Women's narratives during the acute phase of their myocardial infarction

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Aim. The purpose of this study was to illuminate the meaning of lived experiences during the acute phase of an acute myocardial infarction (AMI).

Method. Ten women (< 60 years old) afflicted with AMI narrated their experiences during their stay in the coronary care unit (CCU). The interview texts were interpreted using a method with a phenomenological hermeneutic approach, inspired by the philosophy of Ricoeur. The text was divided into meaning units that were condensed and abstracted. Three themes were then extracted from the text.

Findings. One theme was 'oneself as vulnerable' with the subthemes: 'the feeling of being dependent upon others', 'the feeling of being insulted' and 'the feeling of being a troublesome person'. Another theme was 'oneself as distanced', with the subthemes: 'not facing the reality', 'captive in an unreal situation', and 'inhibition out of concern for others'. The last theme was: 'oneself as making sense' with the subthemes: 'acquirement of some insight' and 'discovery of a new meaning with life'.

Conclusion. The reported comprehensive understanding revealed the phenomena guilt and shame. These, in combination with the experience of being in an unreal situation and the withholding of feelings may have led to a deterioration of communication. It seems that relatives and the staff at CCU were not allowed to share the burden of being afflicted with an AMI.

Keywords: acute myocardial infarction, communication, guilt, interviews, shame, women nursing care

Introduction

As reported by the National Swedish Board of Health and Welfare (NSBHW 2000) approximately 30 000 people in Sweden during 1997 were diagnosed as having acute myocardial infarction (AMI). During 1997, 68% of AMI patients were men and 32% women. The incidence for the women is comparable with that for men 10 years younger (NSBHW 2000). While there has been a reduction in mortality for both women and men in recent years (Statistic 1998) the number of patients with unstable angina and non Q-wave myocardial infarctions has increased (Johansson *et al.* 1992, Orth-Gomer & Schenck-Gustafsson 1992, Hammar *et al.* 1994).

To be afflicted with AMI is a very traumatic experience, physically (Young & Kahana 1993), psychologically (Cassem & Hackett 1973, Lisspers *et al.* 1998), and psychosocially (Conn *et al.* 1991). The person has experienced an abrupt change from well-being to being seriously ill and has been reminded of her/his own mortality. It is quite common that patients have a gloomy perception of their life prospects after AMI, in that the heart could be seen as 'life itself' (Strain 1978, Ohler 1998). Cassem and Hackett (1979) state that the person not only has an AMI, but that this also leads to an 'ego-infarct'. AMI patients have reported having near to death experiences in the acute phase. Depression is also usual among people with AMI (Lesperance *et al.* 1996).

Compared with men, women wait longer before they seek treatment. Women seem to experience higher levels of anxiety and depression, and have stronger feelings of guilt about their disease (Moser 1997). Billing *et al.* (1980) found that anxiety in women tended to decrease as age increased; in both women and men, higher age was associated with fewer reports of social stress. Billing *et al.* (1980) also state that Swedish women reported more anxiety than did men, but the men in their study displayed significantly more denial than the women.

According to Young and Kahana (1993) women are more likely to develop cardiac distress symptoms and complications after AMI than men. Benson *et al.* (1997) have found that women feel as if they were 'outside of the whole experience', in that they cannot believe that they are having an AMI. However, they did not let having had an AMI interfere with their normal life at home.

The majority of researchers studying AMI have focused on the male patient and/or mostly from a medical perspective. Review of the literature shows that there is still little known about the patient's own narrated experiences, especially about women afflicted with AMI. Earlier studies in this area have neglected women, and there is now a need to learn how to meet, as well as how to listen, to these women in order to offer them adequate care based on a deeper understanding of their own narrated experiences.

Earlier we have published our findings concerning the acute phase of AMI, from the nurses' and the patients' partners' perspectives (Svedlund *et al.* 1999a, 1999b). Nurses' views disclosed a deeper understanding of the nurses' oscillation between distance and relation in their caring for AMI inpatients. The partners' narratives showed that they adapted passively to what had happened and perceived powerlessness during their female partner's stay in hospital. The women's own experiences during their stay in hospital are therefore an important domain for nursing research.

The study

The aim of this study was to illuminate the meaning of the lived experiences of being afflicted with acute myocardial infarction, as it is narrated by women during the acute phase of the disease.

Method

Clinical settings

Data for this study were collected at a coronary care unit (CCU) in northern Sweden that cares for about 1600 patients per year, roughly 450 of whom have been diagnosed with AMI or suspected AMI, and about 140 of whom are women. The hospital is located in a city with 55 000 inhabitants and serves a sparsely populated area of 134 000 inhabitants. The CCU has eight intensive-care beds and eight beds for mobile patients. The patients are usually ready for discharge from the hospital 7–8 days after AMI. Rehabilitation starts as soon as the patients are well enough and increases successively. The staff are engaged in care planning and primary nursing. They try to gain a holistic view of the patient's life and to create a new platform for a more positive future. The AMI patients are invited to special physical training and are also invited to visit the coronary care nurse (CCN) 2 weeks after discharge. An information package is available for all patients and their relatives. Some patients are, however, not able to participate in the training programme due to the fact that they live too far from the hospital. These patients are therefore offered follow-ups with a physician closer to their homes. The acute care at the CCU is a crucial ingredient in these patients' rehabilitation.

Selection of participants

The following criteria were used to select participants for the study: (a) employed women, younger than 60; (b) living in a partnership (the data obtained from the partners will be discussed in another study); (c) the diagnosis of AMI or suspected AMI (diagnosed as probable) made on the basis of symptoms and electrocardiographic changes and/or confirmed by an abnormal elevation of cardiac enzyme levels; (d) physical and mental ability to participate in the study according to the physician; (e) cared for in CCU; and (f) residing within the hospital services area.

After gaining consent from the physician (see criterion d), the CCN asked the patient if the first author could contact her later concerning an interview during the stay in CCU. After receiving permission the CCN contacted the first author/interviewer who then arranged for the interview to be carried out, if possible during the acute phase of the illness.

Both oral and written information was given concerning the aim of the study. The ten women who participated in the study had spent from 5–10 days in hospital (median = 6 days). The women were aged from 47 to 57 years (median = 52). Nine had suffered their first myocardial infarction and one woman suffered her second.

Five women lived in the city near the hospital and five lived at a distance of 100–200 km, in a rural area. All of the women had grown-up children who had left home. All were healthy and employed prior to being afflicted with an AMI, with the exception of one woman who was sick-listed with neck-pain after a car accident.

Ethics

The study was approved by the Ethics Committe of the Medical Faculty, Umeå University (§ 96-023). The ten women invited to take part in the study gave their informed consent. The participants were guaranteed strict confidence and anonymity.

Interviews

Personal narrative interviews (Mishler 1986) were held in a private room at the CCU during the women's hospitalization, that is, during the acute phase of the AMI (5–8 days after having been taken ill) or as soon as possible (5 days) after discharge – in one case 14 days after having been taken ill. The women were treated with benzodiazepines or narcotic drugs on a regular basis prior to admission when they suffered from chest pain, but none of the women had been treated with such drugs on the day of the interview. The first author carried out the interviews. The interviewees were asked to narrate their experiences of being ill. The interview began with: 'Please tell me how you experienced your myocardial infarction.' They were encouraged to talk freely and the interviewer asked clarifying questions only when the woman did not understand the issues or wanted to further develop the interviewee's story. Further clarifying questions were asked, such as: 'So, then what? What happened? How do you feel about this?' The nine interviews, which were tape-recorded with permission, lasted 25–80 minutes. For the one woman who did not want to be tape-recorded notes were taken during the interview, which lasted about 45 minutes. The tape-recorded interviews were transcribed verbatim.

Data analysis

The text was interpreted with a phenomenological hermeneutical approach inspired by Ricoeur's philosophy (1976, 1991). The researcher's intention was to uncover the reality that opens up and develops in front of the text. The method has been developed and used in nursing research at Umeå University, Sweden (Söderberg *et al.* 1997) and at the University of Tromsoe, Norway (Talseth *et al.* 1999). Ricoeur's theory of interpretation (1976, 1991) integrates explanation and understanding in a constructive dialectic that is rooted in the properties of the text. To understand a text is to move from what it says to what it actually points to. The different parts of the method repeatedly turn in a spiral fashion from understanding to explanation and back to understanding. The method involves three steps: naive reading, structural analysis, and interpreted whole/comprehensive understanding.

- Naive reading: Each interview is read through and reflected upon in order to obtain ideas about its sense and about how to analyse it in more detail in the structural analysis.
- Structural analysis: The structural analysis involves several phases: (a) Meaning units comprising one or several sentences related through their contents are identified. (b) Each meaning unit is condensed to a shorter form. (c) These condensed meaning units are further abstracted and organized, to form subthemes. (d) New themes arising from the subthemes illustrate central abstracted aspects in the narrated interviews. (e) Each interview is compared with all the other interviews.
- Comprehensive understanding: In the final step, the text is considered as a whole again to obtain a critical understanding. The preunderstanding (experiences as nurses) of the authors, the naive reading, and the structural analysis are all taken into account, and reflected upon.

This interpretation advances from a naive to a critical understanding through explanation. The dialectic between understanding and explanation which is characteristic of Ricoeur's theory of interpretation (1976, 1991) implies a spiral movement between the three phases; while employing a dialectic approach to the whole and the parts. This spiral process is difficult to show in the presentation; the method appears more linear than it is. The interpretation of the text was carried out by the first author and validated by the coauthors. All the authors have discussed and agreed on the interpretations. We have not discussed the meaning of lived experience as a general phenomenon but in relation to the women studied.

Interpretation and findings

Naive reading

The narratives given by the women illuminate their struggle with their pain and the illness itself. Some reported how they had to ask their relatives for help. Some traces of shame and

feelings of disbelief were apparent. The women did not feel involved in what was happening. They sought a reason: 'Why me?' They did not want to sacrifice their present life-style but seemed to understand that they had to come to grips with their problems sooner or later. They either did not want to worry their relatives or they found it difficult to talk to them about their feelings. The text discloses the meaning of the lived experience of being afflicted with acute myocardial infarction as being one of guilt and shame for having to be dependent upon others.

The naive understanding enriched the preunderstanding of the women's own narrated experiences thus guiding the identification of meaning units during the structural analysis.

Structural analysis

As mentioned before the structural analysis involves several movements; meaning units, condensed meaning units, subthemes and themes. An example from the structural analysis is shown in Table 1.

The organization of themes and subthemes is shown in Table 2.

The findings in the structural analysis are organized in themes: 'oneself as vulnerable', 'oneself as distanced', and 'oneself as making sense'. These themes were constructed from the text during the structural analysis.

Oneself as vulnerable

The text discloses feelings of being vulnerable, that is, the women appeared dependent, insulted and troublesome. Therefore, the theme '*oneself as vulnerable*' contains three subthemes: 'the feeling of being dependent upon others', 'the feeling of being insulted', and 'the feeling of being a troublesome person'.

The feeling of being dependent upon others. The narratives reveal that afflicted women experience an AMI as being flung into the role of patient without any warning. It is apparent that it is extremely uncomfortable to have a patient role. Women were normally very capable of taking care of 'everything' in their homes and relatives were accustomed to seeing them as strong and active individuals, independent of others; giving rather than receiving care. The narratives show how women, in the acute phase of AMI, became dependent upon their relatives for help. An example was: '…I used to be the strong one and take care of others, and now it was I who needed them'. It appears that women spent a great deal of their time in the hospital worrying about how their husbands and children would cope with the situation.

The feeling of being insulted. The narratives disclose feelings of being degraded, and not being as strong and capable as one used to be. Being ashamed of being sick and feeling like 'a miserable person' right from the start of the illness appears in the narratives: '…and then he had to help me to undress, and help me walk, and this isn't easy. I don't think it is'.

The feeling of being a troublesome person. The narratives divulge that women were reluctant to disturb, and did not want to be seen as being a troublesome patient, such as, to refrain from bothering their relatives with questions about their disease and from troubling the staff in the ward with their 'small problems'. An example: 'Then he [physician] thinks this is a troublesome patient…who nags and asks questions the whole time'.

Oneself as distanced

The text discloses that the women were distanced from the event, that is they felt that this has not happened, is not real, and they had more concern for others than for themselves. Therefore, the theme 'oneself as distanced' contains three subthemes: 'not facing the reality', 'captive in an unreal situation', and 'inhibition out of concern for others'.

Not facing the reality. The narratives disclose how women distanced themselves from the disease and their symptoms, and denied them. It seemed to be a process of waiting to see if the symptoms would disappear. Refused to admit that they were ill, they did not react adequately to what was happening – they just wanted to be normal. The narratives reveal women's efforts to convince others that they were all right. Despite a gnawing feeling that they were not 'all right' women often seemed to continue to deny that they had a serious problem.

Just how uncomfortable women were about seeking help is apparent. It appears they were caught between a desire to maintain control and the realization that they were in need of assistance. The pain and the stress 'overwhelmed' them. Nevertheless, rather than face what is happening, women continue to distance themselves by refusing to believe. The text discloses a lack of understanding as to why they had to be in the hospital; they wanted to go home as soon as possible: 'I thought, why do I have to be here? I have nothing to do here and don't need to be here'.

The narratives reveal that it may be their men rather than the women who distance themselves from what is happening and who cannot understand and therefore do not want to face the reality and the consequences in the acute phase. Some example: 'My husband thought this is the end of it all…our sex life and everything'.

Table 1 The structural analysis, some examples

Meaning units	Condensed meaning units	Sub-themes	Themes
I couldn't even control my own body…this was what I thought was humiliating…I used to be the strong one and take care of others, and now it was I who needed them…and I felt miserable.	Could not take care of her self and was dependent upon others	The feeling of being dependent upon others	**Oneself as vulnerable**
He thought it was awful, he's used to seeing me on my feet all the time and never still…and then he had to help me to undress, and help me walk, and this isn't easy. I don't think it is…	Could not undress herself and had feelings that it was awful and felt insulted when she needed help	The feeling of being insulted	
Then he [physician] thinks this is a troublesome patient…who nags and asks questions the whole time…you don't want to be that kind of patient.	Do not want to be a troublesome person	The feeling of being a troublesome person	
When I breathed it felt peculiar. It was almost like something bubbling up in my throat. I didn't think it was anything…until suddenly I felt I was in a cold sweat. I felt sick and I didn't know how I could move but I thought I couldn't just sit here. I wouldn't show them how sick I felt…I didn't want to. I thought it would go over. This is quite mild and it's passing… he asked, if he could call for an ambulance…I said 'no, you shouldn't do that…I want to go home first'.	Did not want to show how she felt in front of others	Not facing the reality	**Oneself as distanced**
I couldn't quite say how I felt, I felt almost like a hypochondriac… what might people think, and I wondered myself how I really felt. Am I ill or is it my imagination?	It so unreal or it is an imagination	Captive in an unreal situation	
Then after the dinner I took my temperature again. It had gone up to 38·1°C I wondered what I should do, if I should call home and say good night…and if so, say something about the temperature …that may worry him, and make it hard for him to sleep tonight and so on.	Does not want to worry her partner and keeps her illness for herself	Inhibition out of concern for others	
In one way, the family is more affected than I, because I cannot manage the same way as before and with this follows so much… I still want to live and feel that I can manage, and I think I will.	Knowing that the illness would affect the daily life	Acquirement of some insight	**Oneself as making sense**
When I understood what it was it was a relief, because I've felt so sick…and now they are taking care of it…I thought it was good that it happened, maybe I can feel better in the future… This is a warning, a heart attack, but a small one.	It felt good that this has happened and she could have hope for the future	Discovery of a new meaning with life	

Table 2 Themes and subthemes as disclosed in the structural analysis

Oneself as vulnerable	Oneself as distanced	Oneself as making sense
The feeling of being dependent upon others	Not facing the reality	Acquirement of some insight
The feeling of being insulted	Captive in an unreal situation	Discovery of a new meaning with life
The feeling of being a troublesome person	Inhibition out of concern for others	

Captive in an unreal situation. Women seemed to believe that the hallmark of an AMI is excruciating chest pain. Symptoms like nausea, chills, weakness, and excessive perspiration present a confusing picture for the victims. The narratives show how, rather than seek assistance, women tried to ignore the possibility that something serious might be happening to them and attempted to 'carry on as usual' or else recognized and faced the fact that the situation was beyond their own control. When they were taken ill they had simply not thought that it could be an AMI. Maybe the staff were mistaken. As it was such an unreal, and very frightening situation women chose not to become involved. It appears that women then became confused about AMI and uncertain as to whether they had only imagined their symptoms, if they were 'ill or not': 'I wondered myself how I really felt. Am I ill or is it my imagination?'.

According to the narratives the initial days in hospital were 'foggy'. Women disengaged themselves from the ongoing events. They refused to be involved in this 'horror-filled reality'; instead they ignored its existence. The events in the emergency room and the CCU have been disclosed as being 'far away' or 'unreal'. It is apparent that they were not emotionally involved and that they hid their feelings during the ongoing events and found it difficult to believe that the AMI would have a permanent effect on their lives. Once the pain subsided they felt that it was all over and found it difficult to believe that the AMI was 'real'. The feeling of being far away was probably strengthened by the administration of morphine, a drug commonly given to AMI patients in pain.

Inhibition out of concern for others. The narratives disclose how women withheld their experiences of being a sick person, they avoided telling their relatives how they felt and kept their thoughts to themselves out of concern for others. It appears that the women did not want to sacrifice their lifestyle and what they believed to be important for them in their daily life. They were therefore keeping their feelings, and symptoms, to themselves. Nevertheless, in some narratives women have described their men as being very worried about what had happened: '…and if so, say something about the temperature…that may worry him, and make it hard for him to sleep tonight and so on'.

The narratives disclose that women described their men as not wanting to discuss what had happened, because they did not want to show that they were worried, while women did not want to show their men that they were not as strong and capable as they used to be. When women felt sad and wanted to cry, they did it when they were alone. They hid their feelings because they did not want to worry their relatives: '…I want to be tough and not show so much feeling'.

Oneself as making sense

The text discloses that the women had feelings of making sense, they had some insight and saw new meaning with life. Therefore, the theme 'oneself as making sense' contains two subthemes: 'acquirement of some insight' and 'discovery of a new meaning with life'.

Acquirement of some insight. The narratives disclose how it felt to come face to face with one's own mortality, they had to come to some conclusion regarding the experience of having survived a life-threatening situation. The patient must try to make sense out of what has occurred and accept that limitations might be necessary as a result of the AMI. The narrations fell into two groups: women with a positive attitude and those with an attitude that one must 'wait and see' what the future will hold. It appears that women had some insight into what had happened; they knew they had to take it easy for a while and that it was going to be hard to give up smoking and make other adaptations in their daily life. Women wanted to live but with dignity and as normally as possible. They were aware that it was going to be tough for a while and that only they can change their lifestyle. It appeared that life would never be the same: 'I cannot manage the same way as before and with this follows so much'.

It appears that women experienced uncertainty, they were afraid of getting another AMI. They began to consider seriously how best to carry on with their lives, perhaps more slowly, perhaps not in the same way as before. In any case, they want to go on living. It discloses that AMI is seen as a 'warning' and they believe that if they acknowledge 'the problem' they will be able to live long and healthy lives.

Discovery of a new meaning with life. The narratives disclose that the women felt relieved when they were informed of the

diagnosis. It appears, that they could not understand why they had felt so bad for so long, or what their discomfort and strange pain was about. Initially, the thoughts of dying were extremely frightening. They seem to have gained a sense of being grateful for surviving, for being given a 'second chance' to live. This second chance gave these women the opportunity to appreciate life and many of them felt they had not been living life to the full before. This would be easier now that they realized how precious life is. The illness was a warning and they will value their life more in the future. One woman decided that she would from now on enjoy her life and spend more time with her family. Many aspects of their lives have taken on a new meaning. One woman was 'grateful' for her AMI because it forced her to make necessary changes in her life: 'I thought it was good that it happened, maybe I can feel better in the future'.

Comprehensive understanding

Comprehension

In the comprehensive understanding the text is considered as a whole again, taking into account the authors' preunderstanding, the naive reading, and the structural analysis, and reflected upon in order to gain a more critical understanding. An understanding of the deeper meaning of being a woman in the acute phase of an AMI is gained when the themes are further interpreted in relation to each other.

Guilt and shame at being ill and not being as strong and independent individuals as they used to be were the central phenomena, which emerged from the themes and subthemes in this study. Feelings were disclosed of being in an unreal situation and of keeping thoughts about the event to themselves out of concern for others. This, together with feelings of guilt and shame lead to a deterioration in communication. Here it seems that the relatives and staff at CCU were not allowed to share the burden of being afflicted with an AMI.

Discussion

This study illuminates the meaning of a group of women's lived experiences of being afflicted with AMI. The feelings of guilt and shame of being ill were brought up as a central phenomenon in the comprehensive understanding. While the terms guilt and shame are often interchanged, they represent distinctly different affective experiences (Lindsay-Hartz 1984, O'Toole 1987). To understand the meaning of both guilt and shame in a deeper sense further clarification is needed.

Guilt is the feeling we have when we believe that we have done something wrong that may result in punishment or disapproval (Robertson 1994). Lindsay-Hartz (1984) suggests that we feel as if we are bad when we feel guilty; this means that experiences of guilt may help us to hold on to the conviction that there is some order and meaning in the world when facing traumas and losses that threaten this belief. Shame occurs when we view ourselves through the eyes of another and realize that we are someone we do not want to be. If we believe that we cannot be otherwise, or in other words, that we are helplessly stuck with our negative identity, we feel we are small and worthless (Lindsay-Hartz 1984). If our deceptive behaviour continues and becomes a part of our self-definition, for example, 'I'm a liar', then shame is experienced (O'Toole 1987).

Women in present study might feel guilty by 'keeping their thoughts to themselves' and that guilt arose in relation to their partners and families. Guilt has been found in other studies of AMI. Billing *et al.* (1980) among others describe guilt as a symptom among patients with AMI and depression. Cassem and Hackett state that depressed patients with AMI are in need of support from the third day after having been taken ill (1973, 1979) or early in the recovery phase (Doerfler *et al.* 1997). None of the women in this study were diagnosed as having a depression or another psychiatric diagnosis at the time for the interview. For the women studied, guilt and shame were coupled with a feeling of being insulted when AMI struck them and that they felt ashamed of being a troublesome person who caused extra work, of being dependent upon others. That women did not want to be a burden is the prime base for this feeling of guilt. Shame is generally a more difficult and painful emotion for patients to recognize and discuss, so they keep it hidden even from themselves.

The findings showed that the women distanced themselves from reality and from facing their own vulnerability. Distance in this context meant avoiding close contact with another person and this can be a way of isolating oneself from one's own emotions. O'Toole (1987) states that isolation could be seen as a way of handling guilt. This could explain the phenomenon 'women's keeping thoughts to themselves' in the present study: they saw themselves as 'bad' and denied what was happening, a strategy to relieve the guilt they felt for being an inferior person. We often interpret 'distancing' in a negative way. To hold others at a distance can be seen as a desire to escape from problems, in reality dissociation from one's own situation (Buber 1962a, p. 411–423).

Distancing usually occurs during the first days in the hospital. The majority of the women in this study seemed to maintain a distance until they were ready to cope with their AMI; a few experienced a feeling of having brought on their AMI because of their way of living. Women tend to see themselves as the 'carer' and not as 'the cared for', and do not

want to experience themselves as a burden for their loved ones (Johnson 1991).

Women in the present study disclosed that they distanced themselves from the illness because it threatened their roles in daily life. It appeared as if they had to struggle to preserve a sense of self. As they gained some insight they began to see how everything depends upon them, that is being ill, coming back to normal, and feeling guilty and ashamed for shutting themselves off from their loved ones. The lack of communication was apparent: there was no dialogue between the women and their partners in this phase of the illness. This phenomenon has also been shown in another study by the authors (Svedlund *et al.* 1999b). Benson *et al.* (1997) report that the reintegration into roles held prior to AMI is both a desire and a burden, that the women are in need of help and support to gain a new sense of independence.

A person who feels guilty has to find her/his own way to feel normal. The staff can help the patient to the point until a vision of this personal path begins to take form (Buber 1962b). If a patient experiences that others confirm her/his being and gains some insight, their feelings of guilt and shame can be relieved. It is vital that patients are relieved of the feeling of being guilty and ashamed of being ill.

Afflicted women have been more or less ignored in studies in this area thus far and it is therefore high time that women's needs are focused on from their own perspective. During their short stay in CCU they need to be prepared to meet their 'new life' after discharge from the hospital. AMI can lead to chronic ill health, both physically and psychosocially. Cowie (1976) describes AMI patients' experiences during their stay in the hospital and found that they are not strong enough to understand what is happening to them. That there is also a lack of communication is confirmed in a study of the CCN's view of AMI patients (Svedlund *et al.* 1999a).

Implication for nursing

The findings in this study are of importance for nursing practice and further research in this field. Previously there has been no focus on women's experiences regarding affliction with AMI. The most important implication for practice ought to be that it is necessary to understand women's feelings in order to properly assess, plan, implement and evaluate nursing care. The text discloses that women in this study had feelings of guilt and shame. An understanding of these phenomena can help nurses in CCU as well as other care units who meet such distanced and vulnerable patients, to be able to support them in a better way and to help them give words to their feelings. This can also make it easier to give the support and education that these patients need, with regard to coping with adaptations in their daily life after discharge from hospital. Those women most commonly afflicted with AMI today are still in the age group where partners do not necessarily share domestic responsibility. Family members should also be offered information and support inasmuch as they share the illness and the situation it leads to (Svedlund *et al.* 1999b).

Conclusion

In an acute illness such as AMI, women's narrated experiences disclosed that they felt vulnerable and distanced for the moment, but even at this early phase of the illness, they believed in a future. After further interpretation findings revealed the phenomena of feelings of guilt and shame of being a sick person in general and an AMI patient in particular. All this, combined with the experience of finding oneself in an unreal situation and the withholding of their feelings, may have led to a deterioration in communication. Due to this situation there was a risk that their partner and other relatives, as well as the staff, were not allowed to share the patient's burden of being afflicted with an AMI.

The study offers a deeper understanding of the meaning of women's experiences when acutely and seriously ill, which can possibly contribute to a broader knowledge of how women experience trying life situations and the ensuing crisis. It is important to have knowledge about these needs when planning the actual care. While the provision of support to these women is crucial in the acute phase, it is also necessary during the following rehabilitation.

Critical considerations

The interpretation presented in this study is one of several possibilities (Ricoeur 1976, p. 79–80). The method has been developed from Ricoeur's philosophy (1976, 1991). In this present study, however, we have not discussed the meaning of lived experience as a general phenomenon but in relation to the women studied. The ten women in this study lived in a sparsely populated area. Each story should be seen as unique. It is important to see the richness in the lived experiences as they are narrated. The intention with this study was to illuminate lived experiences as phenomena and not to reveal differences in the narratives between the five women who lived in the city close to the hospital and those five women who lived further away in different communities. The woman who had undergone her second AMI was a very verbal person who found it easy to narrate her rich story. It is therefore difficult to say whether this has influenced the findings in this qualitative study. The participant who had suffered her second AMI had similar experiences to the women suffering their first, for example, in

both cases it seems to be an emotional experience as well but may lead to a deeper understanding of the meaning of a woman's experiences of being seriously ill. As this study is qualitative the findings are theoretically if not statistically transferable to similar contexts and could be used by nurses to reflect on the care they are delivering. The themes which were identified, expanded the understanding of this experience in a way that can offer meaningful direction for caring, as well as facilitate future research efforts.

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