually painful and this was no different. True words were spoken by Wolcott (1990: 44) when he said, "regardless on intent feedback tends to be disproportionately critical and negative. Your only consolation may be that the more painstaking the critique, the more you may assume that your critic has taken your effort seriously" and this was the context within which I received feedback. Professor R. Thompson, one of my supervisors, continually urged me to share more of myself as the traveller in this research journey. In her feedback notes she wrote what she had shared with me personally over a number of sessions: "I feel however that you can go deeper with your data as you engage with it as a whole person and not just as a researcher/scientist" so that my writing could achieve what she called a "ring of authenticity". The feedback I received from my husband was very useful too, because as a reader with no knowledge of hermeneutic phenomenology, or qualitative research for that matter, he was able to tell me whether the text made sense to him or not.

Throughout the research process the researcher's perspective is engaged with the data, the end product of which is a description of an experience, presented from that perspective (Oiler Boyd 1989: 18; Rodgers and Cowles 1993: 223; Ray 1994: 126; Walters 1995: 797). It is important to keep in mind that a "phenomenological description is always one interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description" (van Manen 1990: 31).

Maintaining a strong and oriented relation to the research question

van Manen (1990: 33) believes that it is essential that the researcher remains orientated to her research question throughout the study, failure to do so may result in her becoming "side-tracked, or to wander aimlessly and indulge in wishy-washy speculations, to settle for preconceived options and conceptions". This procedural activity is carried out from the time the researcher decides what her

research question is to be. I believe that two factors made it easier for me to remain oriented to the research question. Firstly, I chose a research question I was interested in and secondly the inquiry paradigm i.e. hermeneutic phenomenology, allowed me, the researcher, to become involved with my study. There were times however, such as during the thematic analysis, that I became side-tracked by issues in the text and had to reorient myself on a few occasions.

Balancing the research context by considering parts and whole.

van Manen (1990: 31) lists this procedural activity sixth, but as is the case with the fifth procedural activity the researcher attends to this activity throughout the study. Firstly van Manen (1990: 162) suggests that the researcher considers the effects and ethics of human science research. I have dealt with these issues earlier in this chapter. Secondly, the researcher must explicate the plan and context of the study for the reader. I do so in both chapter 1 and earlier in this chapter. Thirdly the researcher must consider the text. Qualitative research studies are usually presented in the textual form and it is important that the researcher decides beforehand how she is going to write her thesis. She could structure her thesis thematically, analytically, exemplificatively, exegetically, and existentially, or she could invent her own approach (van Manen 1990: 167). I chose to use the emerging themes to structure and guide my text.

TRUSTWORTHINESS

In chapter 2 some of the fundamental differences between quantitative and qualitative research were highlighted. I mentioned that each of these inquiry paradigms is based on different philosophical perspectives, has different worldviews, serves different purposes and uncovers different knowledge. Despite these differences however, there is still an expectation in the research world that qualitative research should meet the same criteria of rigor as that which is applied to quantitative research.

Guba and Lincoln (1989: 233) developed an alternative model that qualitative researchers could use to ensure rigor without sacrificing the relevance of qualitative research. Their model is well developed and has been used by qualitative researchers for a number of years (Krefting 1991: 215) and for this reason has been used in the current study. Guba and Lincoln (1981: 103) believe that the basic concerns of rigor reflected in the criteria commonly used by quantitative inquiry, hold for qualitative inquiry, but some reinterpretation is required to better fit the assumptions of the qualitative paradigm.

To begin with Guba and Lincoln (1989: 233) refer to the rigor of qualitative research as trustworthiness and the four basic concerns of trustworthiness relevant to both quantitative and qualitative research are truth-value, applicability, consistency and neutrality. Guba and Lincoln (1981: 103) describe each of these concerns as follows:

- **Truth value** is concerned with establishing "confidence in the 'truth' of the findings of a particular enquiry for the subjects with which – and the context within which – the enquiry was carried out".
- **Applicability** is the extent to which "the findings of a particular inquiry may have applicability in other contexts or with other subjects".
- **Consistency** refers to whether "the findings of an enquiry would be consistently repeated if the inquiry were replicated with the same (or similar) subjects in the same (or a similar) context".
- **Neutrality** is "the degree to which the findings of an inquiry are a function solely of the subjects and conditions of the inquiry and not of the biases, motives, interests, perspectives, and so on of the inquirer".

In quantitative research the four terms naming these criteria are **internal validity** for truth-value, **external validity** for applicability, **reliability** for consistency and **objectivity** for neutrality (Guba and Lincoln 1981: 104). Guba and Lincoln (1989: 236-242) proposed qualitative analogues for the four terms used in quantitative research, which they deem more appropriate for qualitative research. They are **credibility** for truth value, **transferability** for applicability, **dependability** for consistency and **confirmability** for neutrality. I have used a table (Table 3) created by Krefting (1991: 217) that clearly sets out the four basic concerns of trustworthiness and their quantitative and qualitative analogues. The above criteria of trustworthiness were attended to in this study as follows:

Criterion	Qualitative research	Quantitative research
Truth value	Credibility	Internal validity
Applicability	Transferability	External validity
Consistency	Dependability	Reliability
Neutrality	Confirmabilty	Objectivity

Table 3. The four basic concerns of trustworthiness and their quantitative and qualitative analogues. Krefting (1991: 217)

Credibility

Credibility is achieved when there is a match between the constructed realities of the participants and those realities as presented by the evaluator (Guba and Lincoln 1989: 237). Allowing other experienced researchers to review the research process especially the thematic analysis can enhance the credibility of a study (Sandelowski 1986: 35). Throughout this study my work was submitted to and discussed with both my research supervisors on a regular basis. Cutcliffe and McKenna (1999: 376) argue that it is unlikely that two people will interpret data in the same way especially if the researcher has been involved in the entire research process and the colleague has not. Yet it is precisely because of this point that I found these discussions so useful. Each of my supervisors brought their unique pre-understandings and perspectives to these discussions, which provided me, a novice researcher, with much needed guidance and helped generate deeper insights and more complete interpretations.

I was aware that I could enhance the credibility of my study by returning to the participants with my findings for confirmation that the interpretation of the data was correct (Sandelowski 1986: 35; Koch 1994: 977; Appleton 1995: 996). I had prepared my research participants for this possibility when I obtained consent (See appendix C), however as a result of a long delay between the interviews and the completion of the data analysis I did not return to my participants with the research findings. I conducted my pilot interview on 10 March 1999, the first study interview on 24 May 1999; the fifth interview on 24 January 2000 and completed the data analysis in October 2000. The value of returning to the participants after approximately ten to eighteen months could be debated.

The credibility of a study can be enhanced "when researchers describe and interpret their experience as researchers" (Koch 1994: 977) "in relation to the behaviour and experience of subjects" (Sandelowski 1986: 30). As discussed in chapter two and earlier in this chapter the hermeneutic circle allows the hermeneutic phenomenological researcher to bring her pre-understandings to the research process. For this reason I explored my assumptions and pre-understandings early in the research process and have made these known in chapter one and earlier in this chapter. In addition, as I read each transcript for the first time I observed my pre-understandings, thoughts and emotions in relation to the text and wrote these down in an attempt to access my pre-understandings.

I also kept field notes written soon after each interview in which I detailed the following:

- Preconceived ideas I had become aware of before, during or after the interview

- My reactions to any aspect of the session or the information it provided.
- Questions that had come to mind and insights gained during or after the session.

I have provided excerpts from my field notes to illustrate this:

Preconceived ideas I became aware of before/during or after the interview:
Some of the things that the participant had spoken about I recognised from literature I had read. It is so fascinating, that these same things are coming up in my research. What she told me was so interesting. I felt much better with my interview technique, I do not think I led her too much, I let the interview flow and tried not to let bias creep in, I was so aware that I should not allow this to happen. To interview well takes a lot of energy and concentration!
(Excerpt taken from field notes written after my interview with participant two).

Talking to her on the phone I realized that she was handling the post myocardial infarction phase very well, I remember feeling disappointed that she did not seem to be experiencing the same problems as the previous participant. Then I remembered reading that the more different your data is the better.
(Excerpt taken from field notes written after my interview with participant three)

My reaction to any aspect of the session or the information it provided:
I feel so sorry for these women, they are really thrown in at the deep end and expected to cope. At least with a newborn baby, you can prepare yourself to cope whilst you are pregnant. How do you prepare yourself to cope with this? You don't have nine months. Maybe it is like having a baby at home again, you want to do things for them, check whether they are breathing and make sure that they don't hurt themselves. The heart is seen as the centre of the body, not the brain really. Where do you feel heartsore, not your head! If the heart fails you have lost your husband, it must be nerve-wracking. These women go through a lot it would seem, with very little help.
(Excerpt taken from field notes written after my interview with participant two).

I made a decision during the interview to change my researcher hat for that of clinician when the interview finished. I answered some of her questions, referred them to the Sports Science Institute for cardiac assessment, diet management and possibly counselling if needed.
(Excerpt taken from field notes written after my interview with participant five).

Questions that came to mind, insight gained during or after the session:
How can one not reassure? It is so difficult not to get involved on a clinical and professional level, seeing and hearing how anxious she is and how their quality of life has deteriorated. It is really sad.
(Excerpt taken from field notes written after my interview with participant two)

Support is crucial for the spouse to enable her to cope better. Nonverbal communication between spouses is important when words are difficult or insufficient. She seems to think that if she cooks correctly her husband will be all right – maybe it is because this is her responsibility, her area of his convalescence.
It is difficult being a mother, career woman, wife and nurse to her husband.
Her responsibilities increase as she attempts to shield him from stress. She tries to ensure that he is kept stress-free at all costs.
(Excerpt taken from field notes written after my interview with participant three)

Transferability

Transferability according to Guba and Lincoln (1989: 241) can be achieved by providing as complete a database as humanly possible to facilitate "transferability judgments" for those who would like to apply the study to their own situations. The researcher can contribute to applicability by setting out all working hypotheses, as well as extensive descriptions of time, place, context and culture in which those hypotheses were found to be relevant (Guba and Lincoln 1989: 241-242). " The context must be described adequately so that a judgement of transferability can be made by the readers" (Koch 1996: 179). I believe that since I worked within the context in which my study took place, I was able to provide you with complete and insightful descriptions of the research context and these I have detailed in chapter one and earlier in this chapter. In addition I made field notes after each interview concerning the context and relevant background to the interviews and/or the participant, as well as the interview setting. I have provided excerpts from my field notes to illustrate this point:

Context and relevant background to the interview and/or the participant:
The participant's husband had a myocardial infarction 28 March 1999. He went for a stent [a prosthesis that is inserted into the coronary artery to prevent acute closure and restenosis of the vessel] *at YYY Hospital and has been convalescent ever since. The participant has 2 adult sons and lives in Green Point in a modest flat. The couple are of mixed race* [I have indicated this for cultural reasons for example, their English dialect is slightly different and this will be noticeable in the transcripts]. *He was at cardiac rehabilitation when I went to the flat. I*

had told the participant that it would be best if we conducted the interview when her husband was not at home and at a time when we would be undisturbed, to enable her to speak freely. This is why that particular time and place was chosen.
(Excerpt taken from field notes written after my interview with participant two)

Interview setting
The interview took place at the participant's home at 19:00. At first I thought her husband was going to be there for the interview, but then he excused himself and went out. We sat at a round dining room table, close together, sipping iced tea. I felt relaxed. She put the music off so that it would not interfere with the tape recording, the fridge made a noise, I found it irritating and was concerned that it would affect the quality of the tape recording. [After a short while I became so engrossed in the interview that I no longer noticed the noise from the fridge].
(Excerpt taken from field notes written after my interview with participant five)

The interview was held in the participant's environment, at the YYY Hotel where she works. She booked the boardroom for us [I am unsure whether the boardroom was a natural setting for her or not, but she appeared to be quite comfortable and relaxed there]. *We could sit opposite one another with the dictaphone between us. We were a little tense in the beginning. We were interrupted twice, but this didn't seem to be a problem. I could however see people on the other side of the glass bricks; the participant had her back to them. I could hear them occasionally and I wondered, especially in the beginning, if they were listening.*
(Excerpt taken from field notes written after my interview with participant three)

It is hoped that from the context descriptions provided both here and extensively in chapter 1, you will be able to make judgements of transferability between the findings of this study and contexts outside the study situation.

Dependability

The researcher contributes to dependability, an essential component of trustworthiness, by leaving an audit trail providing explanations and justification for all decisions and changes made at each stage of the research process (Guba and Lincoln 1989: 242; Rodgers and Cowles 1993: 219; Appleton 1995: 997). Rogers and Cowles (1993: 220) have suggested four basic types of documentation that can be used to ensure a comprehensive audit trail and these have been used in this study.

The first is "contextual documentation" or field notes, which are used to describe factors related to the context of and actual data collection process (Rogers and Cowles 1993: 220). Field notes aid in data analysis as they provide valuable clues to events during the interview, which tape recording alone may have missed (Rogers and Cowles 1993: 220). Excerpts from my field notes made just after each interview are presented above to substantiate the credibility and transferability of my study.

Guba and Lincoln (1989: 242) believe that methodological changes and shifts in construction are hallmarks of a maturing and successful study. The second type of documentation Rodgers and Cowles (1993: 221) suggest keeping is "methodological documentation", which are records of the reasons for all ongoing methodological decisions. I kept, what I hesitate to call a journal, but rather my personal research notes, in which I sporadically documented what I was thinking and feeling about my research and research decisions I had made. I also used it to jot down reminders of things I had to do in relation to my study. In the text that follows I provide excerpts from these notes, which detail how I made the decision to use van Manen's (1990:31) "methodological" approach rather than that of Hycner (1985: 279) to conduct the study.

1999-07-09.
I want to use Hycner's method of data analysis, but he wants the researcher to bracket, this is contraindicated in hermeneutic phenomenology. Or is it? Is it that one has to put aside one's presuppositions/be aware of them to avoid involving them, or do you not worry at all and allow your presuppositions to be a part of the data analysis? I will find out soon. Also I have to make use of the hermeneutic circle in the research analysis, for it to be true hermeneutic phenomenology and therefore I should not be, cannot be bracketing. I also want to see what method of analysis other researchers have used in studies they called hermeneutic phenomenology so that I can see whether I am on the right track. I don't think Hycner's method of data analysis is congruent with hermeneutic phenomenology.

1999-08-14
It is a good thing that I have tried to understand the philosophy of hermeneutic phenomenology. I have read some of the critiques of other papers that say they have used hermeneutic phenomenology and they are not, as they clearly state that bracketing should occur and make no mention of the hermeneutic circle. This is not hermeneutic phenomenology. van Manen's methodological approach is more suitable than Hycner's who clearly states in step two that the researcher should bracket and makes no mention of the hermeneutic circle. Max van Manen allows the researcher to use initiative and as Gadamer states there is no strict methodology to follow when doing hermeneutic phenomenology. So

now I have to do the following: read up van Manen again, as I am going to use his analysis method for the reasons above.

The third kind of documentation Rodgers and Cowles (1993: 221) suggest is called "analytic documentation". Analytical notes enable the researcher to demonstrate that reasonable procedures and lines of inquiry were followed during analysis. I clearly documented everything regarding all phases of the analysis, no matter how trivial, in order to ensure a rigorous analysis. An excerpt from my analytical documentation demonstrates an analytical dilemma I had in relation to the theme "Stress of extra responsibility". I was not sure whether to merge this theme with that of "Shield and protect", this excerpt details some of my dilemma and decision making process.

Stress of extra responsibility
What is this about? The wife has to take on more responsibility, tasks etc. than she usually does to ease his stress and protect him from developing another heart attack. She is protecting him, so why haven't I moved this to "Shield and protect"? Because I believe that this is different from shielding and protecting. It is more about continuing with her normal roles and tasks in addition to new ones and how she deals with this and feels about this. I am still grappling with the question; should I merge these two themes? Sometimes they seem so similar and at other times so distinct. If I keep them as separate themes what will I call them? What words will I use to capture the essence of the themes? I am going to look at "Shield and protect" again and then come back to this theme so that I am sure that there is no conflict.

After looking at "shield and protect" and again at this theme I am sure that there is no conflict, yes it has something to do with shielding and protecting but the emphasis here is on meeting the demands of additional roles and responsibilities and surrounding issues.

The theme referred to here, as the "Stress of extra responsibility" was later named "Meeting additional role responsibilities" and the theme referred to "shield and protect" was later named "Being a protective shield"

The fourth piece of documentation suggested by Rodgers and Cowles (1993: 223) is that of "personal response documentation". The dependability of the research is enhanced and my self-awareness increased by describing and interpreting the research area, my background knowledge and psychological and emotional responses to the participants (Rodgers and Cowles 1993: 223; Koch 1994: 977). When I did write personal research notes I sometimes wrote about what I was thinking and feeling in relation to aspects of my study. The following excerpts are shared with you from my

personal research notes, which demonstrate my thoughts about interviews that I had done at the beginning of the data collection process.

> *99-03-10*
>
> *Finally my first pilot interview! I didn't feel that nervous, I didn't become flushed. It was exhausting, I remember beginning to feel dizzy towards the end, I had to concentrate so hard. It was quite hot in the room, she was perspiring, and she spoke a lot. I remember that my wording of the initial question was long and drawn out and could have been more to the point. I asked her leading questions at times and at other times I thought I handled the questions quite well, probing and repeating parts of sentences in a questioning manner. I had to stop myself from speaking too quickly at times; I had to stop myself from interrupting. I felt uncomfortable with silences especially the long ones, I couldn't think what to say for a while. I look forward to reading the transcripts.*
>
> *99-05-24*
>
> *My second pilot interview, I felt that it went well, much better. I couldn't help but feel that I should reassure the participant, she looked and sounded like the world had come to an end – it probably has for her, she no longer leads a normal life and I think that this is awful. I wanted to tell her not to worry, it will get better. I wanted to say that he is not made of glass – just get on with it, but I suppose it is not that easy when you are fearful and anxious. I was really aware of her need for reassurance.*
>
> *My interview technique I thought was much better than the last interview, I didn't seem to go around in circles!*

Confirmability

In qualitative research the researcher and the participant are seen as an interactive entity and therefore the researcher cannot possibly be neutral. For this reason the emphasis of neutrality is shifted away from the researcher and instead refers to the freedom of bias in the research process and product (Sandelowski 1986: 33) and is called confirmability. According to Guba and Lincoln (1981: 126) confirmability refers to the findings themselves, not to the objective or subjective stance of the researcher. For this reason in my presentation of the findings in chapter four, I have quoted extensively from the transcripts of my participants so that you can judge the confirmability this study for yourself. I Guba and Lincoln (1989: 243) suggest that neutrality is established when the criteria of truth-value, applicability and consistency have been attended to. The way in which these criteria have been attended to in this study has been described in the preceding paragraphs.

CONCLUSION

Samuel Johnson (1709-1784) once said, "The use of travelling is to regulate imagination by reality, and instead of thinking how things may be, to see them as they are" (cited by Stevenson 1967: 2030). I found these words particularly relevant to my research in two ways. In the first instance, the research proposal is initially an invention of the imagination; it is substantiated and guided by the literature, but remains the researcher's thoughts of how the study is going to be conducted. It is only by means of actually travelling through the research process that the reality of doing research, and being a researcher, becomes clear.

Secondly, at the beginning of my research I had a question in my imagination: What are the lived experiences of wives of myocardial infarction survivors in the convalescent period? Travelling through the research process enabled me to understand the reality of their experiences, to see them as they were, rather than as I imagined them to be. In the chapter that follows I will share my interpretation and understanding of their experiences using the themes as a framework around which the descriptions have been written.

Chapter four: What I learnt from those I met

"Themes are the stars that make up the universe of meaning we live through. By the light of these themes we can navigate and explore such universes"

Van Manen (1990: 90)

The purpose of embarking on my journey was to gain an understanding of the experiences of wives of first time myocardial infarction survivors in the convalescent period. As I travelled I interviewed women who were living this experience and collected their stories. After an exhaustive thematic analysis of these stories eight themes emerged that I felt described their experiences during the convalescent period.

- In this chapter I describe:
  - The themes:
    - Being a protective shield
    - Life changes.
    - Facets of the relationship change.
    - Meeting additional role responsibilities.
    - Living with fear.
    - Drawing from the support fund.
    - Causal explanations for the myocardial infarction.
    - The need for knowledge.

Direct quotations from the participants have been included. This was done with the purpose of allowing my participants' voices to be heard, to make their feelings or moods more explicit, to authenticate my findings, to clarify the subtleties of their experiences and provide a more vivid reading experience for you (Sandelowski 1994b: 480). The inclusion of quotes also allows you to evaluate my interpretations (Habermann-Little 1991: 190).

THE THEMES

Theme: Being a protective shield

A myocardial infarction occurs when the coronary blood flow is abruptly decreased or totally terminated to a specific area of the myocardium. This occurs as a result of coronary artery disease, which is a subtle, progressive disease of the coronary arteries supplying the myocardium that results in their narrowing or complete occlusion. Specific lifestyle factors have been identified that have been associated with an increased risk of developing coronary artery disease and can be divided into two groups: nonmodifiable and modifiable. Nonmodifiable risk factors include gender, age and family history of cardiac disease. Modifiable risk factors include hyperlipidaemia, hypertension, cigarette smoking and physical inactivity, stress and personality

type. Following a myocardial infarction the patient's risk factors must be identified and addressed so that lifestyle changes can be made to reduce the risk of another myocardial infarction.

Participants 3, 4 and 5 in this study felt that of all the risk factors, stress was the chief precipitating factor of their husbands' myocardial infarction. Their concern was not about the amount or type of stress that he was exposed to but rather his inherent inability to cope with stress.

> He stresses easily, you know, that is something he's got to work on as a person. I mean, that was what sent him that way in any way, you know, because he's not somebody who takes things in his stride, he works himself up to a point that he sweats. P3: 236-239
>
> Because part of which I think what brought on the heart attack was stress, and he is a worrier, he's that kind of person, he stresses all the time. P4: 131-132
>
> He takes everything personally, he is very um, very stressful person actually, always thinks he's responsible for everything and, I don't know he's just one of these... that's why he had the heart attack. I know. P5: 102-104

As a consequence of this belief the participants felt afraid that exposure to stress, especially in the vulnerable convalescent period, would overtax their husbands' heart resulting in another myocardial infarction. They therefore made it a priority to ensure that they protected him from all forms of stress.

> So that is why I don't want to stress him, I don't want to cause him tension or stress, you know, because he might just get sick again and then... P2: 603-605
>
> We still had the painters to go and paint and I we, like we didn't have money [to pay them], and I thought gee whiz, what now, you know, I mean I can't tell this man [her husband] now, I mean if I must talk money now he's gone, you know. P3: 533-535
>
> I knew that anything that upset him would start this whole thing again, you know, so we would definitely then, try to shield him from anything like that. P4: 158-159.
>
> **And this fear of a heart attack happening again makes you want to protect him and not let too much stress get through to him?**
> Ja [yes]. P5: 317-320

They began to act as shields, placing themselves between their husbands and perceived stressors in an attempt to protect them, this involved taking ownership of matters that traditionally he would have dealt with, concealing stressful issues from him and making decisions for him.

> I shield him from all that, those little things, I mean I would never, you know, I try and avoid all those little attacks from people that we owe money to. P3: 598-600

> And also not wanting to let him get upset with things, so you try and hide them, when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know. P4: 63-65
>
> And they [members of his family] would come to him with problems and I had to say, look, you're not doing this, you know, you're not bringing him your problems. P5: 168-174
>
> I know I am protecting him, I'm always looking out for him, you know. I see that he's not overdoing it. P5: 397-402

The participants' experience of acting as protective shields differed. Participant 3 experienced it positively saying that she felt good about being able to protect her husband from the dangers of stress. Participant 4 experienced it negatively saying she found it stressful, but only realised it was so once she began releasing some of her shielding responsibilities. Whether the participants experienced their protective functions positively or negatively, they were unanimous that this was one function that had to be performed.

> **So you purposely did things to make it easier for him when he got home?**
> I had to, I mean gee whiz, imagine here you get an attack and you still sit saddled with the stress coming onto you, you know.
> **How did you feel doing that?**
> I felt great! P3: 566-573
>
> I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know. P4: 53-57
>
> **You say that you felt you were under stress, what do you mean by stress? How did you know that that was stress?**
> Well you can just feel that you are coping with such a lot, you know, and you are having to, and also not wanting to let him get upset with things, so you try and hide... when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know, so I was just trying to cope with things there, and you do feel it, you feel that you're dizzy and you... there's a lot going on, a lot that you're trying to do but I think only afterwards you actually then think, well I was coping with a lot then, but you do it because you have to do it. P4: 59 -72

Two of the participants were careful not to allow their shielding behaviour to be seen as overprotective. They realised that in some ways their husbands' self-esteem may have been affected by the myocardial infarction, and may have left him feeling damaged, incompetent and dependent. Their concern was that if their behaviour was perceived to be overprotective, these feelings would be reinforced resulting in anger and frustration.

If you treat somebody um like an invalid they're going to feel like that all the time. You know they're going to feel um, like dependent on you for every little thing and I didn't want him to be that way, didn't want him to feel like you know he's not a man anymore, you know. I needed to make him feel like he's still there and he is healthy although he had a heart attack. P3: 87-91

No, I'm not going to take his manhood away from him. P5: 671

Um, ja [yes]. I think it's just a case of accepting what's happened and don't let it... I think it's very easy to pamper, but it is not to. I don't know, maybe I'm putting it wrong, let them still be the... not lose their strength, you know. P5: 761-763

The limitations imposed by the myocardial infarction on participant 2's husband left him feeling frustrated. Although participant 2 was unconcerned about the effect of stressors on her husband's health, she did try to protect him, but from other risks such as overexertion. Unfortunately he saw her concern for his well-being as over solicitous, which reinforced his feelings of frustration and made him angry. Unfortunately she became the target of his anger, which left her feeling hurt and confused.

So he's, so he is sometimes very angry with me. Yesterday he was (laughter) he was angry because I wouldn't go out and I keep on saying, if he goes for his walk, he will go for a walk and I would say, um... "Isn't it too cold outside for your walk? Isn't it too windy? Just now you get out of breath?" Or things like "don't go too far, you know, or don't walk too fast?" And that makes him, it makes him very angry because he is also angry because he wants to start jogging and he can't do it yet. And now on top of that I would say, ja [yes], but I think it's too windy; you can't walk too fast in this wind. You are going to get out of breath and you know... and when he becomes angry he doesn't... He will say things that I feel... okay it's, it shouldn't be said or whatever, or like when he say, ja [yes], you know, you... don't treat me like a child! What do think will... Then I would... start feeling hurt, but now why are you doing this, and I mean it is unnecessary to... I am just trying to help you... but I think I am not helping you, I don't know.
Um, so you feel hurt?
I feel hurt yes! I feel very hurt. P2: 217-235

The rest of the participants ensured that their husbands were allowed to feel a certain degree of autonomy so as not to delay the progress of their rehabilitation and to avoid creating conflict.

So had I treated him like an invalid, taken everything to him, taken his glass to him, given him his medicine, he would never have sort of stood on his feet and say, okay, I've got to take it myself. You know, I just feel you have got to do that to a person. P3: 91-94

Ja, no, there are times that I will say "look, don't overdo it" you know, you can do so much and that is all. But I think he knows in himself, I think every time he hits against something where his body says it's too much, he also, he feels that he can't for more than what he can, so he's just got to slow [down]. P4 672-678

He must do what he feels he's capable of doing, but if I see he's taking strain then I tell him to relax, you know, sit down, relax, it's no big deal, you know. But I will leave him until I see he's

taking strain. I don't nag him, or, you know, I am not sort of, like you know don't do this or don't do that, I'm not doing that, you know I just let him get on with what he's doing, sometimes I just say no, you're not going to do that, it's just too strenuous. P5: 204-215

The manner in which the participants dealt with frustrations in their marital relationships was largely governed by the same need to protect their husbands from stress. Participant 2 chose not to be confrontational because she did not want to be responsible for creating stress for her husband. This non-confrontational stance left her feeling angry because she felt that it was unfair that she was unable to voice her displeasure or dissatisfaction about things that mattered to her. She verbalised to me that she did not "know how long it's going to last". I am not sure whether to interpret this as how long she would have to maintain this non-confrontational stance, or how long her marriage was going to last.

I sort of give in, because I must give in. You know, because as long as he's happy, it's okay... But I come second best, but then... I still get mad! You know, I don't discuss it but I still get really... you know why... then I think... ag, Josie you can't ask these questions. As long as he's happy it's okay. So I don't know how long it's going to last. P2: 625-630

Because I thought if we go to Tygervalley [Tygervalley Shopping Centre, 20 kilometres away] we could go to the movies as well, and when he said no, I sort of just accepted it, I don't question it because I also don't want him to get... if I question it and he get upset, you know, I don't want him to get upset. Because now you know if you get upset then you might just get sick, or whatever, so that is why I just leave it, and I feel that is not fair to where I am concerned in fact. P2: 589-594

Participant 5 voiced her frustrations in what she describes as an extremely verbal manner, even though she acknowledged that she was afraid of the negative effects that stress may have on her husband's health. She was able to recognise the potentially detrimental effects that not verbalising her frustrations may have on herself and their relationship.

I had to, I just... but I ended up almost screaming at him, you know. I said no, I have had enough now, I'm trying to placate you all the time, and I am not going to, you're not going to ride me. You know, so I had to shout at...I did, I shouted. P5: 153-155

It's nonsense, but he has got to learn that I'm not going to stand for this, so I think he was quite shocked when I shouted at him. (Laughter) I had to. You know. It was like, ridiculous. It was fine, it cleared the air and that, and I think, I think you have got to speak your mind, when you have to, you know. Otherwise it builds up inside you and then it becomes a like resentment or something, you know. P5: 785-810

So you still speak and say what you want to say if you need to say something.
Oh no, I don't feel like I'm going to give him a heart attack by shouting at him or something... (Laughter). P5: 329-332

The participants took it upon themselves to act as protective shields between stressors and their husbands, sometimes to the detriment of themselves, but always with the same purpose; to shield their husbands from the risks which they believed caused the initial myocardial infarction and that could cause another.

Theme: Life changes

After a myocardial infarction the patient's modifiable risk factors must be identified and addressed so that lifestyle changes can be made to reduce the risk of another myocardial infarction. This involves an understanding of the risk factors, often requiring a complete change in the way that a family conducts their day-to-day activities of living, supported by a belief in the importance of instituting these changes.

As discussed in the theme "Being a protective shield" the participants in the current study seemed to have a good understanding of the role that nonmodifiable and modifiable risk factors play in coronary artery disease.

> I know he... know now that his heart attack was caused by his bad genes that he... is in his family, he was a heavy smoker and that's the two factors that...[caused his heart attack]. P2: 236-238

> You know because all those little things are things that cause heart attacks anyway, you know, stress and all that things, bad eating habits and not exercising. P3: 258-260

They felt that it was necessary and important to take action and institute the lifestyle changes required after a myocardial infarction. In particular participants 3, 4 and 5 believed that compliance with these changes would reduce the risk of another myocardial infarction and get their husbands "back to normal" health.

> I knew we had to lead a more healthy life style, where his eating habits and that were concerned. P2: 504-506

> I said to him if you eat properly and you do what you have got to do then it will be something of the past to you. You know, you have just got to do what, go according to, you know eating and walking habits and exercising and things like that so... So that will set him straight. P3: 65-71

> I'm positive that as long as he leads a good lifestyle we won't have a repeat of it [myocardial infarction]. P4: 549-550

> Okay, but if you live sensibly and just take things a day at a time, you're going to get stronger and you're going to...it's going to be, he'll be back to normal and in fact, like John feels that maybe he'll be fitter than he was before. P5: 629-635

The participants took responsibility for ensuring the introduction of and compliance with new approaches and patterns of behaviour with regards to lifestyle. They ensured that their husbands converted to a healthier lifestyle by checking up on them, planning their exercise programmes and ensuring that they ate the correct diet.

> You know, and I was... like his medication, it is important. Now suddenly he had to have breakfast which you know normally I... he would say no he don't want breakfast you know, but now I... I insisted he must have his breakfast. P2: 88-91

> **You feel that you have got to check up.**
> I have got to do that, yes. I just feel it's important to know that he is doing what he is supposed to do. P3: 731-732

> And what we would do was try to get him to try and do exercises because he wasn't used to walking or he wasn't used to losing weight so quickly so he had to get used to that kind of thing, so you know, um getting him into some kind of system of running, walking or getting his things organized. P3: 24-27

> And during that week that he was at home we only, I think we only started, doing, going to gym and doing things like that about 2 weeks later. But what we were doing the first week was going out for walks and gradually building up a little bit of fitness for him. P4: 27-30

When it came to exercise some of the participants were particularly cautious. They tended to monitor the intensity at which their husbands exercised and would intervene when they perceived that he was overexerting himself and likely to do harm. The participants also seemed to be unsure of what his exercise capabilities should be at that particular stage of convalescence and felt that they needed more information about that.

> I keep on saying, if he goes for his walk, he will go for a walk and I would say, um... Isn't it too cold outside for your walk? Isn't it too windy? Just now you get out of breath? Or things like don't go too far, you know, or don't walk too fast. P2: 218-221

> I would see him suddenly sort of speed up his exercise and I would say "what are you trying to do?" and he would say no, no, I'm just trying... and his heart rate would go right up and I would say "just calm down, you don't have to do that now, there's time for that". P4: 637-640

> So, there was a little bit of holding him in as well, you know, holding him back and saying, listen, this is... you must listen to your body and only cope with what you can, you know. P4: 644-645

> I just let him get on with what he's doing, sometimes I just say no, you're not going to do that, it's just too strenuous. P5: 214-215

> Sometimes when I know he is overdoing things, you know, then I sort of like watch him. P5: 84-85

> Ja, ja [yes, yes] I would like to know where he's supposed to be now you know, physically you know. I don't know, I don't know where he's supposed to be now. P5: 373-377

Compliant husbands who "toed the line" made the participants' task of managing the lifestyle changes that much easier. Participants 4 and 5 described their husbands as being compliant. Their compliance with making the required lifestyle changes meant that there was none of the conflict that may have resulted had the participants needed to use force to make them comply. This gave the participants some peace of mind, since they knew that he was doing something positive towards reducing his risk factors and therefore his chances of having another myocardial infarction.

> You know he, I think also if they listen. He wasn't, I didn't have to keep on sort of making sure that he did what he was told, he has been very sensible about it. And I think because of that it's been a help because he has toed the line as well, he's not, he hasn't complained about... not that we've changed our diet radically but if I sort of said to him, you know you must eat this, you know he doesn't complain, he's just cut back on what he has to when eating in the cafeteria and he's listening, you know. Which makes it easier, you're not fighting with somebody who does not want to be doing what they're told to do, you know, so all in all it has been fine. P4: 110-127

> And maybe if your husband doesn't do what they are supposed to do and they don't change their ways, then maybe that makes it worse, but if they carry on smoking or you know things like that then you think, well it could happen again anytime, then it must be difficult, you know. P4: 555-558

In contrast participant 3 could not rely on her husband to voluntarily comply with the required lifestyle changes and he ignored her requests to do so. She describes her efforts to ensure that he complied as a "burden" and felt that it was because she was female that he ignored her requests to comply. When she enlisted the help of a male family member her husband immediately complied, easing her burden and sparing her from a stressful situation.

> I told him 5 times, I think you have got to walk now, and he said later, he told me later on, don't worry, later! (Laughter) His uncle came home and his uncle said to me, "Did you walk today?" And then he took him for a walk, you see, he wouldn't have listened to me. P3: 937-940

> I mean they eased my burden, one time, you know. Because I am sure I would have strained and stressed, trying to get him to do things he should do, what doctor said he has got to do, you know, so coming I mean coming from a man telling him, gee whiz you've got to walk, you know, you've got to this and you've got to do that and, you know. P3: 916-920

Participant 2 also describes the frustration and anxiety her husbands non-compliance had caused her.

> I say in the one sense my husband gets upset with me... he gets angry with me because I treat him like a child but then in the other sense he doesn't want... he is just not interested to get to know his, you know his medication, he doesn't know what kind of medication he is on. He doesn't... he expects me to sort of remember those things, remember that... that's the name of your medication. And he says as long as I remember, that it's okay, but I feel that I am not with him 24 hours a day now, that he is back at work, I'm back at work, so um... I mean I feel that is not

> right. Anything can happen to him and you know, he must be rushed to hospital, or to a doctor or whatever, and he won't know what medication he is on because he does not carry it with him. P2: 327-337

As the wives had anticipated, their lives changed after their husbands' myocardial infarction as they incorporated the lifestyle changes required of cardiac families into their daily living. However, participants 2 and 5 were totally unprepared for the way their social lives changed, to such an extent that they could no longer describe their lives as "normal".

> I knew...when my husband was in hospital, I knew that I, we... I had to change sort of my lifestyle, but you know, I didn't think that... that it would affect me in the way that I knew we had to lead a more healthy lifestyle, where his eating habits and that were concerned, but I didn't think it would change my lifestyle, you know, from normal activities I would say, like relaxation and that type of thing. P2: 501-507

Participant 2's husband developed his myocardial infarction while driving and this made her afraid to travel in a car with him. As a result of this fear the participant and her husband no longer enjoyed the leisure time activities they shared before the myocardial infarction such as going shopping and taking long drives together.

> He would say come, we go somewhere, we go for a drive and... but because of, of, of him nearly having the heart attack on the road, I say ag no, I don't feel like it. But it is not that I don't feel like it, it's because I sort of fear to be on the road with him. P2: 195-199

To further complicate matters her husband did not know what food choices he should make when eating in a restaurant. She had to decide what he should order which made him very angry and vow never to eat in restaurant again. Thus their leisure time activities were further curtailed.

> He didn't know what to order at the restaurant and I had to like order for him, you know, and that made him so angry that when he came out he was so mad, he said he said he will never ever put his foot in a restaurant again! P2: 527-530

> It is not normal for us. It is not normal for me! It is not my normal life, you know. And um... Are we going to go back to a normal life? P2: 560-561

Usually participant 5 kept busy, rushing around and getting things done, but since her husband's myocardial infarction she felt she had to slow her pace down in order to get him to rest and relax. The way in which they would conduct their business lives as informal traders also changed and his physical condition now determined whether they would do business on a particular day or not. This participant also describes her life as not being the "normal" life she was accustomed to before her husband's myocardial infarction.

I am, I am a person who has always got to be doing things, you know I can't really sit around and... if I must relax then I will be reading or doing a crossword puzzle or and I have to force him to rest so I just say well let's go lie down, you know, and we go and lie down and just... and the next minute he will be sleeping, you know, which was good. P5: 40-44

No, not back to normal.
What is normal?
Rushing around (laughter).
So taking ...being laid back is not ... is still not normal.
No, it's not normal. P5: 639-647

You see, we're informal traders. You know, we sort of do our art and we trade it to the markets. And we used to trade quite regularly now we're just, if I look and see he's really taken, he's tired or I say let's not go today, and he's quite happy to say okay, let's not go, you know, where before he would say no, we are going, you know. So we're not trading as much as we used to, but it's not really worrying me. P5: 431-445

Following a myocardial infarction the patient and his family may see the lifestyle changes they are required to make as a "life sentence". Participant 4 describes how different doctors' approaches can influence the way in which lifestyle changes are viewed and dealt with. The couple saw two cardiologists; one had an extremely "rigid" approach and the other a more relaxed approach to making lifestyle changes. The more relaxed approach allowed them to feel as though life was still "normal" and fun, despite the changes they had to make.

He's a super guy. He's at BBB [hospital]. But so much more laid back than Dr XXX, you know he's very rigid and everything must be... This guy was, he said to Geoff you know obviously you must watch your diet and, if you want the odd steak, have one, just cut the fat off but you mustn't take the fun out of life. And I think maybe also his comment helped. Because I think that if we had only listened to Dr XXX we might have sort of felt, well this is now it, you know, life is going to be very different from now on, but I think he added that little touch of being normal. P4: 949-963

There must be a little bit of leeway and that's why I think with Dr SSS, he's allowing a bit of leeway here and there. It makes you sort of think, well it's not a sentence for life, you know, we can actually still...
Still live.
Yes, of course, so that I think maybe gave us that little bit of extra encouragement. P4: 991-1000

In the theme "Causal explanations for the myocardial infarction " participants 3, 4 and 5 cite their husbands' exposure to and inability to cope with stress as being the main cause of his myocardial infarction. It was not surprising to find that the lifestyle change of particular management importance to all the participants was that of their husbands' ability to deal with stress.

He stresses easily, you know, that is something he's got to work on as a person. P3: 236-240

And I have said to him, the biggest thing is to learn to cope with stress because he knows that whenever he gets upset or something, like if you have got somebody on the phone that is hassling him or one of the children upset him about something, and that's what happens, I said "you've got to learn to control your stress" you know, I said you can't stop being stressed, because that's him, but it's how you cope with it. You have got to either learn to walk away and go and have some deep breaths or go for a... you know, do something, to cope with it. P4: 573-581

So I'm trying to make him less stressful or conscious of how stressful he sometimes is. P5: 115

The other lifestyle change of importance to the participants was that of diet which involved ensuring that their husbands had three balanced meals a day, that they cooked correctly and that he did not eat foods that were harmful to his health.

Now suddenly he had to have breakfast which you know normally I... he would say no he don't want breakfast you know, but now I... I insisted he must have his breakfast. P2: 89-91

I mean the only thing he has to do now is eat properly, and I'll try to fix his diet accordingly. P3: 55-56

Cook well, that is your main concern?
That is my main...I have got to do the things, you know, but then get a kind of diet sheet, that is important to know exactly what kind of food, you know. P3: 801-804

Not that we've changed our diet radically but if I sort of said to him, you know you must eat this, you know he doesn't complain, he's just cut back on what he has to when eating in the cafeteria and he's listening, you know. P4: 120-122

I basically kept the same and watch what we eat, but he doesn't have a cholesterol problem, we have always eaten healthily. P5: 58-63

One might think that it is only the patient who is affected by these life changes but from the findings it becomes clear that the participants' lives are also affected, in some cases negatively. Despite this, the participant becomes the manager of and driving force behind these life changes because in doing so she believes that she can positively influence her husband's quality and quantity of life and this is what motivates her.

So it's things like that you've got to sort of work on, you know, find another way of working with your life and so on, and so on. P3: 256-257

Theme: Facets of the relationship change

It emerged from the data that certain facets of the participants' marital relationships were influenced post myocardial infarction, these were: issues surrounding sexual intercourse, communication between the couple and the intimacy of the relationship.

Participants 2, 3 and 4 discussed sexual issues during the interview. Participant 4 felt that sex, and being able to perform adequately sexually, was important for her husband and their relationship, following the myocardial infarction.

> I think with a man, I think he almost feels that he must prove that it's okay and that he can still carry on with that [sex]. P4: 915-916

> And I mean he was wanting to make love that first week home, he wanted to sort of make sure everything was okay, and I think that once we got over that hurdle, of sort of just doing things, taking it calmly that he realised that it was okay and everything was still functioning (laughter), it also helped him and maybe also helped our relationship, that we tried that early, you know and didn't leave it. P4: 921-929

There was a perception amongst the participants 3 and 4 that sexual intercourse was physically strenuous and a fear that it could possibly damage their husbands' hearts.

> Is this guy going to die on me or his heart, you know, how, how, how is his heart, I mean can he take the kind of strain that, you know, you have during intercourse and so on. P3: 407-408

> And it was a concern for me, was he, was he not going to overdo it [during sex] and cause some damage by doing this. P4: 939-940

The participants 3 and 4 did not initiate the resumption of sexual relations but rather waited until their husbands felt ready to resume them, possibly due to fear and uncertainty about the effects sexual activity may have on the heart.

> So I thought, okay if he feels he wants to have it I will allow it, you know, if he feel he don't want it I will just leave it. P3: 408-410

> I wasn't sort of making him hold back and saying no, no, don't, wait until you're better, wait until you're better. P4: 921-932

His ability to perform successfully sexually was seen as the achievement of a milestone by the participants and an indication that he was regaining his strength and on the road to recovery.

> And I mean, to me, when you know, when he had his first um, when he felt like that, after that I thought okay now, you know you're getting there. P3: 411-413

> And I think that once we got over that hurdle, of sort of just doing things, taking it calmly that he realised that it was okay and everything was still functioning. P4: 921-923

Participant 2 describes how her husband experienced erectile difficulties and as a result, at the time of the interview, they had not attempted sexual intercourse again, presumably due to a reluctance that this may reoccur. The participant describes sexual relations with her husband as being no longer "normal" following his myocardial infarction, suggesting that there were no pre-existing problems in their sexual relationship.

> Where I would say we tried it since he was discharged once, and yes it was all right but um... It wasn't, I don't think he was, it was a bit difficult for him because I think he...he couldn't, it is probably, I don't think he could get an erection easily, and that was I think... it worried him, it was on his mind, you know, but um... I don't know if that is normal? P2: 760-764

> It... it... it... it's not as normal as it used to be you know. P2: 786-787

She saw this as a problem for her husband rather than for herself, recognizing the importance that being able to perform successfully sexually held for him. She was concerned about the anxiety that his impotence was causing him. She felt that the problem stemmed from a lack of knowledge and put the blame squarely on the shoulders of the medical profession. She believed that had they been instructed and reassured regarding sexual matters before discharge the problem may never have arisen. The couple did not feel comfortable enough about the situation to discuss it between themselves, so neither had the opportunity to verbalize fears and concerns, but chose rather to abstain from sex, with possible detrimental effects on their relationship.

> I'm getting worried, you know, is it, okay, because those are things and I sort of think we should have been discussed at, we should have discussed that with the doctor or with a sister or whatever... is it okay for him at, or at what stage is it okay. P2: 756-759

> It is not a problem for me but I think with my husband it will probably be a problem. He hasn't discussed it with me though and... but... um, yes I feel that... If it affected him, if the heart attack affected that part, you know, then, you know, that's things that should have been... I say it is better to be forewarned. P2: 773-778

Issues surrounding communication, both verbal and non-verbal, between the participants and their husbands seemed to be very important following a myocardial infarction. Participant 3 describes how her husband was not very good at communication and the problems this posed following his myocardial infarction. She describes how she would worry about him as she could sense he was troubled and anxious, but found it difficult to comfort him, as he would not discuss

his feelings with her. She reports however that her husband did discuss his fears and anxieties with a family member, so it would seem that he did have a need to talk to someone, but in this case did not choose his life partner.

> He doesn't talk easily. I mean he doesn't say this is wrong and, you know, I mean, I won't get information. P3: 309-310

> But he still does not let out easily what is on his mind, you know. He does not let it, I mean I can see, I can see when he is troubled about, I am sure he worries about having another attack or something like that, you know. P3: 317-320

> But the thing is like when his aunt was there he spoke to her and he would say, like, he is worried about me, you see, and she told me that. He doesn't say anything, you know.
> **He doesn't tell you.**
> No. He doesn't say but he told her that. He told her that he is worried, you know, about us and worried about us being alone and things like that. P3: 348-354

Participant 3 overcomes this verbal communication problem by using non-verbal techniques to communicate with her husband, which she found to be an effective substitute.

> You know, you know like a squeeze from behind or that kind of thing. And you can feel the tension leaving, or head rub, or you know, that kind of thing, so it does help, you don't, I mean if people are not verbally inclined there is other ways of easing the tension. P3: 402-404

> **You don't communicate verbally much but your non-verbal communication is much more important.**
> Yes. P3: 666-667

Participant 4 also describes how non-verbal communication played a role in providing reassurance and comfort for each other.

> All our marriage we have slept in a double bed but we don't touch at night. P4: 509-510

> But it is amazing how that since he's come back [from hospital], he will always like touch me with his foot or you know, he wants to know that I'm there all the time, you know, so it has definitely made a difference. P4: 516-518

Participant 4 describes how she experienced a new closeness in her relationship with her husband after his myocardial infarction. She attributes this to what she describes as a "near death experience" that brought her face to face with the fact that his life span is governed by nature's time limits which can be imposed suddenly and with little warning. She says that having to contemplate a life without him has made her more appreciative of him and has had a positive effect on their relationship.

Um, I think that it changed both of us, we're both looking at life very differently as a result of it, I think that you, you have been through a sort of near death experience if you can call it that, and suddenly I think you realise that you are not going to be here forever and, you know, you have got to sort of cope with that kind of thing. P4: 456-459

I mean you think you take each other so for granted when you are married, we have been married for 25 years, so when you have been married for a long time you actually, you know, the other person is always there, you know, and I think you wake up to the fact that, you know, they are not always going to be there and he nearly didn't... and you sort of think about what could have happened if he wasn't, you know, if something had gone wrong, how would I have cope with it all? So it does make you think a bit, it makes you more appreciative of everything around you and of your partner as well, you know. P4: 485-495

So it has had a positive affect on the relationship?
Definitely, ja [yes], I think it has had a very positive effect. P4: 501-503

Thus it would seem that following the myocardial infarction the participants viewed their husbands' ability to perform successfully sexually as an achievement or a milestone. Fear made some participants feel cautious about initiating sexual intercourse and a lack of knowledge prevented one couple from successfully resuming intercourse. Communication between the couple, both verbal and non-verbal, assumes a new significance as concerns, needs and reassurance are conveyed by these means. Due to the nature of their husbands' illness the participants begin to contemplate their husbands' mortality and a life without them. This seems to make them more appreciative of him and a new closeness develops in their relationship.

Theme: Meeting additional role responsibilities.

Approximately 5 days after a myocardial infarction the patient goes home in the care of a significant other, in the current study that person was his wife. Not withstanding the fact that the participant is a layperson with no health training she was given the responsibility of caring for her husband, who has a life threatening disease. Over and above the participants' usual daily roles of wife, housewife, mother and professional, she now has another role to perform, that of caring for her convalescing husband which has its own responsibilities that have to be met.

Because I mean me being the wife and having the kids to see to as well, I don't always have the time to go, you know taking an hour's walk [with her husband], because they are at home and I got to see that things go right for them. P3: 134-136

Following the myocardial infarction the participants felt that any unnecessary stress would be harmful to their husbands' health and for this reason they began meeting responsibilities that were traditionally his thus adding further to their day-to-day role responsibilities.

> I mean I have been dealing with the car people now for the past 2 months, you know, I would never let the guy phone him. You know. P3: 593-595

> I shield him from all that, those little things, I mean I would never, you know, I try and avoid [him being exposed to] all those little attacks from people that we owe money to. P3: 599-600

> Ja [yes], obviously, obviously as a mother you're keeping a business [her husband's business] going, plus you are having to make sure that the family still runs and the home still gets seen to, you know, as far as cooking and cleaning and all that. P4: 47-49

Two months following the myocardial infarction Participant 5 reported that her husband had resumed some responsibility for household chores, but not quite to the same extent as before the myocardial infarction. This means that for that time his neglected household chores become her responsibility.

> Ja [yes], I mean he still like, we always do housework together, you know like when we clean the flat, we work together and he still helps, you know. Well his first weeks... but I mean he's almost back to doing exactly what he was doing before his heart attack but um... ja [yes], no, we're still doing things together, we always have. P5: 705-711

Participant 4 perceived the time that her husband was in hospital to be more stressful than when he was at home because of the extra demands that hospital visits placed on her daily routine.

> And I think maybe in a way when they come home it is a little bit less stressful than when they are in hospital because you are not having to run backwards and forwards for the meetings and things like that as well, so that part...the stress was slightly less, I think, when he came home. P4: 607-610

She suggests that in order to cope during the convalescent period women need to maintain a "normal life". She found that fulfilling her day-to-day role demands provided a welcome distraction preventing her from dwelling on issues surrounding her husband's illness.

> "Life's got to go on, and as long as you carry on with what you're doing then you cope with what's happening, you know, sort of I couldn't stop what the children had to do, everything just carried on, so as long as you're dealing with that you have got so much going on that you haven't really got time to sit and worry about things, to stew about it and think, is everything going to be alright. I think that helps you to cope as well because...
> **It takes your mind off it?**
> Ja [yes], I think so. P4: 800-809

Participant 4 acknowledged that having to meet her old and new role responsibilities was stressful, but that she only recognised that this was so once her husband began to resume some of his responsibilities. It would seem that until then she had been too preoccupied to notice.

> I think afterwards you start um, you feeling, you start feeling the stress a bit, and once he started getting back into work again and taking on more responsibility and I could start releasing some of it, then you start realising that you were under a bit of stress but at that time it wasn't a big problem, you know. P4: 53-57

It would seem that being the wife and primary care giver of a man who has survived his first myocardial infarction brings with it many new role responsibilities during the convalescent period. The demands of these responsibilities have to be met in addition to the demands of the role responsibilities they held prior to the myocardial infarction. The participants described their experience of this as positive yet at the same time as a negative, and one in which they had little choice. As one participant commented, "life's got to go on".

Theme: Living with fear

A myocardial infarction is a dramatic, life-threatening event, the culminating point in the development of coronary artery disease. It occurs with little or no warning and can be very frightening for both the patient and his wife. After the myocardial infarction the couple are faced with the knowledge that he has a chronic illness, the implications of which have to be managed for the rest of his life. One of the implications of coronary artery disease that the participants in this study were very aware of is that their husbands could have another myocardial infarction as suddenly as he had his first one, which he may not survive.

> And I would go to the shop once and get everything for the next day and that, because I wouldn't leave him! Because that fear was always like, you know, he might just have another heart attack and I am not there! P2: 92-103

> The heart is one of your main organs and you're gone if you have a major attack, you know, so that's the worst part, I mean you're here today and tomorrow you're gone if you have a major heart attack. P3: 183-185

At the time of the myocardial infarction each participant came face to face with the reality of ageing and mortality. When men and women take their marriage vows they promise to love until "death us do part", but never expect to have to face this reality whilst in the prime of their lives. They suddenly have to consider what life will be like without their partner.

> The thing happened so suddenly and it, I think it, I felt my husband was sick, very sick, because he could have, I... the way I looked at it and I thought about it and I read about it, he could have died, because there are a lot of people that die of mild heart attacks. P2: 651-655

> You know, I was sort of grateful for that, you know I mean to bring a kid up, a mother on my own, would have been tough. P3: 49-51

So you know, being the father in the house, I mean, it meant a lot to me that it didn't go that far and he can come out of it. P3: 54-55

We have been married for 25 years, so when you have been married for a long time you actually, you know, the other person is always there, you know, and I think you wake up to the fact that, you know, they are not always going to be there and he nearly didn't, and you sort of think about what could have happened if he wasn't, you know, if something had gone wrong, how would I have coped with it all? P4: 486-490

Unfortunately the death threat of coronary artery disease never goes away, but is ever present as these women are well aware. They live each day with this knowledge and the fear of losing him to another myocardial infarction.

The fear, it was like um... the fear was like, death! He is going to die. That was the fear. P2: 107-109

It's one of those things, it's there, it's a stigma, you know, it's going to be there, that he had this heart attack. P3: 178-179

Yes, it will always be there, you know. I know it's going to be there. I mean I know, there's nothing, it's not like they are going to do x-rays and say, you know, I don't know how bad it can get. P3: 204-20

Ja [yes], I'm quite scared, you know that it will happen again, and that I won't be able to revive him again. Ja [yes], that's probably the fear. P5: 250-255

That it might happen again?
Ja [yes]. Especially when he complains that he's got pains in his chest. P5: 257-259

It looks like you're still very upset by this whole experience.
Um, I'm fine, it's just when I think about it, it's quite nerve wracking. Um, ja, I'm fine. I just don't want it to happen again. P5: 279-285

This fear caused all the participants to become extremely vigilant. Their senses became honed as they analysed all the information they received from him, searching for warning signals of an impending myocardial infarction or activities that may induce one. Nothing escaped their senses, which seemed to operate on both a subconscious as well as a conscious level.

And this fear made me even wake up during the night and look at him and think, and even sometimes feel his chest... is he still breathing? P2: 114-116

And I never went out... I wouldn't go out on my own; I wouldn't, because I wouldn't leave him alone! I wouldn't even go down to the shop [next door] and I mean, you can see we that ... we have got a Superette here. I wouldn't... I would rather stay here in the house with him all day and wait until my son comes in the evening and then go to the shop, for whatever I needed. And I would go to the shop once and get everything for the next day and that, because I wouldn't leave

him! Because that fear was always like, you know, he might just have another heart attack and I am not there! P2: 92-103

I've just got to, just watch and check up and see if things are right. P3: 172-173

I would see him suddenly sort of speed up his exercise and I would say "what are you trying to do?" and he would say no, no, I'm just trying... and his heart rate would go right up and I would say "just calm down, you don't have to do that now, there's time for that". P4: 637-640

I don't know, I used to wake up in the middle of the night and feel his pulse. He's stopped snoring, because he's quite a hectic snorer and I think that used to worry me a bit um, because then he breathes very softly you know and I used to think is he breathing you know. Then I check his pulse. P5: 14-25

Sort of always vigilant?
Ja [yes], subconsciously. P5: 307-309

Since the death threat of coronary artery disease would always hang over them it was essential for the participants to find ways to live with the fear of loss since it was to become a part of their everyday lives. If they had not, the fear could have engulfed them in the way it did Participant 2 whose fear was so great that she developed physical symptoms and was forced to seek medical treatment.

And I used to get a lot of headaches, from the neck up right into my head, the back of my head. I used to get a lot of headaches. I used to get up in the morning with a headache, go to sleep at night with a headache and I just felt myself taking more and more tablets, like Panados [paracetamol tablets] all the time. And that is why the doctor prescribed something stronger than the Panados, but um... and I used to perspire all the time! I used to get so hot, you know, um... and I think that made me really go to the doctor and the doctor said no it is anxiety, especially that tearfulness, you know because I wanted to cry all the time and the least little thing sort of upset me. P2: 405-414

Participant 2 found that living with this constant fear influenced her personality to the extent that she reacted to people and situations in a completely differently way compared to before her husband's myocardial infarction.

That it would really take over part of me, you know, that I am living in this fear all the time. P2: 508-509

And I was very agitated. I was very short tempered with people. The phone rang too much and it worked on my nerves at work. People asked me too many questions and it worked on my nerves. I snapped at people that even asked... I snapped at them because of, of, of what was going on inside of me! P2: 716-724

Participants 3, 4 and 5 believed that by implementing the lifestyle changes that are required by the patient and the family following a myocardial infarction, in respect of risk factors,

they could prevent the reoccurrence of a myocardial infarction. An extremely positive attitude was noticed amongst these three participants.

> I'll be positive about the whole thing. I am not going to sit and think gee whiz when is he going to get another one and, you know, that kind of thing. P3: 171-172

> So I mean I have just got to see that things go smoothly in the house, you know.
> **What do you mean by "see that things go smoothly"?**
> With us now, all of us now you know, see that he does things properly, we as a family do things the way it should be done, you know, the eating habits and the exercising and check ups and things like that. So that's important, I feel it must be done that way, you know. P3: 216-227

> I think that hopefully, maybe I'm being naïve there as well (laughter), but I feel positive about it, I feel as long as he keeps doing what he should be doing and we sort of try and keep him healthy I don't think it should happen again. P4: 647-649

> I do believe he's going to be his old self within a short time, you know, I do believe he's going to get better, you know. I really do believe that, you know. As long as he doesn't do stupid things. P5: 406-415

The participants seem to live from day to day with the knowledge that their husbands run the risk of having another myocardial infarction with potentially fatal consequences; this knowledge causes a vigilance born from the fear of losing him. A firm belief in a healthy lifestyle gives them the hope they need to sustain them from day to day.

Theme: Drawing from the support fund

Social support and spiritual support, and by this I refer to the Christian faith, emerged as an important theme from the experiences of the participants. Social support is defined by Thoits (1995: 64) as "a coping resource – in this case, a social "fund" from which people may draw when handling stressors". Cohen and Wills (1985: 313) identified and defined 4 types of support. These are: emotional, instrumental and informational support, as well as social companionship. The participants in this study received emotional and instrumental support, informational support however was found to be lacking in some cases. The support that was available to the participant can be compared to a fund which provided the participants with peace of mind knowing it was accessible and provided great assistance to them when they drew from it.

The support fund consisted of family members, especially adult children, friends and work colleagues who provided the participants with invaluable assistance and support.

> My mother-in-law and all my family around me to help me out, you know. P3: 15-16

> I mean because my children are older they helped, they were very helpful and very supportive. P4: 262-263

> But otherwise my family were supportive as well, my kids were very supportive of the whole thing, you know, they all helped incredibly. P4: 610-611

From some of the descriptions it seemed that it was not necessarily received support that was important to the participants, but rather perceived support. Participant 3's perception that support from her neighbours and friends was available if required appeared to be a source of comfort and reassurance to her.

> It is nice to know there are neighbours and friends and things, around. P3: 151-152

Participants 4 and 5 reported that their faith in God was a powerful source of support and felt that the situation was under His control.

> I mean, you know you've got to believe in God because things worked out perfectly, you know. Everything just worked out. P3: 543-544

> Um... I think my one thing is that I know God has got everything in control, you know, I think that's been a big help. And... well
> **So faith is your support?**
> Oh, vitally ja [yes].
> **Ja, ja** [yes, yes]
> No, I mean very much so. P5: 445-455

The participants' support fund provided emotional support for them by providing them with opportunities to talk about how they were feeling and by showing concern for their well-being.

> My human resource manager at work, she was a social worker so... I had a chat, she asked me once come sit with me... just tell me how's things going and... you know, I think, I think I had a chance also to speak what I was actually feeling. P2: 182-185

> So that was a great help having so many people around me that was considerate and, and helped me out, you know, in the time that he was like that. I think if there weren't people around me I would have moped about it and, you know sort of felt sorry. P3: 37-40.

> And also, also just the support of friends and family as well, with what you're going through, you know, that they keep phoning and say "How things going?" and "Are you okay?" "are the children okay ?" you know "Is everybody coping?". P4: 248-251
> Lot of friends showed a lot of concern, and that as well. Ja [yes], a lot of... you're surprised at how many friends you actually have, you know. P5: 507-508

The support fund provided the participants with instrumental support by helping them with practical matters like cooking meals and providing transport to the hospital. The participants

found this kind of support particularly useful because it provided solutions to practical problems and took care of some of their tasks so that they had more time to devote to other role responsibilities.

> The only thing was that I was not really independent because I don't drive, and I had to sort of find my way to work and find the kids... you know. So my next-door neighbour was good and they offered to bring me to work and take the children to school, and that kind of thing. P3: 152-155
>
> One of them brought everything, from the supper with the pudding and the whole lot (laughter), you know, all prepared and cooked and ready just to be eaten. Which is, that's a great help, I mean it's the cooking and that is part of what you do every day anyway, but when you're busy and you're tired and you've had a busy day as well, and then you have got to try and cope with that on top, you know, it is not easy, so that definitely helped a lot. P4: 243-248

Generally informational support was one area that was found to be seriously lacking in the current study and is discussed fully in the theme "The need for knowledge". Participant 3, however, was fortunate enough to have access to informational support from family members who themselves had coronary artery disease. The result was that her need for knowledge was met most of the time with experiential advice and guidance from laypersons and this proved to be invaluable for her.

> I mean, his parents were there, my father was there every day, you know, bringing him books on heart ailments and heart attacks and videos and things, you know, having somebody else encouraging him that had the same problem. P3: 142-145
>
> And of course being, having the people around him, who experienced something, you know, the uncle, so that was good for him, you know, having somebody that went through exactly the same kind of fear, the same kind of allergies on the body, you know. P3: 335-3380
>
> We know much more about heart attacks now than I ever knew in my whole life. P3: 457-458

The support received by the participants had a positive influence on their experiences during the convalescent period. They found it reassuring to know that there were people who cared and to whom they could turn before they became overwhelmed by the burden of having to cope with the stressors of this period.

> It is good to know that you can turn to somebody and that the burden of this whole thing isn't on you alone, you know. That was the nicest part. P3: 163-165
>
> It is nice, nice to know that there are people around you as well that care, you know. P3: 988-989
>
> They came round all the time and kept on making sure everything was alright, and visiting, and just sort of making sure that we were coping at home. P4: 717-718

Participant 2 describes the opportunity she had to talk to another woman who had been through the same experience that she was currently undergoing. This woman had already lived through the experience and could therefore identify with the participant in a unique way and provide her with the reassurance that the way she in which she was reacting and feeling was valid and expected. After the participant experienced this empathetic understanding she felt a lot calmer and able to cope.

> She said, don't worry; I went through exactly the same thing. P2: 486-487
>
> And this was the most wonderful thing to me, you know, that there was somebody there that, that know what I was going through. And they could tell me, okay, it's okay, you know, and to me that was so wonderful and I think after that I started calming down, because she said it's okay, it's natural, you are going to feel this, you are going to feel that, and so it's okay. P2: 725-730

Participant 4 got the opportunity to compare her husband's progress with someone else that had also suffered a myocardial infarction and felt that it was a positive experience.

> **It sounds like it was useful to compare your husband's recuperation to someone else's, it sounds like it has had...**
> I think a positive...
> **A positive effect?**
> I think it does. P4: 329-336

It seems that being able to make comparisons makes it easier for the participant to judge whether her husband is convalescing in the same way as a similar patient, lagging behind or perhaps overdoing it.

> So I don't know, you know, I haven't got anybody to compare with. It's hard. I don't know how much activity he should actually be doing you know. P5: 532-540

Participant 4 describes experiencing a feeling of deep loneliness when she had to leave her husband in the critical care unit for the first time after his myocardial infarction, a time when emotional support was really needed, but was sadly lacking.

> It was one of the things I often found, when you walk away from here, after visiting, then you're by yourself and there is nobody out there, you know, you sort of feel very alone, and those times, especially the day that I left him here [at the hospital] the first time, when he came into ICU [intensive care unit], and I walked away [went home] And I actually said, you know there should be people here, just to come and see that you're alright, and sort of see you out, almost like a buddy system where somebody can just come to you say, look here, I know what you've gone through and I feel for you, and don't worry, but I walked away from here very alone and... but I mean I suppose that is part of it. P4: 718-726

It is a terrible feeling just to walk away. P4: 747

Not all the emotional support that the participants received was appreciated. Participant 4 and 5 commented that they were inundated with telephonic enquiries from concerned friends and family and although these calls were initially appreciated they eventually became a source of stress and irritation to them.

That was also part of it a lot of people making enquiries, I found that was a bit stressful. To have a lot of people phoning and saying, you know, oh I just heard about Geoff, is he all right? And you have got to go through the whole thing again. I mean, you can't deny the people because they are showing concern so you tell them each the same story. I mean, he got to eventually take over, they started phoning him... (Laughter) and finding out from him... (Laughter), I think he also got tired of it in the end, you know, in the beginning it is a novelty but then afterwards it starts becoming irritating. P4: 870-888

A lot of phone calls from people. P5: 507

The value of the support fund and the emotional, instrumental and informational support it provides is not to be underestimated. It would seem that support enables the participants to cope with the experience rather than be overwhelmed, as the following descriptions from participants 3 and 4 illustrate.

The support was very important I mean, for any woman I can tell you if there is, if they have got family around then it is good support. P3: 162-163

I can guarantee that had I not had people around it would have been very different. P3: 906

I think the support from people around you is amazing, it's incredible, I think if you don't have that then you... it would be very difficult to cope. I've got all, my family are here and friends are here, you know, and I think it makes it all so much easier when people rally around you, you know, you do tend to cope. P4: 699-702

Theme: Causal explanations for the myocardial infarction

All the participants in the study had a causal explanation for their husbands' myocardial infarction. Frequently risk factors such as hereditary factors, stress and smoking were named as causes.

Participants 3, 4 and 5 believed that their husbands' inability to manage stress was the cause of their myocardial infarction. They could all cite specific events that they believed were the precipitating stressors of the myocardial infarction, for example participant 3 blamed the stress created by organising and supervising building extensions to their home as the cause of her husband's myocardial infarction.

> He stresses easily, you know, that is something he's got to work on as a person. I mean, that was what sent him that way in any way, you know, because he's not somebody who takes things in his stride, he works himself up to a point that he sweats or he... you know, I mean us building at home that was one of the worst things. P3: 236-240

Participant 4's husband manages his own business. His myocardial infarction coincided with the end of the month, a time when certain activities typical to most businesses such as sending out accounts to clients and paying salaries, takes place. Participant 4 blamed the stress of these additional month end responsibilities for causing his myocardial infarction.

> Because part of which I think what brought on the heart attack was stress, and he is a worrier, he's that kind of person, he stresses all the time and um when it happened, it happened at a bad time for us in the business because it was month end when we're running our accounts, paying staff and having to do all sorts of bank transfers and things, and his biggest worry is whether the reps are performing, whether they are selling enough and whether the figures are good enough. P4: 131-136

Participant 5 felt that the in-laws were the cause of her husband's myocardial infarction. She describes her husband as a "stressful person" who assumed responsibility for solving his family's problems, which created unnecessary stress for him and precipitated his myocardial infarction.

> He is very um, very stressful person actually, always thinks he's responsible for everything and, I don't know he's just one of these...that's why he had the heart attack. I know. P5: 102-104

> And they [his family] would come to him with problems and I had to say, look, you're not doing this, you know, you're not bringing him your problems, that's why he had the heart attack in the first place. P5: 169-175

Participant 2 believed that her husband's genes and his excessive smoking caused his myocardial infarction. He has a strong familial history of coronary artery disease and the participant blamed her mother-in-law in particular for not telling them about this familial predisposition, saying that had they known they could have done something to prevent it.

> I know he... know now that his heart attack was caused to his bad genes that he... is in his family, he was a heavy smoker and that's the two factors that... P2: 236-238

> But I feel angry... because I didn't know that...that, that... my husband had such bad genes. And now, that... angry because I feel he's... his, his, his parents should have been more open and it could have perhaps been prevented. P2: 247-250

> She (her mother-in-law) never said a word until he had a heart attack, and she said oh, you know, I didn't want to worry you, but my brothers all died of heart attacks, and all under the age of 50.

That made me very, very angry because that is why I have got this anger that um... The XXX brother's are to blame. P2: 296-300

Participant 4 experienced feelings of guilt because she felt that perhaps her cooking was to blame for her husband's elevated cholesterol levels. She describes feeling a great sense of relief once she had established that her own cholesterol levels were normal.

One of my concerns was also his cholesterol level, it was maybe the way we were eating, and I went and had my cholesterol level checked as well and that, that was also a thing, now am I feeding you incorrectly, together we actually, the whole family had got a cholesterol problem, is it the way were are eating,? When I had mine checked and it was okay that actually made me feel better. P4: 1002-1007

I think in your own mind you sort of feel maybe I'm the guilty party, maybe I caused what's happened you know there was that sort of feeling, well what, is it something we're doing together, you know, as a family that's wrong, you know. I think... there was a feeling of... it was a relief to know this, that it was in fact. P4: 1020-1023

Participants 3 and 5 believed that their husbands had received prior warning that they were at risk for a myocardial infarction. Participant 3's husband was warned by a pharmacist and participant 5's husband, she believes, by God. Both participants felt that their husbands were to blame for their myocardial infarction since they failed to heed these warnings and take the necessary precautions.

So I mean you have actually got yourself to blame for the situation you're in. Um, that kind of situation, when you were aware, I mean, you know, when you were aware that there could have been something dangerously wrong with you and not taken precautions. P3: 269-272

Like I believe that God gave him a lot of warnings prior to it, but he ignored those warnings and there was no helping him because he ignored the warnings. A lot of people like say, you know, oh you have got to blame God, why did... you know... and I say no, I don't blame God, it's his own stupidity, you know. P5: 456-463

You know the warnings were there, you know.
But he ignored them
Ja, ja [yes, yes], but no, we bring everything upon ourselves. P5: 467-471

Each participant in the study felt that she knew exactly what had caused her husband's myocardial infarction. Participant 4 states that:

I think that you try to, we all try to find whose to blame for whatever happens. P4: 1021-122

It would seem that it is human nature to try to understand and explain that which affects people's lives and this is no different when illness occurs, people continue to seek understanding by finding causal explanations for disease states.

Theme: The need for knowledge

Due to the high cost of medical treatment and pressure from health care funders the patient's hospital stay is short. Patients who have had uncomplicated myocardial infarctions will be discharged from hospital approximately five to six days after the event, which somewhat limits the provision of adequate information and counselling to him and his wife. There is no cardiac rehabilitation programme available to patients and their families at the hospital at which the current study was conducted. Some patients are referred by their doctors to cardiac rehabilitation centres within Cape Town, but only a month after discharge and only once they have undergone a stress test. At these centres the main focus is on exercise and seldom includes the wife. Patients and their families need information about how to address modifiable risk factors so that they can prevent the reoccurrence of a myocardial infarction. They need information regarding symptom recognition and management and how to deal with emergencies. This is essential so that they can respond appropriately, thus decreasing the delay in getting to hospital and further damage to the myocardium. The patient and his wife also need information about how the dynamics of their personal and family relationships may change during the convalescent period so that they are adequately prepared for it. The need for knowledge emerged as a predominant theme in this study and was mostly unmet.

Most of the participants said that they had received no preparation or patient education from the medical or nursing professions on discharge, some did not even get an opportunity to talk to the doctor before their husbands were discharged.

> Not even on discharge did I... was it said to me, look, this is how... what you must do, that is how you must do it, please let your husband absolutely nothing, I mean, I could have... I didn't even see the doctor, when I got to the hospital my husband was waiting for me. He was discharged. P2: 668-672

The participants felt unprepared for the responsibility of caring for their husbands. Participant 2 compares this experience to that of a mother having to take care of her firstborn.

> There was nobody to share anything with, or to ask, or you know, it's like having a newborn baby, you don't know. P2: 692-693

During the convalescent period the participants have no access to sources of professional knowledge and assistance, which caused them to feel extremely isolated and abandoned. They could contact the critical care unit but this is not encouraged as the nurse who takes the call may not know the patient and give inappropriate advice, which may be detrimental to the patient, as well as expose the nurse to medico-legal risk.

> And there was just nobody that we could speak to, that we could ask, that we could, that could give us that support... or answers, or... you know to the questions and that type of thing and I just felt that um... very lonely! P2: 688-691

> And there was just nobody, but nobody that I could speak to. P2: 677-678

For most the only opportunity they had to seek information was at the follow up visit with the doctor. However this is usually a few weeks after discharge, which means that the participants have to resort to speculation, which could be to the detriment of the patient. For example when Participant 4's husband got chest pain again she was completely unprepared for it with no knowledge of how she should interpret it or manage it. Fortunately his chest pain was not of a sinister nature.

> I think when he came, he came out, on the Saturday he came home and on the Sunday evening he was lying in bed and saying that his chest was a bit sore. And not having been there before you don't know what... and I suddenly immediately thought now what is this, is this now the start of another heart attack or what are we doing here, you know. P4: 142-150

Participant 2 felt that the problems that she and her husband were experiencing with their sexual relationship stemmed from a lack of knowledge and she puts the blame squarely on the shoulders of the medical profession. She believes that had they been instructed and reassured regarding sexual matters before discharge they may not have found themselves in that situation.

> I'm getting worried, you know, is it [sexual activity], okay, because those are things and I sort of think should have been discussed at, we should have discussed that with the doctor or with a sister or whatever... is it [sexual activity] okay for him at, or at what stage is it [sexual activity] okay. P2: 756-759

> If it affected him, if the heart attack affected that part, you know, then, you know, that's a thing that should have been... I say it is better to be forewarned. P2: 775-778

Some of the participants had many unanswered questions, most of which could be categorized in two ways, those questions that had definitive answers, such as:

> Am I doing the right thing? Am I cooking the right food? Am I giving him the right...? P2: 87-88

> I sometimes think why is he on the tablets? P3: 362
>
> Ja, ja [yes, yes] I would like to know where he's supposed to be now you know, physically you know. I don't know, I don't know where he's supposed to be now. P5: 373-377

and those to which there could be no definite answer, such as:

> I mean... um... will my husband have another heart attack? Will he need open...? I mean like a bypass, you know those types of questions. P2: 321-323
>
> The normal pains like that, that you would have, but um, nobody said that would be a normal pain, so I must admit both of us that night were a bit anxious, and I did think, was it the start of something or is it, is it normal, you know? P4: 197-199
>
> I don't understand a lot of the things, like often he like rubs his chest as if he is still supposed to get pains. P5: 85-86

No matter which category these questions fell into each woman felt a real need to be able to talk to someone who could provide support, reassurance, guidance and knowledge. Some of the participants made attempts to contact their doctors telephonically to discuss their concerns but found that gaining telephonic access to them was very difficult. This may have been because the receptionist omitted to give the doctor the message or the doctor did not bother to return the call.

> And when I phoned the Monday, he was discharged on the Saturday, I phoned the Monday and I spoke to the receptionist and I said, look, can I speak to Dr ZZZ, I need to ask him things and she said I'm sorry doctor's already in theatre and I think that was about 7.30 in the morning, and he will be there the rest of the day. P2: 672-676
>
> You know now he still gets them [chest pains], in fact he phoned the other day and actually tried to speak to Dr XXX, just to say you know, is it normal for me to... every time I feel stressed that that I will start feeling a bit of tightening in the chest, you know, and he hasn't had an answer (laughter) from him as far as that goes (laughter). Well he actually said (to Dr XXX's secretary), I don't need to speak to him, if you can just ask him and then come back and tell me, that's all I need (laughter) and he hasn't had an answer back from her at all, so you know. P4: 173-185
>
> Well I had phoned and said if he could just phone and... so we could just talk, you know, because I was worried about these dizzy spells he was having, and um... anyway eventually we had an appointment and we went and saw him. P5: 357-359

The follow up appointment with the doctor would have been the participant's rightful opportunity to have her needs for reassurance and knowledge met, however this was not the case, as the doctor either glossed over their concerns or didn't communicate effectively.

> When he saw the doctor the first time after he was discharged, which was I think 3 – 4 weeks after he was discharged from hospital, that doctor was so swamped with work that he... okay yes, he didn't rush it, he didn't really have time to... he just said okay, that's normal, that's normal, that's... P2: 805-809

> Dr YYY. But he's not very communicative.
> **So Dr YYY is not very communicative?**
> No. You know you have got to sort of like... squeeze him for... [information]. P5: 352-356

The participants cited two reasons for not getting the knowledge and support they required from the nursing and medical professions. Firstly, participant 2 felt that nurses and doctors are too busy to do so.

> But everybody was too... I know, okay, I... am working as well so I know what it is like, outside, and the doctors and nurses are under a lot of pressure... but there was just nobody for me that I... that could answer the questions I had. P2: 702-705

Secondly participants 4 and 5 felt that nurses and doctors are so accustomed to treating patients who have had myocardial infarctions that they forget that this is a new experience for the lay person and that they need knowledge, support, reassurance and guidance.

> I think that the patient does tend to get a bit left out as far as this goes... I think people in the medical field know, you deal with it every day, it's routine for you, but the lay person doesn't, so you actually don't know what to expect or what to prepare for, you know. P4: 185-188

> Okay, I just feel that um, maybe they see too many patients. That they are so used to it that it's commonplace to them, that they don't know um, what to actually tell you. P5: 587-592

The layperson's need for knowledge and support and the value of providing it should not be underestimated by the health care team. It is essential for the care of the patient, the functioning of each individual as well as their relationship. As one participant describes:

> So yes I was really uncertain and um... and I think, correct me if I am wrong, but I think that it could... wasn't the uncertainty part of the fear? Because when you are uncertain about something, you fear that because you, if you know, knowledge makes you, like, very confident? And I think it was because I didn't have knowledge of, of what I am going into, that is why I was so anxious and so fearful and you know! So um... I think the more information I get the better it makes me feel. As a, as a person, as a wife. P2: 822-833

Chapter 4

CONCLUSION

It would seem that a myocardial infarction has an appreciable impact on the lives of the wives of myocardial infarction survivors during the convalescent period. All the participants underwent a series of psychological, social, relational and role adjustments aided by social support and hindered by a lack of knowledge. I began to feel that I had achieved the purpose of my journey.

Chapter Five: My findings in perspective

"All our progress is an unfolding, like the vegetable bud.
You have first an instinct, then an opinion, then a knowledge".
Ralph Waldo Emerson (1803-1882)

Ralph Waldo Emerson (1803-1882) said, "All our progress is an unfolding, like the vegetable bud. You have first an instinct, then an opinion, then a knowledge" (cited by Stevenson 1967: 1054). I had started my research journey with an instinct which as I had progressed had unfolded like a vegetable bud and burst forth into newfound knowledge. Following the thematic analysis I had a better understanding of the nature of the lived experiences of my participants. In the preceding chapter I have attempted to share this newfound knowledge through a process of writing and rewriting so that you may understand their experiences too. I then proceeded to read the discoveries chronicled by others who had journeyed along similar routes in an attempt to gain further insight into my findings from their understandings. This process gave new substance to my discoveries as I compared and contrasted their discoveries and understandings with those of my own, often finding answers to aspects which previously I could not explain.

I also thought further about the limitations of my journey, what research journeys I would recommend future travellers to take, and the implications of my discoveries for nursing and health care practice.

- This chapter includes:

  - A discussion of the findings and the related literature which is presented theme by theme
  - Limitations of the study
  - Recommendations for further research
  - Recommendations for nursing practice
  - Recommendations for nursing education

DISCUSSION OF FINDINGS AND RELATED LITERATURE

Being a protective shield

I found that the wives in the current study tried to protect their husbands from stressors either by concealing them, or by dealing with the stressors themselves, even if this meant that they bore an additional burden. These findings are supported by the literature (Mayou, Foster and Williamson 1978b: 450; Segev and Schlesinger 1981: 845; Schott and Badura 1988: 130; Marsden and Dracup 1991: 289). Excerpts from Marsden and Dracups' (1991: 289) sample illustrate this point: "I think that basically I don't burden him with problems that I might have.", "I have shielded him a lot..." and "Anything that I thought would upset him, I wouldn't bring up the subject". I found similar descriptions from the wives in the current study, for example participant 4

explains how she protected her husband by saying: "so you try and hide them, when there are problems try and solve them before it gets to him, but, because that was one of the biggest things, was not to let him stress out, you know". I believe that we have all done this sort of thing at some time or other in our lives. For example if our parents become ill we assume responsibility for their affairs and deal with issues without troubling them with the details, even if this means that an additional burden is placed on us, we do so anyway because we care.

Protecting their husbands often meant that the wives had to accept many new role responsibilities, some of which were traditionally his, for example, dealing with builders and creditors. Some husbands feel humiliated seeing their wives perform traditionally male tasks and frustrated when they are not performed properly (Mayou et al's 1978b: 450). I think it must have been equally difficult for the wives in my study to have to reverse roles after 20-30 years of marriage, but they did so anyway, in an attempt to protect their husbands from the stresses of his roles.

Some of the wives in the current study suppressed appropriate annoyance or anger towards their husbands because they were afraid that such action would provoke another myocardial infarction. Coyne and Smith (1991: 405) term this type of relationship-focused coping strategy as "protective buffering". Protective buffering can be defined as the practice of "hiding concerns, denying worries, and yielding to the partner to avoid disagreements". Coyne and Smith term the opposite of protective buffering, "active engagement", which they define as the practice of "involving the partner in discussions, inquiring how the partner feels and other constructive problem solving" (Coyne and Smith 1991: 405). The use of protective buffering by wives of myocardial infarction survivors in the convalescent period has been well documented (Wishnie, Hackett and Cassem 1971: 1294; Mayou et al 1978a: 699; Stern and Pascale 1979: 84; Seveg and Schlesinger 1981: 845; Nyamathi 1987: 90; Arefjord et al 1998: 1213; Stewart et al 2000: 1356). An internal conflict ensues between the wife's need to express herself and the need to ensure her husband's safety, which can result in frustration and disguised aggression (Seveg and Schlesinger 1981: 845). I would imagine that this could also lead to decreased communication and marital estrangement between the couple. It seemed that the wives in this study did not mind temporarily sidelining their needs in an attempt to protect their husbands' health. It could be argued that the wife is seeing to her needs by sacrificing in the short term, thereby ensuring a healthy partner in the long term. Arefjord et al's (1998: 1213) study does not support this supposition. They found that this kind of passive marital coping strategy, which Coyne and Smith (1991: 405) term protective buffering, had a high stability amongst their sample of wives at 10 year follow up. The authors (Arefjord et al's 1998: 1213) suggest that the use of this coping

strategy is "not limited to the specific illness situation" but reflects a more habitual personality trait in the couple before the myocardial infarction.

The wife's concerns regarding the negative effects that stress may have on her husband's health are well placed. After a myocardial infarction the patient may perceive certain emotional, behavioural and socio-cultural demands placed on him during the convalescent period as threatening and stressful. A United States physician Charles H. Mayo (1865-1939) said, "Worry affects circulation, the heart and the glands, the whole nervous system, and profoundly affects the heart. I have never known a man who died from overwork, but many who died from doubt" (cited by Daintith and Isaacs 1989: 191). Interviews with 2320 myocardial infarction survivors in America revealed that relatively high levels of stress post myocardial infarction made a significant contribution to the risk of death over a three year period (Ruberman, Weinblatt, Goldberg and Chaudhary 1984: 558).

It is well documented that wives can become overprotective towards their husbands following myocardial infarction (Wishnie et al 1971: 1294; Skelton and Dominian 1973: 101; Granger 1974: 606; Stern and Pascale 1979: 85; Johnson and Morse 1990: 131; Fiske, Coyne and Smith 1991: 14; Marsden and Dracup 1991: 288) and that this behaviour can last for up to a year after the myocardial infarction (Mayou et al 1978b: 450). Marsden and Dracup's (1991: 288) suggestions that overprotective behaviour may be a way of reducing the anxiety created by an unreliable future, or that it may occur as a result of female socialisation to the role of caring are valid. Fiske et al's (1991: 16) suggestion that it may be a response to the near threat and continuing threat of loss of a close and valued relationship is equally valid. Johnson and Morse (1990: 131) point out that a husband can only describe his wife's behaviour as overprotective when the perceived support outweighs his perceived needs. This means that the wife's behaviour will only be seen as overprotective if it is perceived as such by her husband. He could therefore either accuse her of being overprotective or unsympathetic, depending on his perception of the way in which she shows her concern.

The obvious question to ask is whether the wife's overprotective behaviour has beneficial or adverse effects for her husband? Riegel and Dracup (1992: 533) investigated whether overprotection could cause cardiac invalidism after a myocardial infarction and concluded that overprotection by family had a beneficial effect on the psychology of the patient and speeded up his recovery. It emerged however in Stewart et al's (2000: 1354) study that overprotective behaviour by the wife was a key stressor for the patient and as mentioned earlier, stress may have negative effects on the well-being of the patient. Clarke, Walker and Cuddy (1996: 376) investigated the role of perceived overprotectiveness in the recovery of 52 men three months post

myocardial infarction. Their findings showed that there was no correlation between perceived overprotectiveness and functional recovery of the cardiac patient. Their study did show however that those patients who perceived themselves to be overprotected by their wives reported more depression, anxiety and difficulties with quality of life and adaptation.

Johnson and Morse (1990: 131) investigated the process of adjustment that patients undergo after myocardial infarction. Descriptions were obtained from cardiac patients about how they felt as the recipients of overprotective behaviour. They describe feeling like "dolls" or "babies" who were being passively cared for with little consideration for their needs. They saw the overprotective behaviour as the family members' personal need to release their own anxiety and guilt and therefore accepted the overprotective behaviour as a gesture of support and understanding to them. Not all patients are as accepting when the wife fails to achieve the ideal balance between supportive and overprotective behaviour. Husbands can respond with anger and abuse in response to perceived overprotective behaviour; an occurrence which is vividly described by one of the participants in this study (see data clip P2: 217-235 on page 66). This finding is supported by reports from wives in Nyamathi's (1987: 91) sample. Wives who are already stressed from trying to deal with the consequences of the myocardial infarction are often left feeling hurt, angry, confused and resentful. This must surely have a detrimental impact on the wife's psychological well-being as well as on her marital relationship. Fortunately, it would seem that wives intuitively know that they should not allow their behaviour to be perceived as overprotective. 50% of the wives in Mayou et al's (1978b: 450) sample and 60% of the wives in Nyamathi's (1987: 91) sample, as well as most of the wives in the current study, protected their husbands, but in concealed ways. It would seem that the wife of a first time myocardial infarction survivor walks a tightrope each day knowing that a wrong move either way could have serious consequences for her, so she has to ensure that she gets the balance right.

Life changes

I found that all the wives in the current study were implementing the lifestyle changes required by their husbands to reduce risk factors. Almost two-thirds of the families in Dhooper's (1983: 28) study as well as all the wives in the current study reported that they had made permanent changes in their lifestyles due to their husbands' myocardial infarction, for example, diet control, exercise, non-smoking and learning to relax.

The wives in this study took charge of their husbands' convalescence and lifestyle changes. Similar findings have been previously documented (Croog and Levine 1977: 238, Mayou et al 1978a: 700; Nyamathi 1987: 90). Various explanations have been proposed for this

phenomenon. It could be an attempt by the wife to control the long-term consequences of his disease, or as Skelton and Dominian (1973: 101) suggest it may be because some wives believe that they are the cause of the myocardial infarction. She could also be motivated by the strong emotional ties that she has with her husband, as Schott and Badura (1988: 132) concluded, the more a woman loved her husband the more she was concerned about his health. They don't say however, how they quantified love. Another possibility is that the role of overseeing a household and nurturing and caring come naturally to a woman. I sensed that nurturing and caring instincts, strong emotional ties and the need to control the long-term consequences of the disease motivated the wives in the current study.

The finding in this study that wives monitored their husbands' behaviour to check compliance is paralled by that of Nyamathi (1987: 90). The question is: Why did these women feel that they had to check up on their husbands? Research done by McGee, Graham, Newton and Horgan (1994: 214) found that wives were significantly less certain than the patient that he could avoid unhealthy behaviours. The answer may be that wives are mistrustful and don't believe their husbands have enough willpower to comply with lifestyle changes. The wives in this study found that the implementation of lifestyle changes was made easier when their husbands complied with the prescribed therapeutic regime. In an American study, Doherty Schrott, Metcalf and Iasiello-Vailas (1983: 841) concluded from structured interviews with 150 male participants, their wives and medical staff, that those wives who believed strongly in the value of a therapeutic programme were most likely to support their husbands, and those men whose wives were supportive, were more likely to be compliant. Furthermore, the behaviours of wives that were positively correlated to their husbands' compliance were: showing an interest in the therapeutic regime and reminding the husband to take his medication. Nagging was however negatively correlated to compliance (Doherty et al 1983: 840). I conclude from these findings that it is important to provide the wife with the necessary information and skills that will enable her to support her husband because her support will determine his compliance and therefore his recovery. My conclusion receives little support from Hilbert (1985: 217) who in a study two years later, interviewed 60 couples and found no correlation between the wife's support and compliance after a myocardial infarction. Possible reasons for this finding are that the wife's supportive behaviour may not be seen as such by her husband, or her supportive behaviour was in response to his noncompliance (Hilbert 1985: 220).

Two lifestyle changes that were of particular importance to the wives in this study were stress reduction and dietary compliance. Stress was cited by some of the wives to be the cause of their husbands' myocardial infarction. McGee et al (1994: 214) listed 7 unhealthy behaviours: smoking, being overweight, a high fat diet, no regular exercise, heavy drinking, stress and

medication non-adherence. The researchers asked thirty currently married male patients and their wives to rate the difficulty of avoiding these unhealthy behaviours in the three months that followed the myocardial infarction. Both partners considered stress to be the most difficult unhealthy behaviour to avoid. Miller, Garrett, Stoltenberg, McMahon and Ringel (1990: 309) studied a sample of 52 patients to determine what stressors they experienced one month following a myocardial infarction. Stress was defined as "distress related to appraisals of harm, loss or threat" and most of the stressors experienced related to the recent experience of a myocardial infarction in the form of thoughts and feelings, rather than external events. The four stressors most frequently identified by the sample were: "physical health, the inability to partake in gratifying behaviours, job responsibilities, and guilt about not exhibiting expected behaviours" (Miller et al 1990: 308). Furthermore the three most common stress management behaviours identified by Miller et al (1990: 309) were: expressing feelings, ignoring situations and avoiding situations. Clearly the stressors of day-to-day living cannot be avoided so I believe that it is probably appropriate that the wives in this study tried to make their husbands more aware of stressors. The use of negative stress management behaviours such as ignoring and avoiding situations should be discouraged at an early stage before they become self-perpetuating. The answer may be to teach the patient effective stress management behaviours either before discharge from hospital or at a cardiac rehabilitation centre.

The wives in this study felt almost entirely responsible for dietary changes. This was probably because buying food, meal planning and preparation is traditionally the function of a woman. Although diet was an area of importance to the wives in this study they did not appear to have any problems managing the dietary changes, a finding which is supported by that of Bramwell (1986: 581), but which contrasts with that of Stewart et al (2000: 1354). The majority of spouses in Stewart et al's sample reported that dietary concerns were a major source of stress for them, all of whom except for one were female. I speculate that the reason that the wives in the current study did not have problems with diet management was because a registered dietician advised the couples before they left our hospital; Stewart et al makes no mention of a similar practice. The ownership that wives take for dietary changes is reflected in Turton's (1998: 776) results. He found that the spouses in his study, who were mostly female, ranked dietary information as the third most important category of information included in post-myocardial infarction education, whereas the patients only rated it sixth. Duryee (1992: 222) reviewed the literature published on inpatient education from 1975-1989 and found that diet was considered the most difficult lifestyle area to change post-myocardial infarction, despite formal patient education. This is not surprising since the education programmes were directed towards the cardiac patient, who is usually male, and as we learnt earlier from Turton (1998: 776) does not

consider dietary information to be very important. A study investigating the impact of in-patient dietary information programmes with the wife as its focus is needed.

The wives in the current study constantly observed their husbands to ensure that they did not overexert themselves physically and cautioned them when they thought they were. Wives are sometimes unsure of what their husbands' physical capabilities are and there is a fear that they will overexert themselves and tax what is already perceived to be a weak heart (Skelton and Dominian 1973: 102; Mayou et al 1978a: 700; Taylor, Bandura, Ewart, Miller and DeBusk 1985: 637). This perception is probably reinforced in the way that the patient is managed whilst he is in hospital. For the first 48 hours following the myocardial infarction the patient's activities are restricted, he is placed on strict bed rest and self care activities are seen to by the nurse. On the third day following his myocardial infarction the patient is allowed to sit out in a chair at the side of the bed and his response to mobilisation is carefully noted. At this stage self-care activities are carried out by the patient at the bedside. By the fourth day the patient has been transferred to the ward where he is allowed to mobilise and go to the bathroom, his response to mobilisation however, is still carefully noted. It is possible that the wife notes our cautious management and believes that she should do the same at home. An interesting study was undertaken by Taylor et al (1985: 637), who noticed that the perception of the wife and the perception of the husband concerning his physical capabilities were highly discrepant. Husbands considered themselves to be reasonably fit, while their wives considered them to be physically and emotionally weak. In an attempt to change this perception one group of wives waited in the waiting room while their husband performed a stress test. The wives in the second group watched their husbands perform the stress test, while the wives in the third group not only watched but also performed the same stress test as their husbands. Afterwards each couple met with the cardiologist to discuss the implications of the test. Those wives in the third group substantially increased their perceptions of their husbands' physical capabilities in comparison to the other two groups. It would seem that both the patient and his wife should be clearly instructed before he leaves hospital as to the milestones he should be achieving with regards to exercise. Those who run cardiac rehabilitation programmes should where possible encourage wives to join their husbands and actually work through his exercise programme. Wives like those in Taylor et al's (1985: 637) study, would then have a much clearer idea of their husbands' physical capabilities and would refrain from discouraging them from taking much needed initiatives.

Some of the wives in this study describe how the recreational part of their lives had changed. This finding is supported by Mayou et al (1978a: 700) and Dhooper (1983: 23). Reasons stated for this by the wives in the current study include firstly, a fear of travelling in a car with their husband because that is where his myocardial infarction occurred and secondly, a

forced reduction in activities to ensure that he got enough rest. Dhooper (1983: 23) found that even after a year the couples in his study had still not resumed recreational activities such as picnics, day trips or going out to eat. I suggest that the patient's reluctance to eat in a restaurant stems from an uncertainty about what to order within the constraints of his diet, this could however be easily addressed by a dietician. The patient may also associate eating out with indulgence and perhaps it is at times like that, that he is acutely reminded of his dietary restrictions. Those of us who have been on a diet will certainly be able to relate to this. One of the wives in the current study seemed to feel resentful and frustrated towards the changes that had occurred in her recreational life. Dracup, Meleis, Baker and Edlefsen (1984: 121) and Stewart et al (2000: 1355) reported similar feelings amongst the wives in their studies, twelve weeks after the event.

Facets of the relationship change

The wives in this study described how facets of the marital relationship such as sexual concerns, communication and the intimacy of the marital relationship, were influenced following their husbands' myocardial infarction. Their experiences regarding inadequate sexual information, the resumption of sexual intercourse and the risks involved in doing so, have been highlighted in previous studies (Papadopoulos, Larrimore, Cardin, and Shelley 1980: 39; Bramwell 1986: 582; Stewart et al 2000: 1355). Wives may incorrectly equate sexual behaviour with strenuous physical activity and the risk of another myocardial infarction and this may lead to problems relating to the resumption of sexual activity. The importance of sexual activity for the patient and the marriage is highlighted by Beach et al (1992:36) who concluded that the wife's comfort with sexual activity such as hugging and foreplay was highly correlated with recovery of the patient and that these activities were also highly correlated with marital satisfaction. Therefore it is not intercourse itself that is important, suggesting that perhaps health professionals should rather be encouraging hugging and foreplay.

Papadopoulos et al (1980: 40) interviewed 82 wives and found that in the majority of cases fear did not prevent sexual activity, but played a role in affecting the frequency and quality of sexual activity. This study reported similar findings. During sexual intercourse it is important that a woman is relaxed and focused on the sexual experience and I would imagine that entertaining thoughts of fear would certainly affect the quality of the sexual encounter. Bramwell's study (1986: 582) found that wives would only resume sexual activity when their husbands felt physically and emotionally ready to do so. Some of those who had resumed sexual intercourse had done so with some trepidation, but felt that the benefits for the husband outweighed the risks. The findings of this study paralleled those of Bramwell. It would seem that

following a myocardial infarction, the wife puts her sexual needs and fears aside and allows her husband to decide when sexual activity is to be resumed, even if at the time of resumption it goes against her better judgment. This is probably because wives view sexual activity as beneficial in restoring their husbands' masculinity and their successful sexual performance is seen as an achievement and an indication of returning strength.

Of the 3 wives who discussed sexual issues with me, one reported having tried unsuccessfully to resume sexual intercourse. Papadopoulos et al (1980: 39) investigated the sexual concerns and needs of the wives of myocardial infarction survivors six months to 3 years after their myocardial infarctions. They found that of the 100 wives interviewed, 76 had resumed regular sexual activity, this was called group 1, in group 2, 14 had tried intercourse and failed, and in group 3, 10 had never tried to resume sexual intercourse. It is noted that the mean age of the couples in groups 2 and 3 was higher than that for group 1, and the frequency of intercourse a month before the myocardial infarction was also reduced in groups 2 and 3, when compared with group 1. It would seem that age may be a factor influencing the resumption of sexual activity post myocardial infarction, and that perhaps the myocardial infarction hastens the discontinuation of sexual intercourse that sometimes occurs as couples grow older.

One of the wives in this study felt that sexual counselling would have alleviated the sexual problems that she and her husband experienced. This assertion is supported by Cole, Levin, Whitley and Young (1979: 125); Papadopoulos et al (1980: 40) and Steinke and Patterson-Midgley (1998: 405) who found that the couples have a need for information and counselling regarding sexual issues post myocardial infarction. Turton (1998: 777) found that the patients and wives/partners did not rate sexual issues as a high priority informational need, but this may be because it doesn't rate as highly when compared to the other informational needs. Steinke and Patterson-Midgley (1998: 403) found that survivors of a myocardial infarction preferred to receive sexual counselling whilst still in hospital. Papadopoulos et al (1980: 40) sheds some light on the issues surrounding the preference of the wife with regards to who should be giving the information and who should be receiving it. He reported that 43% of wives preferred to receive sexual instructions from their husbands' physician and 43% from both the physician and the nurse and importantly most of the wives preferred to receive sexual instructions as a couple. Two months after the myocardial infarction, the survivors in Steinke and Patterson-Midgleys' (1998: 406) sample required information regarding sexual issues concerning specifically:

- "The effect of the cardiac event on sexuality".
- "Partner concerns".
- "Warning signs".

- "The effects of medication on sexuality".

The 4 most common questions that the wives in Papadopoulos et al's (1980: 40) study wanted answered were:

- "Is it unusual for a man to lose his desire for sex after he has had a heart attack?"
- "Do men have the same ability to become excited sexually after they have a heart attack?"
- "Why does my husband have more difficulty getting an erection since his heart attack?"
- "Why can't my husband maintain an erection?"

One of the wives in the current study had similar questions.

Surprisingly Papadopoulos et al (1980: 40) found a significantly higher percentage of wives who feared sexual activity had received instructions regarding the resumption of sexual relations. The authors suggest that this may have been because the instructions were ambiguous or incomplete, or that discussion heightened the question of risk. This highlights the importance of ensuring that sexual counselling is effective. Ineffective counselling may be as a result of sex being considered a sensitive issue and one, which the health professional, and here I include myself, may not feel comfortable discussing or feels that discussion may offend the couple. The result is that the couple leave hospital with vague information, if any, having to rely on myths and misconceptions. Nurses need to be taught coping skills that will enable them to perform sexual counselling without feeling uncomfortable, in addition a sexual counselling program can be made available that the nurse can use as a guide. Cole et al (1979: 126) and more recently Cohen (1986: 24) outline such programmes designed for cardiac patients and their wives and suggest guidelines that health professionals can use to facilitate the counselling process.

The following studies illustrate that good communication between the couple is essential for the maintenance of good marital relationships, the resumption of sexual intercourse, the readjustment of the patient and the reduction of the couple's stress levels. Papadopoulos et al (1980: 40) reported that a significantly higher percentage of couples who talk about their sexual relations resume intercourse. Communication also plays a significant role in promoting the cardiac patient's readjustment (Ben-Zira and Eliezer 1990: 530). According to Helgeson (1991: 629) those patients who were less able to disclose to their wives what they were experiencing were the ones most likely to suffer more severe chest pain a year after the myocardial infarction. Communication enables the wife to empathise appropriately (Bramwell 1986: 581), and is a

predictor of life satisfaction (Helgeson 1993: 838). With regards to communication I found that two couples in this study were reluctant to reveal to each other what they were experiencing, or to discuss their concerns surrounding issues relating to the myocardial infarction. You will remember that Coyne and Smith (1991: 405) referred earlier to this type of relationship-focused coping strategy as "protective buffering", the opposite of which they term "active engagement". The wives in my study seemed to use protective buffering more frequently than active engagement and this is cause for concern because the use of protective buffering has a detrimental effect on the stress levels of both the wives and the patients. Coyne and Smith (1991: 410) concluded that those wives who practiced protective buffering were more distressed than those who used active engagement. Suls, Green, Rose, Lounsbury and Gordon (1997: 344) confirmed and then extended these findings a few years later, when they reported that protective buffering was maladaptive for the patient too. I propose that those who use protective buffering do not benefit from the catharsis of active engagement and instead keep everything "bottled up" inside of them, which can result in physical and psychological stress. This stress, added to the already considerable stress created by the myocardial infarction may have serious consequences for the couple and their marital relationship. Health professionals dealing with these couples both during hospitalisation and in the convalescent period need to alert the couples to the negative effects of protective buffering and encourage them to communicate with each other. If verbal communication is difficult they could try alternative forms of communication such as writing memos or letters to each other, as long as they benefit from the catharsis of active engagement.

Two wives in the current study highlight the important role of non-verbal communication between the wife and her husband post myocardial infarction. Where protective buffering was practised, non-verbal communication techniques such as touching, hugging and massage were used as a substitute for active engagement. These non-verbal communication techniques were used to convey reassurance, provide comfort and ease tension, which is entirely appropriate if the couple don't communicate on a verbal level. I could not find reports of similar findings in the literature and would be interested to know if the negative effects of protective buffering are still applicable when non-verbal communication techniques are used. I would suggest that this finding warrants further investigation.

One of the wives in this study described how her marital relationship improved following the myocardial infarction. It would seem that the life-threatening nature of a myocardial infarction caused the couple to consider life without each other, resulting in a renewed closeness and a greater appreciation for each other. Whilst none of the wives in this study actually reported a deterioration in their marital relationships, from the data I suspect that one marital relationship had deteriorated during the convalescent period. A number of studies have found that some

patients become depressed, irritable and frustrated during the convalescent period, which creates tension and hostility which may cause the marital relationship to deteriorate (Skelton and Dominian 1973: 103; Stern, Pascale and Ackerman 1977: 1683; Mayou et al's 1978a: 700). At six weeks 47% of the wives in Thompson and Cordles' (1988: 226) sample reported an improvement in their marital relationship, 16% felt there had been deterioration and 37% felt there had been no change. Mayou et al (1978a: 700) and Schott and Badura (1988: 126) reported similar findings at one year, however there is little consensus amongst the studies concerning the percentages of marriages thought to have improved or deteriorated.

Married patients benefit from the marital relationship. Euripides 484-406 B.C. wrote: "In the hour of sorrow and sickness, a wife is a man's greatest blessing". These words seem particularly applicable during the convalescent period. Helgeson (1991: 629) cautions that it is a good marriage, rather than marriage per se, from which the benefits are derived during the convalescence period. Schott and Badura (1988: 132) found that the more a woman loved her husband the more she was concerned about his health and according to Waltz (1986: 802) this "love resource" determines how effectively the patient will cope and adapt to the consequences of his illness. Waltz, Badura, Pfaff and Schott (1988: 149) extended this finding a few years later by concluding that the degree of intimacy between the patient and his wife was inversely related to the patient's level of depressed mood following a myocardial infarction. In 1994, Brecht, Dracup, Moser and Riegel (1994: 82) concluded that the "quality of the marriage affects the degree of emotional distress experienced by the patient, which in turn affects psychosocial adjustment". This finding lends further support to a growing body of evidence that the quality of the marital relationship can positively or negatively influence the patient's readjustment during the convalescent period. This, I believe is because a good marital relationship provides the patient with a safe environment in which he can adjust to the long-term consequences of his illness with the comfort of knowing that there is someone who is genuinely concerned about him.

Poor psychosocial adjustment of the wife in the convalescent period is associated with marital difficulties experienced before the myocardial infarction. Stern and Pascale (1979: 85) reported that those wives who were symptomatic i.e. could be diagnosed as anxious and/or depressed all reported some marital problems prior to the myocardial infarction and worsening marital problems during the convalescent period. From the data provided by the husbands of the wives in the symptomatic group the authors were able to conclude that their husbands were "major or moderate deniers". This term was coined by Hackett and Cassem (1974: 94) and is used to describe those men who "deny fear, are tough and self-reliant". The wives of major/moderate deniers live in marriages that are devoid of warmth and companionship and have to pester and threaten to have their needs met. During the convalescent period they do not

pester and threaten to have their needs met as they are afraid their husbands may have a relapse. Instead they practice protective buffering with the result that they become anxious and depressed. I would recommend that those who deal with survivors of myocardial infarctions and their wives, for example coordinators of cardiac rehabilitation programmes, should keep information such as this in mind. An attempt could be made to identify those men who are major or moderate deniers and couples with pre-infarction marital problems, so that counselling can be provided and unnecessary psychological problems circumvented.

One of the wives in my study experienced symptoms of anxiety. It was unclear from the data whether her husband was a major/moderate denier and it did not seem as though they had pre-existing marital problems. Of concern to me was that she practiced protective buffering which appeared to be affecting the quality of their marital relationship. I believe that active engagement should be promoted in the convalescent period which will ensure the psychosocial adjustment of both the patient and his wife and enhance and improve all the facets of their marital relationship.

Meeting additional role responsibilities

Following a myocardial infarction the wife is usually her husband's main source of support as he comes to terms with the fact that he has a chronic illness. She sees to his welfare by implementing therapeutic regimes, changes in lifestyle and absorbing his share of household, family and other responsibilities. This study found that the demands made by this new supportive role impacted on the time that the wives had available for their usual roles; similar descriptions from the wives in Stewart et al's (2000: 1357) sample support this finding. A wife in this study reported that she found it beneficial to continue working during the stressful convalescent period, because it provided a welcome distraction from the stressors associated with this time. Skelton and Dominian (1973: 101) reported similar findings which were later confirmed by Mayou et al (1978a: 700), who concluded that those wives who experienced the least stress a year after their husbands' myocardial infarction were those who continued to enjoy their jobs and maintain their own leisure activities. Skelton and Dominian (1973: 101) also reported however that the wives of husbands who were self employed did not find it beneficial to continue working, due to the extra responsibility and workload. This is in contrast to the current study, where I found that despite having to run her husband's business the wife still found working to be beneficial. I think that this is because under normal circumstances they ran the business together, so the responsibilities were not completely new to her.

One of the wives in this study reported that after two months her husband had almost resumed the household chores he was responsible for before his myocardial infarction. This

tendency to be excused from chores is well described in the literature. Mayou et al (1978a: 700) found that 61% of husbands did fewer family chores post-myocardial infarction thus placing an extra burden on the wife; these findings are supported by Dhooper (1983: 22); Schott and Badura (1988: 126) and more recently Theobald (1997: 598). The wife assumes her husband's household responsibilities in order to ease his burden and protect his heart and doesn't appear to mind. Only 10% of the wives in Mayou et al's (1978a: 700) sample expressed unhappiness about this, a finding that is paralleled by this study. Croog and Levine (1977: 226) provide an interesting angle on the subject of resuming household chores. They found that those patients who were rated by the physician to have "partial" or "limited" recovery after a year were less likely to resume household chores. Therefore we can conclude that a patient will be more passive and assign his roles to others more frequently depending on how he perceives his level of health. In a more recent study Arefjord et al (1998: 1213) reported only limited changes in the husband's responsibility for household chores. Could it be that the patients in their study had a better perception of their health or is it that men in the late 1990's are less able to excuse themselves from household responsibilities?

In this study I found that the roles of the wife and her husband had changed, possibly due to a perception that he was vulnerable or because she felt that he was physically and mentally unable to meet his responsibilities. This change in marital and family roles between the wife and her husband following a myocardial infarction has been previously documented by Segev and Schlesinger (1981: 845); Dhooper (1983: 23) and Schott and Badura (1988: 130). Those wives whose husbands regress may develop maternal behaviour towards them and this creates a great deal of conflict and difficulty for the wife because she has to play the role of wife and mother simultaneously. This may also contribute to a disruption of family life (Seveg and Schlesinger 1981: 846). None of the wives in this study reported that their husbands had regressed, and most were careful to ensure that their behaviour was not perceived by their husbands to be overprotective.

Whether or not the wife will experience the role changes as stressful will depend on three conditions according to Schott and Badura (1988: 130-131). The first is the patient's employment status; the second is the patient's state of health as assessed by the wife; and the third is the wife's concerns about her husband's health. In other words they found that those wives whose husbands did not return to their usual employment, who perceived their husbands to be seriously ill and who worried more frequently about their husbands' health, experienced the role changes as most stressful. Croog and Levine (1977: 233) found that these role reformulations were still valid a year post myocardial infarction.

Living with fear

An overriding fear of all the wives in the current study was of the reoccurrence of a myocardial infarction and the threat this posed for the physical, personal and psychological well being of the patient, his wife and his family. This finding has been well described by numerous other studies (Skelton and Dominian 1973: 102; Dhooper 1983: 17; Dracup et al 1984: 122; Thompson and Cordle 1988: 224; Thompson and Meddis 1990: 257; Marsden and Dracup 1991: 289; Arefjord et al 1998: 1213; Kettunen et al 1999: 483; Stewart et al 2000: 1355). The literature suggests that this fear is ongoing and even if it diminishes with time, it seldom goes away. At one-year post myocardial infarction, 90% of the wives in Schott and Baduras' (1988: 125) sample described themselves as frequently or very frequently concerned about their husbands' health and at 10 years the wives in Arefjord et al's (1998: 1214) sample reported that the myocardial infarction was not a closed episode in their lives. It would seem that fear becomes part of the daily life of the wife of a myocardial infarction survivor and something she has to learn to live with.

I found that this fear caused the wives in the current study to become extremely vigilant towards their husbands, a finding supported by three recent studies (Thompson et al 1995: 710; Daly et al 1998: 1203; Stewart et al 2000: 1355). The reluctance of the wives in the current study to leave their husbands unattended is paralleled by reports from Daly et al (1998: 1203). Two of the wives in this study monitored their husbands' breathing patterns whilst he was asleep to check that he was still alive resulting in sleep disturbances for the wife. Skelton and Dominian (1973: 102); Nyamathi (1987: 90) and Thompson et al (1995: 710) describe similar findings. Sleep disturbances have also been described by wives in previous studies (Mayou et al 1978a: 699; Hentinen 1983: 521; Thompson and Cordle 1988: 224; Daly et al 1998: 1203; Kettunen et al 1999: 486), but as a symptom of psychological distress; they do not specifically say whether this was because of vigilant behaviour. Thompson et al (1995: 710) speculate that this vigilant behaviour may be a result of the wives' need to manage their anxiety. I can compare the wife's vigilant behaviour to that of the nurse caring for a critically ill patient. Vigilant behaviour gives the nurse something concrete to do and ensures that she will detect abnormalities as they occur. Due to the unpredictable nature of a critically ill patient this probably allows the nurse to feel some level of control, which may reduce her anxiety when caring for the patient. In the same way the wife's vigilant behaviour provides her with a concrete task, the benefit of which is early detection of abnormalities and a reduction in her anxiety as she cares for her husband.

Other symptoms of psychological distress commonly experienced by wives in the convalescent period were anxiety, depression, fatigue, loss of appetite and poor concentration (Skelton and Dominian 1973: 101; Mayou et al 1978a: 699; Dhooper 1983: 18; Thompson and

Cordle 1988: 224; Arefjord et al 1998: 1213; Kettunen et al 1999: 483; O'Farrell et al 2000: 101). Nyamathi, Jacoby, Constancia and Ruvevich (1992: 163) found that despite having a greater network of support persons, younger wives experienced more emotional stress after their husbands' myocardial infarction, than did older wives. This finding is supported by O'Farrell et al (2000: 101) who report that younger wives (mean age of 51.99 years and a deviation of 9.94 years) are more likely to be distressed compared with older wives (mean age of 55.74 and a standard deviation of 10.54 years). This may be because the occurrence of coronary artery disease at a relatively young age is unexpected and is therefore never contemplated or as O' Farrell et al (2000: 103) suggest, the younger wife has less life experience to draw on to help her cope. Perhaps it is because younger couples often still have children living at home and rely on dual incomes to maintain their standard of living. A myocardial infarction forces the wife to consider the financial implications for herself and her family should he die or become disabled. The wives in this study were all less than 50 years old and can be considered to be younger wives. Despite psychological distress during the convalescent period being so well described in the literature, especially in younger wives, it is surprising that only one of the wives in the current study described such symptoms. This particular wife described how the anxiety created by living with fear caused her to become agitated, short tempered and impatient in her interactions with people. She states that she had to seek medical advice for symptoms of anxiety, a finding that has been previously reported by the wives in studies done by Skelton and Dominian (1973: 101); Mayou et al (1978a: 699); Hentinen (1983: 521) and Thompson and Cordle (1988: 224).

Results of a study done by Croog and Fitzgerald (1978: 176) indicate that subjective stress levels of wives following their husbands' myocardial infarction are not closely related to external influences but rather to her "personality orientation and capacity for coping". Lazarus and Folkman (1984: 152) describe two types of coping strategies: problem-focused coping strategies and emotion-focused coping strategies. Problem-focused coping strategies include defining the problem and creating alternative solutions, emotion-focused coping strategies include avoidance and seeking positive value from a negative event. Nyamathi et al (1992: 163) investigated whether there was a correlation between personality orientation and coping strategies used by wives during the convalescent period. They concluded that wives who reported more positive personality orientation (good self esteem, optimistic) used problem-focused coping and those who reported more negative personality orientation (anxious, depressed) used emotion-focused coping and experienced greater emotional and physical distress. This is probably because negative personalities do not equip the wives to deal with major role changes, to manage their husbands' responsibilities, to be self-sufficient and to make decisions. I could identify one wife in this study, (the same wife mentioned in the previous paragraph who displayed symptoms of anxiety), who I thought displayed negative personality

orientations such as anxiety, fear and anger and seemed to be using avoidance, an emotion-focused strategy, in order to cope.

The use of problem-orientated strategies becomes more involved. According to Kahn, Wolfe, Quinn, Snoek and Rosenthal (1964) there are two kinds of problem-orientated strategies: those that target the environment and those that target the self (cited by Lazarus and Folkman 1984: 152). Environmental strategies alter environmental barriers and procedures, whereas self-strategies are directed at mastering new skills and approaches and developing new patterns of behaviour. I found that three wives in my study had a fervent belief that the institution of and compliance with lifestyle changes would protect them from further consequences of the disease. Daly et al (1998: 1204) reported similar beliefs amongst the wives in his sample. It is possible that by instituting new approaches to life and new patterns of behaviour, that the wives in this study as well as those in Daly et al's study were using problem-oriented self-strategies because it gave them purpose and hope which offset their fear.

I also found that these same three wives appeared to face the convalescent period with an extremely positive attitude. According to Lazarus and Folkman (1984: 150) the wives may have been practising a cognitive form of emotion-focused coping called "cognitive reappraisals". Phrases such as: "I considered how much worse things could be" and "I decided there are more important things to worry about" are all examples of this form of coping. By using cognitive reappraisals the wife is able to change the way she interprets the situation without changing the actual situation, thereby modifying her emotions.

In summary the wives in my study appeared to use problem-focused coping strategies, in particular self-strategies, such as making lifestyle changes to deal with the convalescent period. They also used emotion-focused coping strategies in the form of cognitive reappraisals. A quote from participant four illustrates my point: "but I feel positive about it, I feel as long as he keeps doing what he should be doing and we sort of try and keep him healthy I don't think it should happen again"

Drawing from the support fund

The wives in this study found their social support systems to be of great value. Thoits (1995: 64) in his article on stress, coping and social support processes defines social support as "a coping resource – in this case, a social "fund" from which people may draw when handling stressors". Cohen and Wills (1985: 313) authored an article ten years earlier than Thoits which dealt with stress, social support and the buffering hypothesis, and according to them there are 4

support types: emotional, instrumental and informational support as well as social companionship. These they define as follows: emotional support is the kind of support that enhances the individual's self-esteem, provides a feeling of caring and security and shows acceptance no matter what the difficulty. Instrumental support refers to the provision of material resources and services, which can reduce stress by providing solutions to instrumental problems or by creating time for leisure activities. Support that provides the individual with knowledge and advice that enables her to understand and gain control of a problematic event is known as informational support. Social companionship is a type of support that others provide to a stressed individual when she spends time with them, relaxing or partaking in recreational activities. They fulfil her need for social contact, provide a welcome distraction from stressors and elevate her mood. The wives in the current study experienced emotional and instrumental support, their need for informational support was mostly unmet and they did not experience social companionship; in fact one participant even reported a reduction in this respect.

The support the wives received was primarily from family and relatives, as well as from friends or from their personal religious beliefs. Wives in other studies have reported similar sources of support during the convalescent period (Dhooper 1983: 20; Hentinen 1983: 522; Nyamathi 1987: 89; Thompson and Cordle 1988: 226; Yeh, Gift and Soeken 1994: 110; Theobald 1997: 598). This study as well as those by Mayou et al (1978b: 450) and Dhooper (1983: 20) documents the valuable support roles played by adult children during the convalescent period.

Brenner, Norvell and Limacher (1989: 835) investigated supportive and problematic social interactions and found that the greater the number of individuals in a person's support network the greater the person's life satisfaction. The presence of social support however does not necessarily mean that the stressed individual will not experience psychological problems. Nyamathi et al (1992: 160) concluded that there was no statistically significant relationship between "support provided by the wife's social network and the outcome variables of emotional and physical distress". *Perceived* rather than *received* support was found by Helgeson (1993: 839) to be the better predictor of psychosocial adjustment. Perhaps this is because receiving support from sources can also result in negative social interaction (Brenner et al 1989: 835). For example in this study unremitting telephone calls from concerned family and friends were well meant but eventually became a tiresome intrusion, an example of well intended received social support that became a negative social interaction. Negative social interactions are an excellent predictor of poor psychosocial adjustment to illness, decreased life satisfaction (Helgeson 1993: 835) and depression (Pagel, Erdly and Becker 1987: 801), and may have a significant impact during times of stress, such as the convalescent period.

In his discussion of types and timing of social support, Jacobsen (1986: 254) provides a theory of support timing, based on the assumption that the sequence of a stressful event, such as a myocardial infarction can be divided into a crisis, transitional and deficit state. Weiss (1976) defines crisis as "a situation of sudden onset and limited duration", that is "severely threatening to one's well being" and is "marked by emotional arousal". He defines transition as "a period of personal and relational change that involves a shift in a person's assumptive world" and deficit as "a situation in which an individual's life is defined by chronically excessive demand" (cited by Jacobsen 1986: 254). The type of support that the wives will find most helpful will depend on the state that they are in (Jacobsen 1986: 254). During the crisis state emotional support is perceived by individuals as being most helpful because they feel secure in the knowledge that there are people who are willing to provide care and security. During the transitional state, informational support is perceived as most helpful because it enables the wife to grasp the meaning of the changes that she is experiencing. Whilst in the deficit state instrumental support is perceived to be most helpful as it addresses the imbalance between needs and actual resources. Furthermore Jacobsen states that support that is not provided in this sequence will not be recognised as helpful.

In this study I found that the greatest need of all the wives during the convalescent period was for informational support (see the theme "The need for knowledge"). Instrumental and emotional support was definitely valued, but not as highly as informational support. Jacobsen's (1986: 254) theory of support timing sheds light on why informational support was so important to them. I believe the convalescent phase can be compared to Weiss' transitional state (1976, cited by Jacobsen 1986: 254). During this time the wife has to make lifestyle changes, adapt to changes in her marital relationship and review her dreams and plans for the future as she comes to terms with the unpredictable nature of her husband's chronic disease. Thomas Hobbes (1588-1679) said, "Knowledge is power" (cited: Stevenson 1967: 1057), and this is certainly the case during the transitional state. I believe that the informational support that a wife receives allows her to grasp the meaning of the disease and to understand the rationale behind the changes she is required to make. This knowledge will give her a sense of power and control, which will help to reduce her stress levels.

Wives need to feel that others have their welfare at heart and they also need to talk about their feelings and fears during the convalescent period (Moser, Dracup and Marsden 1993:110), especially to others who have had similar experiences (McGee et al 1994: 209). Thoits (1986: 420) states that "effective support is most likely to come from similar others who have faced or are facing the same stressors, and who have done so or are doing so more calmly than the distressed individual". Some of the wives in this study found receiving emotional support from

wives who had had similar experiences very useful because they could identify with each other. If the helper has experienced similar emotional reactions to those that the wife is experiencing, she treats her with greater understanding and rejection is unlikely. This was the case with one of the wives in this study; empathetic understanding from a helper provided her with the reassurance that her emotional reactions were "normal". It helps if there are similarities in cultural background because then the coping or managing techniques suggested by those who have been through the experience are usually viewed as acceptable (Thoits 1986: 420). This information suggests that wives of myocardial infarction survivors would benefit greatly from support groups, especially if the group is of a similar cultural background. I would therefore recommend that wives are encouraged to organise themselves into support groups and have discussed this recommendation more fully under "Recommendations for nursing practice" later in this chapter

Causal explanations for a myocardial infarction

In the current study all the wives had causal explanations for their husbands' myocardial infarctions, such as specific risk factors, precipitating stressful events and his failure to heed health warnings. I believe that the need to have a causal explanation may stem from the fact that none of the wives saw their husbands as typical myocardial infarction victims and a causal explanation may have made it easier for them to understand why their husbands had the myocardial infarction.

One wife in the current study blamed herself for her husband's myocardial infarction. The wife's tendency to see herself as the cause of her husband's myocardial infarction has been previously reported by Skelton and Dominian (1973: 101). Descriptions from their sample of wives that illustrate this finding include, "I ought not to have left him to do so much decorating", and "perhaps I forced too much food on him or nagged him too much". Anyone who has ever caused someone else pain and suffering can certainly understand the guilt that these women must feel. These feelings of guilt in addition to the stressors already experienced by the wife in the convalescent period must take their toll psychologically. This was confirmed by Stern and Pascale (1979: 84), who found that those wives in their study who were anxious or depressed thought they were the cause of their husbands' myocardial infarction. It is important that this issue is discussed and wives are reassured during counselling or education sessions.

Stress was most frequently cited by the wives of this study as the cause of their husbands' myocardial infarction. These findings are in agreement with Rudy (1980: 355) who studied the patients' and wives' causal explanations of a myocardial infarction and found that

tension or stress at home, work and in general, was most frequently cited by both patients and wives as the cause of the myocardial infarction. More recently Billing, Bar-On and Rehnqvist (1997: 370) found that "patients attributed their myocardial infarction more to their 'own neglect' and 'age', while wives attributed it more to 'others did it to him' and 'pressure of life'". According to Rudy (1980: 355) the reason that stress is so often quoted as a causal explanation is that it cannot be measured and therefore disputed. I agree that stress may be one of the causes of a myocardial infarction but from my experience "own neglect" is probably a more accurate cause of a myocardial infarction.

Finding the cause of the myocardial infarction seems to provide the wives with an explanation and something concrete to focus on. As Vergil (70-19 B.C.) once said, "Happy the man who has been able to understand the causes of things" (cited by Stevenson 1967: 226) and this seems to be the crux of this theme.

The need for knowledge

The findings of the current study reveal that a newly diagnosed cardiac family needs and seeks vital information and assistance from the health care system if they are going to be able to successfully re-establish their equilibrium and place in society.

The wife's need for information relating to her husband's condition, cardiac rehabilitation and the emotional and sexuality issues that surround the convalescent period is well supported in the literature (Skelton and Dominian 1973: 101; Mayou, Williamson and Foster 1976: 1578; Hentinen 1983: 522; Bramwell 1986: 580; Orzeck and Staniloff 1987: 65; Thompson and Cordle 1988: 227; Hickey 1990: 414; Moser et al 1993: 111; Thompson et al 1995: 709; Jamerson, Scheibmeir, Bott, Crighton, Hinton and Cobb 1996: 471; Theobald 1997: 600). In fact, it has been reported that wives valued educative information post myocardial infarction more highly than the patient. (Turton 1998: 776). The wives in this study were the primary care givers charged with the responsibility of caring for their husbands, promoting his well-being and ensuring that no harm came to him. Due to the unpredictable nature of coronary artery disease and the husband's young age the myocardial infarction was a completely unexpected event, which meant that the wives had no time to prepare themselves for this new role. This is unlike pregnancy for example, where the mother has nine months to gather information about infant care from books or other mothers that will prepare her for the role of primary care giver. This lack of informational preparedness creates anxiety and fear in the heart of the wife. Bramwell (1986: 581) found that the wives in her sample experienced extreme anxiety during the convalescent period; especially the first 72 hours post discharge. A patient commented in Stewart et al's (2000: 1354) qualitative

study that informational support would have gone a long way in reducing his wife's fear and anxiety. A similar comment was made by one of the wives in this study, who said, "because I didn't have knowledge of, of what I am going into, that is why I was so anxious and so fearful and you know! So um... I think the more information I get the better it makes me feel. As a, as a person, as a wife".

The wives in this study were understandably anxious to do the right thing but they found it difficult to do so since a lot of uncertainty surrounded their husbands' care. They reported that their husbands were discharged suddenly from hospital with little or no preparation or informational support and they also described the difficulties they had accessing relevant information post-discharge. Previous studies have reported similar findings (Mayou, Williamson and Foster 1978: 443, Hentinen 1983: 521-522, Stewart et al 2000: 1354). This was a concern to me as a member of the team that cared for their husbands. I could add in defence that two of the patients were transferred for cardiac catheterisation and were therefore discharged from a different hospital, however this would be a poor excuse because as members of the health care team, albeit an extended one, each of us had a opportunity to touch the lives of those couples. Wives who are not provided with the necessary informational support cannot care for their husbands with confidence and have to resort to speculation and word of mouth. When dealing with someone's life, as these wives were, it is understandable that their psychological distress will increase. I can relate to these findings as I have found myself in a similar situation as a critical care nurse. I experience a certain amount of psychological distress when caring for a patient with a condition that I am unfamiliar with. It is only once I have consulted informational resources and gathered the appropriate information that I am able to nurse my patient with confidence. The problems created by little preparation or informational support, and the difficulty wives experience trying to access relevant information could be addressed directly with health professionals by members of support groups. Perhaps if health professionals were made aware of the wife's needs during the convalescent period they would change their practice.

Two studies highlight the detrimental effects that excluding the wife from aspects of her husband's medical care may have on her stress levels during the convalescent phase. The first by Schott and Badura (1988: 133) who reported that those wives who were not actively involved in their husbands' medical care were found to be more distressed during the convalescence phase than those who were. Of concern is that this group comprised two-thirds of their sample of wives. The second by Coyne and Smith (1991: 408) who found a relationship between the distress of wives of 56 men who had had a myocardial infarction, and inadequate contact with medical personnel during their husbands' hospitalisation. Of note here is that most of the wives who received psychotherapy during their husbands' convalescence belonged to this group. One

of the wives in my study described how she never got an opportunity to discuss her husband's condition with any of the health professionals caring for her husband. She subsequently required medical assistance for symptoms of psychological distress. This finding together with the studies described above suggest that the wife's psychological stress can be prevented or at least alleviated if health professionals involved her in her husband's care. This can be done by allowing her to remain at her husband's bedside whilst the doctor examines him, including her in discussions regarding medical and nursing interventions planned for the day and providing her with an opportunity to ask questions.

The wives' attempts to gain access to the physician for informational and emotional support during the convalescence period were denied almost every time. I found myself feeling angry with the doctors concerned when I heard how the participant's requests for a telephonic word with the doctor were fobbed off with an excuse from his secretary, or how they waited in vain for the doctor to return their calls. Here were a group of wives who were concerned and anxious because the medical profession had chosen to ignore their informational needs during hospitalisation. Now the medical profession was turning their backs on them again during the convalescent period. I wondered when doctors would realize that their affective support is as important as their diagnostic and clinical skills. Ben-Sira (1984: 732) concluded from his sample of 523 Israeli Jewish adults with chronic illness, that professional emotional support from the physician is most sought after yet least attainable for alleviating the distress of individuals with chronic illness. In the current study as well as that of Ben-Sira (1984: 732) the physician does not seem to be aware of the powerful therapeutic abilities his affective behaviour may have. This is probably because the physician believes that curing the physical complaint will alleviate the emotional distress. Ben-Sira points out that emotional distress can cause a further deterioration in chronic illness, so physicians who do not recognize the patient's affective needs may actually be contributing to the deterioration of his condition. The question that can be asked at this point is why did the wives not contact the nurses in the critical care unit for advice. The answer to this is that we do not routinely invite the wives to do so. This is because the nurse who receives the call may not know the patient, his specific problems or the doctor's unique approach to managing his patients and may give inappropriate advice, with medico-legal implications. I can assure you however that should the wife contact the critical care unit requiring help the nurse would certainly steer her in the right direction even if it means contacting the doctor on her behalf.

Hentinen (1983: 522) reported in her Finnish study that only 31% of her sample of 59 wives had received support from a registered nurse. Similar findings have been reported in British studies done by Thompson and Cordle (1988: 226) and Thompson et al (1995: 710). Hickey (1990: 408) reviewed eight articles, published between 1976 and 1988 that dealt with the

needs of families of critically ill patients, all of which were based on the Critical Care Family Needs Inventory. Three studies asked the question "Who met families' needs?" Only one sample identified the nurse as being the most instrumental in assisting the family to meet their most important needs, the other two identified the physician. Thompson et al (1995: 712) found that the family's preferred source of information was the physician and suggest that because of this preference the couple do not value and may not be very receptive to the educative attempts of the nurse.

Since the nurse is with the patient and his wife 24 hours a day she is best positioned to assess learning needs and has a better opportunity for patient teaching than any other member of the health team has. Why then is she not using these vital opportunities? It may be because she is overloaded by clinical duties and too busy, a reason cited by one of the wives in the study. Alternatively it may be that caring for myocardial infarction patients and their wives is so routine for nurses that they forget what a crisis it is for the couple, the other reason cited by the participant in the current study. I believe it is a combination of factors; firstly the nurse is so focused on the acute care of the patient that she forgets about the informational needs of the couple in the post myocardial infarction period. Secondly, some nurses may have no idea what the needs of the wife are in the convalescent period, as in my case before I embarked on this study. Thirdly, having working in dedicated coronary care units I am not convinced that a medical and surgical critical care unit is the ideal place to nurse cardiac patients and their families. In a medical and-surgical critical care unit like ours, patients are cared for with different diagnoses, needs and levels of acuity and the needs of the coronary patient and his family may be overlooked. In a coronary care unit however the cardiac patient and his family are the only focus of care. In addition patients and their wives are sometimes reluctant or unable to ask appropriate questions. In 1984 Marsland, then a medical student and Logan, a physician (1984: 408) examined the responses of patients and their wives to a coronary education programme. They suggested that doctors should be anticipating questions and providing answers in understandable language, bearing in mind that they are talking to laypersons. They go on to suggest that the nurse's educational role should be complementary and not a substitute for that of the doctor and further suggest that she can facilitate the communication between the doctor and the couple by assisting them to formulate questions.

The following questions are debated in the literature concerning information-giving and counselling for wives and their husbands following myocardial infarction and will be discussed in the text that follows:

- Who should information giving and counselling sessions be aimed at?

- In-patient or out-patient programs?
- Individualized or group sessions?
- How should the information be presented?
- What facts should be included?

Who should information giving and counselling sessions be aimed at?

The literature suggests that educative efforts in the acute phase should perhaps be aimed more at the wife rather than at the patient. This is because despite being stressed during this time she has a greater ability to learn than the patient has (Christie, Logan, Lake and Dutch 1988: 324). This finding is supported by Chan (1990; 1144) who found that patients perceived learning to be much more practical during the convalescent period than during the acute phase. This could be attributed to the psychological and physiological turmoil experienced immediately post myocardial infarction that makes patients less receptive to learning. In my experience the patient is often exhausted after his myocardial infarction and spends the first 24 hours after admission sleeping and is understandably not very receptive to educative efforts. In our unit we do not set aside time to talk to the couple, however once the patient begins to feel better we provide him with an informational booklet called "Heart attack, what now?" (Bennett et al 1993). Few patients ask questions as they are reading and this may be because they don't feel comfortable asking questions or that the information in the book is so clear that they don't need to. It may also be as Christie et al (1988: 324) and Chan (1990:1144) point out that the patient is not receptive to learning at that time. These studies re-emphasise the importance of including the wife in all aspects of the patient's care whilst in hospital especially with regards to information giving.

In-patient or out-patient programs?

The wives in the current study expected to receive information while their husbands were in hospital and had a real need to be able to access information on an out-patient basis. In-hospital counselling for the wives of cardiac patients is essential if one looks at Thompson and Meddis' (1990: 257) finding that the mean anxiety scores of wives was statistically lower in the group who had received in-hospital counselling. It is essential too that members of the health care team and support groups take time to build a relationship of trust and open communication with the wife, while her husband is still hospitalised. It is only after discharge that she will realise what it is that she needs to know and it is these relationships that will support and sustain her during this period. In-patient counselling should be followed up by out-patient counselling during early convalescence, which places the emphasis on psychosocial as well as medical factors (Mayou et al 1978a: 701; Thompson and Cordle 1988: 227). This can be provided once again by members of the health care team and support groups, as well as cardiac rehabilitation centres.

Individualized or group sessions?

The literature supports individualized versus group counselling for patients and wives, if the aim of such a program is to change risk behaviour. Sivaranjan, Newton, Almes, Kempf, Mansfield and Bruce (1983: 72-73) investigated whether teaching and counselling programmes for patients and their wives on an out-patient basis can facilitate changes in behaviour with regards to risk factors. They concluded that it did not provide the stimulus required for a long-term change in behaviour, and speculated that one of the reasons for this was that they had used a group approach rather than an individualized approach. Fletcher (1987: 197) confirmed their speculations a few years later when he concluded that an individualized teaching programme for patients and their wives resulted in a sustained change in risk behaviour at 6 months, in comparison to the control group. These findings remind us that when providing information the health professional should take into account that every patient and family will respond differently to illness, have different life experiences and different educational needs and abilities to learn.

How should the information be presented?

The preferred manner in which information is provided varies. Some wives have reported preferring information to be given in the form of written instructions (Mayou et al 1976: 1578; Hentinen 1983: 522; Wenger 1985: 70; Steinke and Patterson-Midgley 1998: 406). This may be because the critical nature of a myocardial infarction makes the couple less able to comprehend and process information as efficiently during the acute phase than in the convalescent phase. Information given in the written form can be read when they feel they are cognitively and emotionally able to do so. Written instructions also provide a convenient reference for the couple and prevent problems that may arise as a result of vague or ambiguous information (Wenger 1985: 70). Other couples found discussions with the doctors and nurses to be more helpful than audiovisual aids (Christie et al 1988: 324). I would therefore suggest that information be presented in both verbal and written form.

What facts should be included?

Many studies have tried to determine what kind of information wives and their husbands need and consider important. A finding of this study indicated that the wife required information related to survival, such as symptom management and modification of risk factors and this is supported by Orzeck and Staniloff (1987: 64); Chan (1990: 1144) and Turton (1998: 776). Moser et al's (1993: 112) sample of wives ranked the need for information about what to do in an emergency the highest, yet this need was often the need least met. Dracup, Guzy, Taylor and Barry (1986: 1760) caution about the possible adverse psychological effects that teaching family members how to perform cardiopulmonary resuscitation (CPR), may have on those patients at risk for sudden death. Contrary to what one might expect, they found that the patients whose

family members were taught CPR were significantly more anxious than the control group 3 months after the myocardial infarction, and had a poorer overall adjustment to illness at 6 months. I wonder whether the teaching of CPR to family members made the patient more aware of his potential for a sudden cardiac arrest, if this is so, then it does not surprise me that these patients felt anxious and struggled to adjust. The authors recommended that CPR should be taught to family members because it is often a family member that witnesses a patient's cardiac arrest, but recommend that CPR training sessions be taught with follow-up support sessions. Dracup, Moser, Taylor and Guzy (1997: 1434) investigated whether these recommendations made eleven years previously could be scientifically supported. 337 patients and their wives were randomly assigned to four groups: a control group, a CPR with social support group, a CPR with education group and a CPR only group. They concluded that the patients of family members who were taught CPR combined with social support intervention reported better psychosocial adjustment and less emotional distress than those patients in the other groups, thus supporting Dracup et al's (1986: 1760) earlier recommendations.

It could be considered negligent to assume that wives and patients will learn on their own, nor is it ethical to expect wives to play an active role in the care of the patient if they have not been provided with adequate education. They should have easy access to support and information about cardiovascular disease, risk factors, medication and lifestyle management from health professionals, support groups and cardiac rehabilitation centres. This will enable them to assume responsibility for the management of this disease. The findings of this study have highlighted the need for our unit to rethink the way in which we manage our cardiac patients and their families, especially in terms of their informational needs. We need to endeavour to spend more time with the couple, creating a trusting relationship within which we can provide information, counselling and support and within which they can feel comfortable discussing concerns and asking questions.

LIMITATIONS OF THE STUDY

The limitations of this study include the fact that the sample was restricted to participants who were female and married. It is probable that the experiences of a male spouse of a first time myocardial infarction survivor will be different to that of a female spouse. I did not return to my participants with the research findings as a result of a long delay between the interviews and the completion of the data analysis. As a part-time student with a demanding full-time profession it was often difficult to find time to concentrate on my thesis. I conducted my pilot interview on 10 March 1999, the first study interview on 24 May 1999; the fourth interview on 24 January 2000 and completed the data analysis in October 2000. The worth of returning to the participants after

ten to eighteen months is debatable. The descriptions provided during the interview by the research participants of their lived experiences are interpretations of these experiences, and not identical to the experience itself (Oiler 1982: 179). I wondered whether the participant's interpretations and descriptions of their experiences would still be the same ten to eighteen months after the initial interview. I understand that by omitting to return to the participants I may have reduced the validity of the themes that emerged.

Hermeneutic phenomenology recognises the experiences of the participant as being unique because they are described from within the context of her life world. For this reason it should be noted that a criticism of this study is the inability to generalise the findings of a hermeneutic phenomenological study to the entire population. Instead the qualitative researcher describes the extent to which the findings can be transferred to other settings or groups. According to Lincoln and Guba (1985: 316) the qualitative researcher "cannot specify the external validity of an inquiry; he or she can provide only the thick description necessary to enable someone interested in making a transfer to reach a conclusion about whether transfer can be contemplated as a possibility". The way in which I attended to the transferability of the study has been discussed in detail in chapter 3.

RECOMMENDATIONS FOR FURTHER RESEARCH

Thorsten Veblen (1857-1929) said, "The outcome of any serious research can only be to make two questions grow where only one grew before" (cited by Daintith and Isaacs 1989: 176). Questions have emerged from this study, which I believe are worthy of further investigation:

- Further qualitative research is needed to provide a deeper understanding into the experiences of spouses, both male and female, of myocardial infarction survivors in the convalescent period, since the needs of each may be different. I would recommend that the male spouse and his experience are explored and contrasted with that of the female spouse.

- The findings indicate that further research surrounding the use of non-verbal communication techniques, as a substitute for active engagement and as a way of providing reassurance and comfort, are required.

- Further research could elucidate how committed long-term dietary changes can be made easier for the patient and his family.

- It may be worth gaining further insight into the coping strategies used by wives in the convalescent period as well as the role that personality orientation plays.

- Issues surrounding the apparent apathy of health professionals in the provision of counselling and education of these patients and their wives need urgent exploration.

- Further studies are needed to explore the nurse/doctor behaviours that wives perceive to be supportive and which allay anxiety and facilitate adjustment.

- There may be differences between the experiences of wives of first time myocardial infarction survivors in the private health sector and their counterparts in the public health sector and this warrants further investigation.

RECOMMENDATIONS FOR NURSING PRACTICE

One of the goals of my journey was to be able to provide nurses and other health care professionals with some insight into the experiences of the wives of first time myocardial infarction survivors in the convalescent period. As John Locke (1632-1704) declared "the improvement of the understanding is for two ends: first, for our own increase of knowledge; secondly, to enable us to deliver and make out that knowledge to others" (cited by Stevenson 1967: 2066). I believe that it is only once the eyes of nurses have been opened that nursing practice can be reviewed and interventions planned that will benefit the wife.

Counselling and education of the patient and his wife needs to start in the critical care unit from the time the initial crisis of the myocardial infarction is over. The nurse is ideally placed to observe the interchange between patients and family and to help them deal effectively with their anxieties and to assess their needs. She is a ready source of information and has the best opportunity for patient teaching of any member of the health team. Inadequate staffing, clinical duties, heavy workloads, a lack of appreciation concerning the wife's needs or inadequate teaching and communication skills may make it difficult for the nurse to fulfil her teaching and counselling functions. Nursing managers should use data and information provided by studies such as this to demonstrate the need for a nurse who has clinical and counselling skills. Her objective could be to provide teaching and counselling to patients and families such as the ones in this study. Information derived from studies such as this can also be used to substantiate requests for more personnel and influence the decisions of health care administrators regarding the distribution of resources. Extra personnel in the critical care unit would mean that the nurse

has more time to spend with the couple answering questions and seeing to their psychological and informational needs.

Registered nurses need to create an environment of trust and accessibility in which counselling can task place. Individualised rather than group counselling is preferable and these sessions should be used to prepare the wife for the convalescent period and to discuss concerns that she may have. She should be given information relating to her husband's condition, symptom management, modification of risk factors and what to do in an emergency as well as information regarding the emotional and sexuality issues that surround the convalescent period.

Both doctors and nurses should provide sexual counselling for the couple whilst the patient is still in hospital. The emphasis should be put on hugging and foreplay rather than sexual intercourse itself and the issues that should be addressed are things like the effect of the cardiac event on sexuality, partner concerns and the effects of medication on sexuality. Cole et al (1979: 127) suggest that for nurses to deal with sexual matters in an open and understanding way they should be taught to do the following:

- "Do not force the patient [couple] to talk about sex"
- "Place sexuality in the context of other problems"
- "Do not place your moral standards on the patient [couple]"
- "Conduct discussions in a clear and frank manner; do not assume that once the topic has been talked over it is forever resolved for that patient [couple]".

The benefit of active engagement between the couple warrants emphasis. Patients and their wives should be cautioned about using protective buffering as a way of protecting each other. Instead they should be encouraged to talk about what they are thinking and feeling and to solve problems together.

It is important when discussing lifestyle modifications that the couple are given realistic, flexible restrictions so that they do not feel as though life is no longer fun. Arrangements must be made for the wife and her husband to consult a dietician so that they understand the principles of a cardiac diet. Wives should be cautioned against grossly underestimating their husbands' physical capabilities, which may discourage them from taking much needed initiatives and impede their recovery process.

Ample opportunity should be provided for the couple to ask questions and discuss fears and concerns. A well-organized booklet of instructions and information that the wife and her husband can refer to at a later stage should also be provided.

Out-patient cardiac rehabilitation programmes for patients and their wives are gaining importance, firstly because the length of stay in hospital is shortened due to pressure from health care funders, leaving little time for patient education and counselling. Secondly it is only when the wife gets home and is faced with certain situations that she realises what she does not know. I would recommend that the patient and his wife join a cardiac rehabilitation programme as soon as possible after discharge. The four-week delay between discharge and enrolment is too long, as the needs of the couple are immediate. Out-patient cardiac rehabilitation programmes must start recognising the value of the wife in the patient's recovery and make her an integral part of the programme. An appointment should be made for the couple within two weeks of discharge for assessment at the rehabilitation centre so that the convalescent period can be reviewed and concerns addressed. Educational sessions that focus on changing risk factors, preventing post-discharge complications and cardio-pulmonary resuscitation training should form an integral part of the rehabilitation programme. It is essential that cardio-pulmonary resuscitation training be followed up with counselling sessions for those receiving the training as well as the patient. Group sessions where wives can discuss how they are feeling and which teach stress management, coping techniques and relaxation training should also be provided. It would be useful if these rehabilitation centres could run help lines so that wives could access information when the need arose, which would probably help to relieve their anxieties and fears.

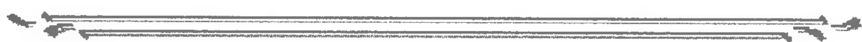
Support groups should be established so that wives can benefit from meeting others who are experiencing or have had similar experiences to them. Members could run outreach programmes for wives of newly diagnosed myocardial infarction survivors. They could visit wives while their husbands are hospitalised and during the convalescent period, providing support and first hand experiential information. A support group could also provide the wife with a safe and understanding environment in which to verbalise her feelings, as all the members are able to empathise with her. Professionals such as dieticians, psychologists and doctors, as well as those who specialise in alternative relaxation techniques such as aromatherapy and reflexology could be invited to address members at group meetings. Support group members could highlight the difficulties of wives of myocardial infarction survivors in the community as well as amongst the health care professionals by distributing information and holding discussions.

RECOMMENDATIONS FOR NURSING EDUCATION

Researchers such as myself who have investigated issues relating to the experiences of the wife and her husband following myocardial infarction should share their findings with other members of the health care profession. Information can be disseminated at in-service training sessions or during continuing medical education forums. I would also like to recommend that this information be included in the curriculum of courses that teach coronary care nursing both at undergraduate and postgraduate level. Nurses should be taught at ward level how to provide information and counselling to the patient and his family. The establishment of guidelines may make it easier for them and ensure that no informational aspects are left uncovered. In particular, nurses need to be taught skills that will enable them to perform sexual counselling without feeling uncomfortable.

CONCLUSION

The destination of the research journey I embarked upon three years ago was to explore the lived experiences of wives of first time myocardial infarction survivors during the convalescent period. After losing sight of the shore for a very long time I feel as though I have finally arrived at my destination. Analysis of the stories entrusted to me by the wives I interviewed, revealed eight themes and each of these have been discussed in the light of the available literature. This study will hopefully contribute to the growing body of knowledge available to those who care for these wives. It should be remembered however that "knowledge is a treasure, but practice is the key to it" (Thomas Fuller 1654-1734, cited by Stevenson 1967: 1054). It is only through practice that health care professionals can use this knowledge to enable the wife to be her husband's greatest blessing in his hour of sorrow and sickness.



REFERENCES

Allen MN, Jensen L. Hermeneutical inquiry. Meaning and scope. *Western Journal of Nursing Research* 1990; 12(2): 241-253.

Annells M. Hermeneutic phenomenology: philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing* 1996; 23: 705-713.

Appleton JV. Analysing qualitative interview data: addressing issues of validity and reliability. *Journal of Advanced Nursing* 1995; 22: 993-997.

Arefjord K, Hallaraker E, Havik OE, Maeland JG. Life after a myocardial infarction – the wives' point of view. *Psychological Reports* 1998; 83: 1203-1216.

Bailey PH. Finding your way around qualitative methods in nursing research. *Journal of Advanced Nursing* 1997; 25: 18-22.

Baker C, Wuest J, Stern PN. Method slurring: the grounded theory/ phenomenology example. *Journal of Advanced Nursing* 1992; 17: 1355-1360.

Barriball KL, While A. Collecting data using a semi-structured interview: a discussion paper. *Journal of Advanced Nursing* 1994; 19: 328-335.

Beach EK, Maloney BH, Plocica AR, Sherry SE, Weaver M, Luthringer L, Utz S. The spouse: a factor in recovery after acute myocardial infarction. *Heart and Lung* 1992; 21(1): 30-38.

Bennet JM, Griffiths C, de Beer M, Prinsloo L, Steinmetz S. *Heart attack – what now?* Cape Town: Parke Davis; 1993..

Benoliel JQ. Advancing nursing science: qualitative approaches. *Western Journal of Nursing Research* 1985; 6(3): 1-8.

Ben–Sira Z. Chronic illness, stress and coping. *Social Science and Medicine* 1984; 18(9): 725-736.

Ben-Sira Z, Eliezer R. The structure of readjustment after heart attack. *Social Science and Medicine* 1990; 30(5): 523-536.

Billing E, Bar-On D, Rehnqvist N. Causal attribution by patients, their spouses and the physicians in relation to patient outcome after a first myocardial infarction. Subjective and objective outcome. *Cardiology* 1997; 88(4): 367-372.

Bramwell L. Wives' experiences in the support role after husbands' first myocardial infarction. *Heart and Lung* 1986; 15(6): 578-584.

Brecht ML, Dracup K, Moser DK, Riegel B. The relationship of marital quality and psychosocial adjustment to heart disease. *Journal of Cardiovascular Nursing* 1994; 9(1): 74-85.

Brenner GF, Norvell NK, Limacher M. Supportive and problematic social interactions: a social network analysis. *American Journal of Community Psychology* 1989; 17(6): 831-836.

Burns N and Grove SK. *The practice of nursing research.* Philadelphia: Saunders; 1987.

Carter MA. The philosophical dimensions of qualitative nursing science research. In: Leininger MM, editor. *Qualitative research methods in nursing.* New York: Grune and Stratton Inc.; 1985. p.27-32.

Case RB, Moss AJ, Case N, McDermott M, Eberly S. Living alone after myocardial infarction. Impact on diagnosis. *Journal of the American Medical Association* 1992; 267(4): 515-519.

Chan V. Content areas for cardiac teaching: patients' perceptions of the importance of teaching content after myocardial infarction. *Journal of Advanced Nursing* 1990; 15: 1139-1145.

Chandra V, Szklo M, Goldberg R, Tonascia J. The impact of marital status on survival after an acute myocardial infarction: a population-based study. *American Journal of Epidemiology* 1983; 117(3): 320-325.

Christie D, Logan R, Lake J, Dutch J. Patient and spouse responses to education early after myocardial infarction.. *Journal of Psychosomatic Research* 1988; 32(3): 321-325.

Clarke DE, Walker JR, Cuddy TE. The role of perceived overprotectiveness in recovery 3 months after myocardial infarction. *Journal of Cardiopulmonary Rehabilitation* 1996; 16: 372-377.

Cohen JA. Sexual counseling of the patient following myocardial infarction. *Critical Care Nurse* 1986; 6(6): 18-27.

Cohen MZ and Omery A. Schools of phenomenology: implications for research. In: Morse JM, editor. *Critical issues in qualitative research methods.* London: Sage Publications; 1994. p.136-156.

Cohen S, Wills TA. Stress, social support and the buffering hypothesis. *Psychological Bulletin* 1985; 98(2): 310-357.

Colaizzi P. Psychological research as the phenomenologist views it. In: Valle R. and King M, editors. *Existential phenomenological alternative for psychology.* New York: Oxford University Press; 1978. p.48-71.

Cole CM, Levin EM, Whitley JO, Young SH. Brief sexual counseling during cardiac rehabilitation. *Heart and Lung* 1979; 8(1): 124-129.

Coyne JC, Smith DAF. Couples coping with a myocardial infarction: a contextual perspective on wives' distress. *Journal of Personality and Social Psychology* 1991; 61(3): 404-412.

Croog SH, Fitzgerald EF. Subjective stress and serious illness of a spouse: wives of heart patients. *Journal of Health and Social Behaviour* 1978; 19: 166-178.

Croog SH, Levine S. *The heart patient recovers: social and psychological factors.* New York: Human Sciences; 1977.

Cutcliffe JR, McKenna HP. Establishing the credibility of qualitative research findings: the plot thickens. *Journal of Advanced Nursing* 1999; 30(2): 374-380.

Daintith J, Isaacs A, editors. *Medical quotes. A thematic dictionary.* Oxford: Facts on File Ltd; 1989.

Daly J, Jackson D, Davidson PM, Wade V, Chin C, Brimelow V. The experiences of female spouses of survivors of acute myocardial infarction: a pilot study of Lebanese-born women in south-western Sydney, Australia. *Journal of Advanced Nursing* 1998; 28(6): 1199-1206.

Denzin NK, Lincoln YS. Introduction. Entering the field of qualitative research. In Denzin NK and Lincoln YS, editors. *Handbook of qualitative research.* California: Sage Publications; 1994. p.1-17.

Dhooper SS. Family coping with the crisis of heart attack. *Social Work in Health Care* 1983; 9(1): 15-31.

Doherty WJ, Schrott HG, Metcalf L, Iasiello-Vailas L. Effect of spouse support and health beliefs on medication adherence. *The Journal of Family Practice* 1983; 17(5): 837-841.

Dracup K, Guzy PM, Taylor SE, Barry J. Cardiopulmonary resuscitation (CPR) training. Consequences for family members of high-risk cardiac patients. *Archives of Internal Medicine* 1986; 146: 1757-1761.

Dracup K, Meleis A, Baker K, Edlefsen P. Family-focused cardiac rehabilitation. A role supplementation program for cardiac patients and spouses. *Nursing Clinics of North America* 1984; 19(1): 113-124.

Dracup K, Moser DK, Taylor SE, Guzy PM. The psychological consequences of cardiopulmonary resuscitation training for family members of patients at risk for sudden death. American *Journal of Public Health* 1997; 87(9): 1434-1439.

Draucker CB. The critique of Heideggerian hermeneutical nursing research. *Journal of Advanced Nursing* 1999; 30(2): 360-373.

Duffy ME. Designing nursing research: the qualitative - quantitative debate. *Journal of Advanced Nursing* 1985; 10(3): 225-232.

Duryee R. The efficacy of inpatient education after myocardial infarction. *Heart and Lung* 1992; 21(3): 217-227.

Field P, Morse J. *Nursing research: the application of qualitative approaches.* London: Chapman and Hall; 1985.

Fiske V, Coyne JC, Smith DA. Couples coping with myocardial infarction: an empirical reconsideration of the role of overprotectiveness. *Journal of Family Psychology* 1991; 5(1): 4-20.

Fletcher V. An individualized teaching programme following primary uncomplicated myocardial infarction. *Journal of Advanced Nursing* 1987; 12: 195-200.

Gadamer HG. *Truth and method.* New York: The Seabury Press; 1975.

Granger JW. Full recovery from myocardial infarction: psychosocial factors. *Heart and Lung* 1974; 3(4): 600-610.

Guba EG, Lincoln YS. Competing paradigms in qualitative research. In Denzin NK, Lincoln YS, editors. *Handbook of qualitative research.* California: Sage publications; 1994. p.105-117.

Guba EG, Lincoln YS. *Fourth generation evaluation.* California: Sage Publications; 1989.

Guba EG, Lincoln YS. *Effective evaluation.* San Francisco: Jossey-Bass; 1981.

Habermann-Little B. Qualitative research methodologies: an overview. *Journal of Neuroscience Nursing* 1991; 23(3): 188-190.

Hackett TP, Cassem NH. Development of a quantitative rating scale to assess denial. *Journal of Psychosomatic Research* 1974; 18: 93-100.

Hagemaster JN. Life history: a qualitative method of research. *Journal of Advanced Nursing* 1992; 17: 1122-1128.

Helgeson VS. Two important distinctions in social support: kind of support and perceived versus received. *Journal of Applied Social Psychology* 1993; 23(10): 825-845

Helgeson VS. The effects of masculinity and social support on recovery from myocardial infarction. *Journal of Psychosomatic Medicine* 1991; 53(6): 621-633.

Hentinen M. Need for instruction and support of the wives of patients with myocardial infarction. *Journal of Advanced Nursing* 1983; 8: 519-524.

Hickey M. What are the needs of families of critically ill patients? A review of the literature since 1976. *Heart and Lung* 1990; 19(4): 401-415.

Hilbert GA. Spouse support and myocardial infarction patient compliance. *Nursing Research* 1985: 34(4): 217-220.

Hycner RH. Some guidelines for the phenomenological analysis of interview data. *Human Studies* 1985; 8: 279-303.

Jacobson DE. Types and timing of social support. *Journal of Health and Social Behavior* 1986; 27: 250-264.

Jamerson PA, Scheibmeir M, Bott MJ, Crighton F, Hinton RH, Cobb AK. The experiences of families with a relative in the intensive care unit. *Heart and Lung* 1996; 25(6): 467-474.

Jasper MA. Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing* 1994; 19: 309-314.

Johnson JL, Morse JM. Regaining control: the process of adjustment after myocardial infarction. *Heart and Lung* 1990; 19(2): 126-135.

Kettunen S, Solovieva S, Laamanen R, Santavirta N. Myocardial infarction, spouses' reactions and their need for support. *Journal of Advanced Nursing* 1999; 30(2): 479-488.

Koch T. Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing* 1996; 24: 174-184.

Koch T. Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing* 1995; 21: 827-836.

Koch T. Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* 1994; 19: 976-986.

Krefting L. Rigor in qualitative research: the assessment of trustworthiness. *The American Journal of Occupational Therapy* 1991; 45(3): 214-222.

Lazarus R, Folkman S. *Stress Appraisal and Coping*. New York: Springer Publishing Company; 1984.

Leininger MM. Nature, rationale, and importance of qualitative research methods in nursing. In: Leininger MM, editor. *Qualitative research methods in nursing*. New York: Grune and Stratton, Inc.; 1985. p.1-25

Leonard VW. A Heideggerian phenomenologic perspective on the concept of the person. *Advances in Nursing Science* 1989; 11(4): 40-55.

Lincoln YS. Sympathetic connections between qualitative methods and health research. *Qualitative Health Research* 1992; 2(4): 375-391.

Lincoln YS, Guba EG. Naturalistic inquiry. California: Sage; 1985.

Marik PE, Lipman J, Eidelman IJ, Erskine PJ. Clinical predictors of early death in acute myocardial infarction. A prospective study of 233 patients. *South African Medical Journal* 1990; 77(17): 179-182.

Marsden C, Dracup K. Different perspectives: the effect of heart disease on patients and spouses. *AACN Clinical Issues in Critical Care Nursing* 1991; 2(2): 285-292.

Marsland CP, Logan RL. Coronary care and rehabilitation: patient and spouse responses. *New Zealand Medical Journal* 1984; 97: 406-408.

May KA. Interview techniques in qualitative research: concerns and challenges. In: Morse JM, editor. *Qualitative nursing research: a contemporary dialogue.* California: Sage Publications; 1991. p.188-201.

Mayou R. Prediction of emotional and social outcome after a heart attack. *Journal of Psychosomatic Research* 1984; 28(1): 17-25.

Mayou R, Foster A, Williamson B. The psychological and social effects of myocardial infarction on wives. *British Medical Journal* 1978a; 1: 699-701.

Mayou R, Foster A, Williamson B. Psychosocial adjustment in patients one year after myocardial infarction. *Journal of Psychosomatic Research* 1978b; 22: 447-453.

Mayou R, Williamson B, Foster A. Outcome two months after myocardial infarction. *Journal of Psychosomatic Research* 1978; 22: 439-445.

Mayou R, Williamson B, Foster A. Attitudes and advice after myocardial infarction. *British Medical Journal* 1976; 1: 1577-1579.

McGee HM, Graham T, Newton H, Horgan JH. The involvement of the spouse in cardiac rehabilitation. *The Irish Journal of Psychology* 1994; 15(1): 203-218.

Meulenberg-Buskens I. The free attitude interview. *Research for the future* 1997: 1-6.

Miles MB, Huberman AM. *Qualitative data analysis: an expanded source book, 2nd edition.* California: Sage Publications; 1994.

Miller P, Garrett MJ, Stoltenberg M, McMahon M, Ringel K. Stressors and stress management – 1 month after myocardial infarction. *Rehabilitation Nursing* 1990; 15(6): 306-310, 318.

Mishler EG. *Research interviewing: context and narrative.* Cambridge: Harvard University Press; 1986.

Morse JM. Designing funded qualitative research. In Denzin NK, Lincoln YS, editors. *Handbook of qualitative research.* California: Sage publications; 1994. p.220-235.

Moser DK, Dracup KA, Marsden C. Needs of recovering cardiac patients and their spouses: compared views. *International Journal of Nursing Studies* 1993; 30(2): 105-114.

Munhall PL. *Revisioning Phenomenology: nursing and health science research.* New York: National League for Nursing Press; 1994.

Munhall PL. Philosophical ponderings on qualitative research in nursing. *Nursing Science Quarterly* 1989; 2(1): 20-28.

Nyamathi A. The coping responses of female spouses of patients with myocardial infarction. *Heart and Lung* 1987; 16(1): 86-92.

Nyamathi AM, Jacoby A, Constancia P, Ruvevich S. Coping and adjustment of spouses of critically ill patients with cardiac disease. *Heart and Lung* 1992; 21(2): 160-166.

O'Farrell P, Murray J, Hotz SB. Psychologic distress among spouses of patients undergoing cardiac rehabilitation. *Heart and Lung* 2000; 29(2): 97-104.

Oiler C. The phenomenological approach in nursing research. *Nursing Research* 1982; 31(3): 178-181.

Oiler Boyd C. Phenomenological research in nursing: commentary and responses. *Nursing Science Quarterly* 1989; 2(1): 9-19.

Orzeck SA, Staniloff HM. Comparison of patients' and spouses' needs during the posthospital convalescence phase of a myocardial infarction. *Journal of Cardiopulmonary Rehabilition* 1987; 7: 59-67.

Pagel MD, Erdly WW, Becker J. Social networks: we get by with (and in spite of) a little help from our friends. *Journal of Personality and Social Psychology* 1987; 53(4): 793-804.

Papadopoulos C, Larrimore P, Cardin S, Shelley SI. Sexual concerns and needs of the post coronary patient's wife. *Archives of Internal Medicine* 1980; 140: 38-41.

Pascoe E. The value to nursing research of Gadamer's hermeneutic philosophy. *Journal of Advanced Nursing* 1996; 34: 1309-1314.

Plager KA. Hermeneutic phenomenology. A methodology for family health and health promotion study in nursing. In: Benner P, editor. *Interpretive phenomenology. Embodiment, caring, and ethics in health and illness.* California: Sage Publications Inc.; 1994. p. 65-83.

Polit DF, Hungler BP. *Nursing research. Principles and methods.* Philadelphia: J.B. Lippincott Company; 1999.

Polkinghorne DE. Phenomenological research methods. In: Valle RS and Halling S, editors. *Existential-phenomenological perspectives in psychology: exploring the breadth of human experience.* New York: Plenum Press; 1989. p.41-60.

Ray MA. The richness of phenomenology: philosophic, theoretic, and methodological concerns. In: Morse JM, editor. *Issues in qualitative research methods.* London: Sage Publications; 1994. p.117-133.

Riegel BJ, Dracup KA. Does overprotection cause cardiac invalidism after acute myocardial infarction? *Heart and Lung* 1992; 21: 529-535.

Robertson-Malt S. Listening to them and reading me: a hermeneutic approach to understanding the experience of illness. *Journal of Advanced Nursing* 1999; 29(2): 290-297.

Rodgers BL, Cowles KV. The qualitative research audit trail: a complex collection of documentation. *Research in Nursing and Health* 1993; 16: 219-226.

Rolland JS. Chronic illness and the life cycle: a conceptual framework. *Family Process* 1987; 26: 203-221.

Rose P, Beeby J, Parker D. Academic rigour in the lived experience of researchers using phenomenological methods in nursing. *Journal of Advanced Nursing* 1995; 21: 1123-1129.

Ruberman W, Weinblatt E, Goldberg JD, Chaudhary BS. Psychosocial influences on mortality after myocardial infarction. *The New England Journal of Medicine* 1984; 311(9): 552-559.

Rudy EB. Patients' and spouses' causal explanations of a myocardial infarction. *Nursing Research* 1980; 29(6): 352-356.

Sandelowski M. Sample size in qualitative research. *Research in Nursing and Health* 1995; 18: 179-183.

Sandelowski M. Notes on transcription. *Research in Nursing and Health* 1994a; 17: 311-314.

Sandelowski M. The use of quotes in qualitative research. *Research in Nursing and Health* 1994b; 17: 479-482.

Sandelowski M. The problem of rigor in qualitative research. *Advances in Nursing Science* 1986; 8(3): 27-37.

Schott T, Badura B. Wives of heart attack patients: stress of caring. In: Anderson R, Bury M, editors. *Living with Chronic Illness. The Experience of Patients and their Families.* London: Unwin Hyman; 1988. p.117-136.

Seaman CH. *Research methods. Principles, practice and theory for nursing*. United States of America: Appleton and Lange; 1987.

Seedat YK, Mayet FGH, Latiff GH, Joubert G. Risk factors and coronary heart disease in Durban blacks - the missing links. *South African Medical Journal* 1992; 82(4): 251-256.

Segev U, Schlesinger Z. Rehabilitation of patients after acute myocardial infarction – an interdisciplinary, family-orientated program. *Heart and Lung* 1981; 10(5): 841-847.

Sivarajan ES, Newton KM, Almes MJ, Kempf TM, Mansfield LW, Bruce RA. Limited effects of outpatient teaching and counseling after myocardial infarction: a controlled study. *Heart and Lung* 1983; 12(1): 65-73.

Skelton M, Dominian J. Psychological stress in wives of patients with myocardial infarction. *British Medical Journal* 1973; 2: 101-103.

Smith L. Ethical issues in interviewing. *Journal of Advanced Nursing* 1992; 17(1): 98-103.

Smith MC. Phenomenological research in nursing: commentary and responses. *Nursing Science Quarterly* 1989; 2(1): 9-19.

Sorrel JM, Redmond GM. Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies. *Journal of Advanced Nursing* 1995; 21: 1117-1122.

Steinke EE, Patterson-Midgley P. Importance and timing of sexual counseling after myocardial infarction. *Journal of Cardiopulmonary Rehabilitation* 1998; 18(6): 401-407.

Stern MJ, Pascale L. Psychosocial adaptation post-myocardial infarction: the spouse's dilemma. *Journal of Psychosomatic Research* 1979; 23: 83-87.

Stern MJ, Pascale L, Ackerman A. Life adjustment postmyocardial infarction. Determining predictive variables. *Archives of Internal Medicine* 1977; 137: 1680-1685.

Stevenson B, editor. *The home book of quotations. Classical and modern.* 10th edition. New York: Dodd, Mead and Company; 1967.

Stewart M, Davidson K, Meade D, Hirth A, Makrides L. Myocardial infarction: survivors' and spouses' stress, coping, and support. *Journal of Advanced Nursing* 2000; 31(6): 1351-1360.

Stewart MJ, Hirth AM, Klassen G, Makrides L, Wolf J. Stress, coping, and social support as factors in readmission for ischaemic heart disease. *International Journal of Nursing Studies* 1997; 34(2): 151-163.

Steyn K, Rossouw JE, Joubert G. The coexistence of major coronary heart disease risk factors in the coloured population of the Cape Peninsula (CRISIC study). *South African Medical Journal* 1990; 78: 61-63.

Strauss MB, editor. *Familiar medical quotations.* London: J & A Churchill Ltd; 1968.

Suls J, Green P, Rose G, Lounsbury P, Gordon E. Hiding worries from one's spouse: associations between coping via protective buffering and distress in male post-myocardial infarction patients and their wives. *Journal of Behavioural Medicine* 1997; 20(4): 333-349.

Taylor CB, Bandura A, Ewart CK, Miller NH, DeBusk RF. Exercise testing to enhance wives' confidence in their husbands' cardiac capability soon after clinically uncomplicated acute myocardial infarction. *American Journal of Cardiology* 1985; 55: 635-638.

The Heart Foundation of South Africa. Statistics: heart disease. (Online). Available: http://www.heartfoundation.co.za/statistics.html, cited 25 February 2001.

Theobald K. The experience of spouses whose partners have suffered a myocardial infarction: a phenomenological study. *Journal of Advanced Nursing* 1997; 26(3): 595-601.

The Oxford dictionary of quotations. 3rd Edition. London: Oxford University Press; 1985.

Thoits PA. Stress, coping and social support processes; where are we? What next? *Journal of Health and Social Behavior* 1995; (Extra issue): 53-79.

Thoits PA. Social support as coping assistance. *Journal of Consulting and Clinical Psychology* 1986; 54(4): 416-423.

Thompson JL. Hermeneutic inquiry. In: Moody LE, editor. *Advancing nursing science through research.* Volume Two. London: Sage Publications; 1990. p.223-281.

Thompson DR, Cordle CJ. Support of wives of myocardial infarction patients. *Journal of Advanced Nursing* 1988; 13: 223-228.

Thompson DR, Ersser SJ, Webster RA. The experiences of patients and their partners 1 month after a heart attack. *Journal of Advanced Nursing* 1995; 22: 707-714.

Thompson DR, Meddis R. Wives' responses to counselling early after myocardial infarction. *Journal of Psychosomatic Research* 1990; 34(3): 249-258.

Turton J. Importance of information following myocardial infarction: a study of the self-perceived information needs of patients and their spouse/partner compared with the perceptions of the nursing staff. *Journal of Advanced Nursing* 1998; 27: 770-778.

van der Zalm JE, Bergum V. Hermeneutic-phenomenology: providing living knowledge for nursing practice. *Journal of Advanced Nursing* 2000; 31(1): 211-218.

van Manen M. *Researching Lived Experience. Human science for an action sensitive pedagogy.* New York: State University of New York Press; 1990.

van Manen M. *"Doing" phenomenological research and writing: An introduction. Curriculum Praxis Monograph Series No. 7.* Alberta: Department of Secondary Education, Faculty of Education, University of Alberta; 1984a.

van Manen M. Practicing phenomenological writing. *Phenomenology and Pedagogy* 1984b; 2(1): 36-69.

Walters AJ. The phenomenological movement: implications for nursing research. *Journal of Advanced Nursing* 1995; 22: 791-799.

Waltz M. Marital context and post-infarction quality of life: is it social support or something else. *Social Science and Medicine* 1986; 22(8): 791-805.

Waltz M, Badura B, Pfaff H, Schott T. Marriage and the psychological consequences of a heart attack: a longitudinal study of adaptation to chronic illness after 3 years. *Social Science and Medicine* 1988; 27(2): 149-158.

Wenger NK. Rehabilitation after myocardial infarction. *Comprehensive Therapy* 1985; 11(3): 68-74.

Wilson HS, Hutchinson SA. Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. *Qualitative Health Research* 1991; 1(2): 263-276.

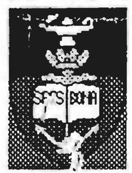
Wishnie HA, Hackett TP, Cassem NH. Psychological hazards of convalescence following myocardial infarction. *Journal of the American Medical Association* 1971; 215(8): 1292-1296.

Wolcott HF. *Writing up qualitative research*. California: Sage Publications; 1990.

Yeh M, Gift AG, Soeken KL. Coping in spouses of patients with acute myocardial infarction in Taiwan. *Heart and Lung* 1994; 23(2): 106-111.

APPENDIX A

UNIVERSITY OF CAPE TOWN



FACULTY OF MEDICINE
ANNE WEGERHOFF
Barnard Fuller Building, Anzio Road, Observatory 7925
Telepnone: 406 6340
Fax: 4478955
eMail : aweger@medicine.uct.ac.za

January 11, 1999

Ms W McLeod
27 Greenways Drive
KOMMETJIE
7975

Dear Ms McLeod

MSc(Med) RESEARCH PROPOSAL

Candidate	McLeod W (MCLWEN005) BCur (UPE)
Degree	MSc in Nursing
Title	The lived experience of the cardiac spouse
Supervisor/s	Prof RAE Thompson, Ms E le Roux

I am pleased to advise that your research proposal has been approved by the Dean on behalf of the Postgraduate Programmes Committee. Formal approval by the Faculty Board will be obtained through publication in the next Dean's Circular MED01/99.

Please find enclosed an information sheet for postgraduate candidates.

Sincerely

Signature removed

ANNE WEGERHOFF
ADMINISTRATIVE OFFICER

Copied to Prof RAE Thompson, Ms E le Roux

c:\msc\cand-app.doc

UNIVERSITY OF CAPE TOWN

APPENDIX B

Research Ethics Committee
Faculty of Medicine
Anzio Road, Observatory, 7925
Queries : Martha Jacobs
Tel : (021) 406-6492 Fax: (021) 406-6390
E-mail : Martha@medicine.uct.ac.za

24 December 1998

REC REF NO: **258/98**

Ms W Mcleod
Nursing

Dear Ms Mcleod

THE LIVED EXPERIENCES OF THE CARDIAC SPOUSE

I have pleasure in informing you that the above study has been **formally approved** by the Research Ethics Committee on 24 December1998.

Included is a list of Research Ethics Committee Members who have formally approved your protocol.

Please quote the above Reference number in all correspondence.

Yours sincerely,

Signature removed

PROFESSOR FOLB
CHAIR: RESEARCH ETHICS COMMITTEE

Queries: Martha Jacobs
Research Ethics Committee
Room 212 Werner and Beit
UCT Medical School
Anzio Road, Observatory, 7925
Tel: (021) 406-6492 Fax: (021) 406-6390
E-Mail: martha@medicine.uct.ac.za

APPENDIX C

LETTER OF CONSENT

27 Greenways Drive
Kommetjie
Cape Town
7975

Dear

Invitation to participate in research study.

My name is Wendy McLeod and I would like to invite you to participate in a research project that I am doing towards a MSc. (Nursing) Degree. The purpose of this study is to gain an understanding of what a woman experiences in the first month after her husband's heart attack. It is hoped that the knowledge and understanding gained from this study will enable those nurses who work in Intensive Care Units to gain greater insights into these experiences. This knowledge can then be used to prepare them so that they can cope more effectively during their husbands' recovery period.

Audiotaped interviews will be used to record information. An initial interview will be conducted with you; it should take approximately an hour.

A typist transcribes the audiotapes, but she will not know your surname and therefore your identity is kept confidential. The text is then analysed by myself. I may request a follow-up interview with you during which time you will have an opportunity to read the transcript and either correct or add to it and clarify any point that may need further explanation.

Personal experiences may be described during the interview and if they are of a sensitive nature you may feel vulnerable revealing them, however you may also benefit from the interview process as you are provided with an opportunity to talk openly and honestly about your experience.

You have the right to refuse participation or withdraw from the study at any time without fear of recrimination.

You are assured that anonymity will be maintained throughout the study. A number will be assigned to identify you. If actual transcripts are to be used in the text, pseudonyms will be assigned to these numbers. At the conclusion of the study, tapes will either be destroyed or returned to you at your request.

I give you the assurance that I will answer all questions that you might have in relation to the study.

I ______________________________________ (full names) have read all the above information and have made a decision whether to participate or not. My signature indicates that I have been informed and have decided to consent to participate in this study.

Date:___/___/___ Signature of participant ___________________

Time:___:___

Signature of researcher ___________________

Thanking you

Wendy McLeod
RESEARCHER

APPENDIX D

CONTRACT FOR THE TRANSCRIBER

TITLE OF STUDY: THE LIVED EXPERIENCES OF THE CARDIAC SPOUSE

I agree to keep all information concerning the participants in this study confidential.

Transcriber

Name: ______________________________

Signature: ___________________________

Date: _________________

Researcher

Name: ______________________________

Signature_____________________________

Date: ________________________