

## Exploring older women's lifestyle changes after myocardial infarction.

By: Patricia B. Crane and Jean C. McSweeney

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### **Abstract:**

The researchers explored the failure of older women to attend cardiac rehabilitation after myocardial infarction, and examined facilitating and inhibiting factors in making lifestyle changes. Three global categories emerged: physiological changes, health decisions and actions, and life outcomes of the change process.

**Keywords:** older adults | women's health | cardiac rehabilitation | nursing | cardiac nursing | myocardial infarction | health decisions

### **Article:**

Heart disease is the leading cause of death and disability in women (American Heart Association [AHA], 2000). Because the risk of developing heart disease increases with age and women compose the majority of the aging population (Administration on Aging, 2001), heart disease greatly affects both the health of the aging population and the federal health care budget. Costs of heart disease, including disability, hospital stay, and outpatient followup care, were expected to exceed \$190 billion in 2001 (AHA, 2000). One of the most effective means of controlling these costs is secondary prevention measures targeted at slowing or halting the progression of heart disease. Secondary prevention is especially important for older women because 356,000 women age 65 and older have a myocardial infarction (MI) annually, and within 6 years, 35% of women compared to 18% of men will have another MI (AHA, 2000).

The AHA's Panel on Secondary Prevention pointed to strong scientific evidence that risk factor modification in persons with heart disease not only improves survival, but also reduces the reoccurrence of MI (Smith et al., 1995). Formal risk factor modification programs such as cardiac rehabilitation (CR) save as much as \$12,000 per person over a 5-year period (American Health Consultants, 1996) and are effective in older women (Lavie, Milani, & Littman, 1993). However, only 15% of older women participate as compared to 25% of older men (Ades, Waldmann, Polk, & Coflesky, 1992). Little is known about the lifestyle changes that may affect cardiac risk factor modification in the 85% of older women not attending CR after MI. This

study explored lifestyle changes of older women who did not attend a formal outpatient CR program after their MI experience, and examined factors that older women perceived as facilitating or inhibiting health-related lifestyle changes after MI.

## Methods

**Sampling criteria and subject recruitment.** The sample comprised women who had been discharged with a diagnosis of MI within the last 3 to 12 months (confirmed by medical record), were age 65 or older and English-speaking, had no previous diagnosis of memory impairment, and did not participate in a Phase II (outpatient) CR program. All informants had been hospitalized and treated for acute MI at a community medical center in the South. A nurse employed by the medical center compared the list of women who attended outpatient CR with the list of women admitted with a diagnosis of MI to compile a list of women who did not participate in outpatient CR. The CR nurse telephoned the women on the list who met the eligibility criteria and briefly explained the study, completed initial screening, and obtained verbal consent from each woman to provide her name and telephone number to the researcher. Then the researcher telephoned potential informants to further explain the study, confirm eligibility, ascertain agreement to participate, and schedule a convenient time to complete the informed consent form and demographic and health status form, and conduct the first interview. The final sample (N=15) represented 56% of the women contacted.

**Data collection.** The women completed the Demographic and Health Status Form (DHSF), the Geriatric Depression Scale (GDS), and in-depth interviews. The DHSF, a modification of a health status form developed by McSweeney (1993), was designed to collect demographic, cardiac, and general health information. The researcher added the GDS, a 30-item screening tool, to the DHSF (Sheikh & Yesavage, 1986). The GDS is designed for elders and has significant convergent validity ( $p < 0.001$ ) with two established depression measures. Then the researcher conducted semi-structured interviews, lasting 1.5 to 2 hours, in informants' homes.

The interviews began with a global question, "Now that you have had time to think, what do you think caused your heart attack?" This question allowed informants to begin the interview with their personal beliefs and focused the interview on the time period surrounding their MI. The researcher then asked probing questions, such as "What are you doing now to prevent another heart attack?", to guide the interview and glean information about lifestyle changes after MI. The researcher conducted 30 to 45 minute followup interviews with each informant by telephone 2

weeks after the initial interview to clarify meanings, ask additional questions, and validate responses. Both initial and followup interviews were audiotaped.

Data analysis. Quantitative data from the DHSF and GDS were analyzed and descriptive statistics calculated. Interviews were transcribed verbatim and entered into the Ethnograph 4.0 computer program (Seidel, Friese, & Leonard, 1995); then using content analysis, the researcher manually coded each interview into segments of data by emerging topics. All segments from each interview were re-entered by line number into Ethnograph, which sorted the text by specific segments. This process yielded text specifically related to lifestyle changes after MI. Using content analysis and constant comparison (Catanzaro, 1988), the researcher combined the raw data segments into related clusters and combined the clusters with similar meanings into global categories (see Table 1). All coding decisions were recorded and validated by an experienced qualitative researcher.

## Results

### **Table can be found at the end of the document.**

The purposive nonprobability sample (N=15) comprised white (60%) and black (40%) women ranging in age from 66 to 88 years (M=74.5; SD=6.5). The majority had a high school education or less (66.7%), were married (47%) or widowed (40%), and had a yearly household income less than \$20,000 (60%). Most of the women (80%) were interviewed 8 to 12 months after their MI. Women reported taking an average of 5 medications a day (range 2 to 9) with 43% taking 2 to 4 medications, 43% taking 5 to 7, and 14% taking 8 to 9 medications daily. Two women scored 11 or higher on the GDS, indicating that they might be depressed.

Forty-seven percent (n=7) of the women reported caregiving responsibilities, and 27% of the caregivers provided care 24 hours a day. Women's family histories included high blood pressure (73%), heart attack (67%), and diabetes (33%). Their personal cardiac risk factors included high blood pressure (80%), diabetes (47%), and high blood cholesterol (47%). Although only three women currently smoked, 40% had a history of smoking.

Qualitative data analysis resulted in three global categories related to lifestyle changes of older women after MI: physiologic changes, health decisions and actions, and life outcomes resulting from changes (see Table 1).

## Physiologic Changes

Physiologic changes were defined as changes in energy or physical and cognitive processes. Within this global category were two clusters, decreased energy and physical/cognitive symptoms.

Decreased energy. Fourteen of the 15 women (93%) experienced decreased energy after the MI. For instance, women reported, "My energy wears out," "I tire out faster," or "I'm more exhausted." A 75-year-old woman interviewed 12 months after MI typified these women's responses related to decreased energy: "I don't know how to describe it. It's just like the blahs, you know, everything is just gone. No energy, no nothing ... I used to be full of energy all the time. And it just wears you out." The women felt less energy in all activities. Twelve months after her MI, a 71-year-old stated, "I'm more exhausted than I was before I had my heart attack with just about everything I do." A 72-year-old woman interviewed 10 months after her MI stated, "Just like fixin' my bed, spreading the covers, I would get tired before I would get through." Elapsed time after MI did not alter their decrease in energy.

Physical/cognitive symptoms. Physical and cognitive symptoms the women identified as occurring only after their MI included shortness of breath (reported by 40%) associated with activities of daily living such as ironing or walking around in the house. For example, one woman said, "That shortness of breath, I thought I would breathe kind of hard [when ironing] that's when I noticed it the most, and when I vacuumed." Another woman noticed shortness of breath while climbing stairs.

Women also experienced pain or discomfort, dizziness, sleepiness, and changes in thinking after their MI. These physical symptoms affected multiple aspects of the women's lives. For example, a 70-year-old woman explained how sleepiness affected her: "Sometimes I find myself sleepy, with those pills I take. I was in church [and] I didn't hear what the preacher preached about. I was asleep, woke up right after. So you know how I felt ... I like to hear the preacher. I want to hear what he talks about. I didn't hear nothing." Another woman identified how changes in thinking and processing affected her communication and learning: "I don't think as clearly as I used to, I'm just not keen on things ... I don't catch things like I used to."

## Health Decisions and Actions

Health decisions and actions encompassed these women's volitional changes in response to their knowledge of cardiovascular disease or to their physiological symptoms. These changes included modifying cardiac risk factors amenable to change, altering activities, changing personal perspectives, and changing compliance/adherence behavior.

Process of modifying cardiac risk factors. The women attempted to alter modifiable cardiac risk factors such as smoking, diet, physical activity, and stress. Three women who continued to smoke after MI said they were trying to quit, but none had completely stopped smoking. Two of the women identified smoking as a means to deal with stress in their lives. In fact, one woman lit a cigarette at the beginning of her initial interview and stated, "When I was getting ready to do this interview, well, that kind of put a little stress on me."

Most of the women (n=11) reported making dietary changes to modify their cardiac risk status. The changes included decreasing fat (n=10) and decreasing salt (n=4) in the diet. Other dietary changes included increasing vegetables; decreasing fluids, starches, and junk food; and switching to decaffeinated coffee. This quotation typifies the dietary changes reported by women: "I'm trying to lose weight ... watch what I'm eating ... lay off sweets ... eating more fruit ... I still eat a lot of garbage ... got to get off of it." However, none of the women reported monitoring their fat grams as a means of controlling their cholesterol.

Most of the women (73%) reported attempting to engage in some physical activity. For example, a 66-year-old woman stated, "I'm starting out using [treadmill] 15 minutes per day." Seven women reported beginning physical activity after their MI, but only four of these women reported performing physical activity lasting longer than 30 minutes three times a week. These four women had also participated in physical activity before their MI. All but one of the women reported walking as their primary physical activity after MI. Interestingly, only one woman viewed housework as physical activity.

Women altered their stress after MI by staying busy and consciously refocusing their thoughts and actions. One mechanism used to refocus thoughts and actions was self-talk. A 67-year-old stated, "Now since I've been sick, I'll say, I'm not going to worry about this.... I'm not going to sit around worrying about this [heart attack]." Staying busy was another technique employed by the women to decrease stress. One woman noted, "When I'm working, my mind isn't on my

problems." Other women reported consciously ignoring or forgetting about stressful situations and using prayer and Bible reading to reduce their stress.

Alterations in activity. Women reported either changing activities of daily living or patterns of activity in response to physiologic symptoms. Changes included stopping and sitting while performing an activity, slowing the speed of the activity, decreasing the amount of activity, or stopping the activity. Two respondents noted, "I've slowed down a whole lot now [after MI]" and "I wasn't going to [wash clothes] any more [cause] I got too tired." Eleven (73%) of the 15 women said they had to stop and sit during activities to enable them to complete the activity. The following quote from a 66-year-old demonstrates how activities were altered in response to physiologic cues: "I noticed [with ironing] I had to go sit down because I was so tired. I'd iron five pieces, rest, iron five more, go back and rest ... had to keep doing that in order to get it done." Physical activities such as walking and the amount or intensity of physical activity were also influenced by physiologic symptoms. A 67-year-old stated, "I don't do enough now [physical activity]. I can't, my leg's giving me problems. I would do more walking than I do but my leg gets so tired, you know ... I just gave up walking." Another woman identified dizziness and a lack of balance as factors influencing her decision not to walk in her neighborhood.

The women adapted or altered their physical activity to accommodate physiologic symptoms by limiting distance or only walking close to their homes, or they stopped their physical activity in response to physiologic cues. A 71-year-old noted how she altered her pattern of activity: "I can go down stairs, though, a lot easier than I can go up. I go out the back door and go around [and use son's wheelchair ramp] rather than go up the steps in the front of the house ... coming up them makes me get out of breath."

Women also changed roles and altered medications in response to physiologic cues. Role changes were often significant. Women who traditionally hosted and cooked for their families on holiday events decided to have other family members cook or host the holiday dinner. Four women changed or stopped medications in response to physiologic symptoms. The following two quotes are examples of this: "I take a lot of medicine ... I've been keeping close check on my blood pressure and one has been doing the work ... the one that causes me to want to sleep so much, I just took myself off it." This woman was initially prescribed two blood pressure pills but decreased her medication to one. Another woman said, "I can tell when fluid is beginning to build, because I'll get that tiredness again. I'll double the fluid pill."

Change in perspective. After MI, women also reported changes in their perspectives or the way they viewed themselves or the world. One woman caring for a demented husband began to focus on herself, as evidenced by the following quote: "I know I need to take better care of me, and I'm doing it too because I don't have anyone to take care of me ... I have started getting along a lot better since I decided to take care of me for a change instead of everyone else." Women reported reprioritizing to accommodate their change in perspective. They said, "A lot of things that I used to think maybe were important maybe it's not as important anymore ... sometimes it doesn't bother you to let it go [housework] for a while," or "I need to be a little more serious about this [heart disease] myself ... I'm exercising more in relation to that [more serious]."

Other women also demonstrated increased awareness of heart disease. One woman said that the American Heart Association had called and asked her to help with fundraising. Even though she felt uncomfortable asking for money, she agreed to assist in their fund drive because she now thought research on heart disease was important.

Change in compliance/adherence. These women changed in their adherence to medical advice or prescribed regime after MI. Three women said that they now took their medication "religiously." Four reported that they now followed medical advice. This change was evidenced by a 71-year-old's statement, "[now] I do what I'm supposed to do ... I got appointment to go the doctor, I go to the doctor ... he gives medicine, I'll take the medicine."

### Life Outcomes Resulting From Changes

The third global category included outcomes of the changes in older women's lives after MI. Emotional changes, results of medical management and lifestyle changes, and loss were clusters which emerged as life outcomes.

Emotions. The emotions that women experienced after their MI included fear, anxiety, nervousness, disbelief, and insecurity. Early emotions after the MI were fear and disbelief. One retired nurse stated, "[When I came home] I still was kind of scared to what to expect because I didn't want nothing like that pain. So, I wasn't sure of what I could do." When she came home from the hospital and started thinking about the heart attack, another woman reported that she "couldn't believe it."

An emotion closely associated with fear was insecurity about their health. This insecurity, expressed by 6 of the 15 women, was about another heart attack. Because women felt their health was unpredictable, they were continually concerned about being left alone, not being able to get help if they needed it, and not being able to plan future events. Some women were concerned about having a heart attack while caring for their grandchildren. The following quote from a 80-year-old housewife is an example of insecurity in these older women: "I don't like to be here by myself. That's because I feel like should anything come up as suddenly as it did before ... I want someone here to either help or call 911 or be able to tell them what they need to know ... I wouldn't call it a panicky feeling, just a feeling you'd rather not go through."

A grandmother also noted insecurity regarding health: "I don't like to be left alone with them little babies because it's possible I could have another heart attack or I could have a stroke and then this baby is here depending on me and here I am laying on the floor or something like that. That tells on me more than anything ... I [can't] let them know that I'm down and I've got the baby and I can't do anything. That's what affects me the most."

The insecurity limited their activities and was evidenced by statements such as, "kind of afraid to venture out and do some things ... not sure if you're going to be doing too much or not," or "we don't really like to be that far away from home ... if something should happen seems like you just feel more comfortable with your own hospital and doctor and things." Because of this insecurity, these women did not want to change health care providers or to be admitted to facilities where their providers did not have privileges.

Three women said they cried more often or were more nervous or anxious after their MI. One said, "I cry a lot more since I've had my heart attack ... [because of] my nerves." Other women expressed anger or increased agitation after their MI, as reported by this 72-year-old woman: "Since my heart attack I was easily angered or something ... I witnessed that I am less short patience ... people get on your nerves quicker ... it's not me, you know, my old self." Other women were aggravated by their physical or financial changes after MI. A 67-year-old women said: "I don't have insurance to pay for the medication ... I remember the times I never had to take medicine ... I didn't know the cost of medication ... now that I have to deal with medicine, that kind of vexes me because I know I can't afford to buy the medicine."

Results of medical management/lifestyle changes. Other life outcomes evolved as a result of changes the women made to modify cardiac risk factors, lifestyle, or medical changes. Five



women identified various changes such as losing weight, gaining weight due to inactivity, lowering blood pressure and cholesterol, cutting down smoking, and increasing time performing physical activity. Some noted an increased number of medications (n=5) or changes in medication schedules (n=7). These changes increased their financial burden, as this woman reported, "All this [medicine] is new and yes, [brought lots of new expenses], sure did."

Loss. The last life outcome noted was loss, defined as changes in women's lives due to their MI that required them to give up something they valued. Women identified loss of honesty, health, confidence, income, and enjoyment. Loss of honesty was noted by women who were trying to keep feelings and symptoms from family members. Loss of health and confidence were evidenced in statements such as, "I've lost confidence," "I'm sick," and "I have no control." Three women noted the loss of activities that had brought them enjoyment. Not being able to work as many hours prevented one woman from having extra money to participate in her hobbies. A 76-year-old housewife expressed her loss of enjoyment after MI in the following quote: "We're going to [sell our camper]. That was one of the hardest things that I did, when we gave it up and decided that, you know, [crying] ... and I went down and cleaned [camper] out [crying]." While identified losses were varied, all showed that these older women experienced losses due to the changes occurring in their lives.

### Facilitators and Barriers to Making Health Decisions

Facilitators and barriers were analyzed to examine factors older women perceived as facilitating or inhibiting health-related lifestyle changes after MI. The most frequently reported facilitators were family/friend support (73%), spiritual support (60%), and financial support (40%). Family/friend support was evidenced by quotes such as "My husband stays behind me all the time," or "my son is so supportive ... he's my strength." Statements such as, "Lord, just take that idea out of my mind," "I believe in prayer," and "Bible study is so important to me ... I know He's given me the answer" demonstrated the use of spiritual support to facilitate making health decisions. Women reported financial support as money directly provided to them or as assistance from other social support programs. Financial support assisted the women in obtaining healthy food and medications. Drug companies supplied free medications to some women. One woman stated, "If Bristol Meyers decides not to give me any more [medicine], then I don't know what I'm going to do ... I probably would wind up getting sick again because I certainly couldn't buy it."

Cultural issues such as food preference served as barriers to making change. The women reported difficulty making healthy food choices because of how they had been raised. An 80-year-old retired dietitian stated, "[I] cut out fried foods and stuff like that ... Of course being from the South, we all like fried and everything. I bake chicken now ... haven't cut down enough ... as much as I should. I eat more [fat] than I should. I was raised up that way."

The women also identified lack of family/friend support and financial support as barriers. While family/friend support was identified by most women as essential to their recovery and an incentive to care for themselves, four women viewed family as a barrier to making health decisions. These women recounted financial or time burdens associated with caring for their families as limiting their health decisions and actions. One woman who provided total care to her debilitated husband stated, "I can't buy two different sets of food. Maybe a wiener which I know is full of salt, but it's soft and my husband don't have teeth."

Financial support was thus a facilitator when available and a barrier when lacking. The following quote depicts how lack of financial support affected the health decisions: "I can't afford unsalted canned food. He [husband] got a medicine list just as long as mine. I'm sure we doing \$300 in meds [per month]. I filled a prescription for him yesterday, \$79, one little bottle." Other barriers discussed by the women affected physical activity. Women said their fear of falling, the weather, safety, co-morbidities, and transportation were barriers to physical activity. Interestingly, most of the physical problems that limited their activity involved their legs, knees, or feet.

#### Implications For Adult-Health Nurses And Nurse Practitioners

These older women experienced a variety of changes in their lives after MI. One of the most intriguing findings was the decrease in energy experienced by participants after MI. Other researchers reported decreased energy or fatigue 6 weeks after MI (Varvaro, Sereika, Zullo, & Robertson, 1996). Decreased energy may be associated with depression (Milani & Lavie, 1998), but only two women scored high enough on the GDS to indicate that they might be at risk for depression. In this study, women reported decreased energy from 5 to 12 months after MI, which is similar to the physical symptoms reported by older women with heart failure (Friedman & King, 1995). Because none of these women reported having congestive heart failure, it is not known whether fatigue is a common symptom of older women after MI or whether these women had early undiagnosed congestive heart failure.

Because decreased energy after MI affected the older women's ability to perform activities of daily living and to participate in physical activity, it had an impact on their quality of life and cardiac risk profile. Therefore, future studies should evaluate decreased energy or fatigue later in MI recovery in older women. This is especially important in light of the fact that almost half of the women in this study were primary caregivers to spouses, disabled children, or grandchildren. If the causes of this fatigue are not determined and appropriate interventions developed, older women may increase their own use of health care resources and also use of health resources to provide care to their dependents.

In this study, women not only decreased their activity but also changed the pattern of activity to accommodate for their physiologic symptoms. These results were consistent with those of Hawthorne (1993) and Fleury, Kimbrell, and Kruszewski (1995). Women in this study used physiologic symptoms to guide their activities of daily living and cardiac risk factor modifications, and to alter or stop their medications. Because the sample was small, additional research is imperative to assess the influence of physiologic symptoms on health decisions and actions of older women.

The facilitators and barriers to making health decisions in this study were similar to those from previous studies (Ades, Waldmann, McCann, & Weaver, 1992; Ades et al., 1992; Biggs & Fleury, 1994; McSweeney, 1993; McSweeney & Crane, 2001; Melillo et al., 1996). However, women reported cultural influences such as food preference as a unique barrier to making health decisions. Because older women have more atherogenic lipid profiles that increase their risk for progression of CHD, diet is especially important in this population (Tsang, Barnes, Gersh & Hayes, 2000). Women in this study were older, poorer, and on multiple medications, necessitating financial support to make healthy decisions. Therefore, health care providers must advocate for changes in the cost of low-fat and low-salt foods. Further, health care providers must become aware of and actively participate in designing or changing health policies to assist older women to obtain the support they need to purchase medications.

Modification of risk factors after MI can have a cascading effect on other risk factors. Most of the lifestyle changes these women reported to modify cardiac risk factors were still in process. Although they engaged in physical activity to alter their cardiac risk status, only four women participated in physical activity with sufficient frequency, length, or intensity to elicit cardiac effects (AHA, 1998). This is disturbing because a reduction in cardiovascular risk factors resulting from lifestyle changes after MI appears to hold as much importance as medical intervention; it reduces not only progression of CHD but also hospitalizations for cardiac events and death (Haskell et al., 1994; Hunink et al., 1997). Interestingly, the four women actively

participating in physical activity after MI reported engaging in physical activity before their MI. Further investigations of physical activity should include (a) the influence of participation in physical activity before MI on physical activity after MI, and (b) the factors that enable women who did not exercise before MI to begin a physical activity program after MI. Additionally, because physiologic symptoms affected the performance of physical activity in this study, research on interventions to foster physical activity in older women should evaluate the impact of physical symptoms on participation and outcomes. Because strength training is directly related to improved physical performance even in frail older adults and may be an effective way to foster physical activity in older adults (Buchner, 1997; Mazzeo et al., 1998), developing and testing the use of strength training in older women after MI is warranted.

### Practice Implications

One of the most important implications of the study relates to teaching. Because women in this study altered their activity and modified their medication regime based on their physiologic symptoms, education on what symptoms may be expected as well as what symptoms to report to health care providers is essential. Further, education should be culturally appropriate to facilitate adherence to the prescribed plan. Therefore, detailed assessment of cultural influences that may affect the patient's adherence to the health plan must be explored.

The nurse should obtain a list of foods preferred by various cultures. Then, when assessing cultural food preferences, the nurse could review this list with the patient and ask the patient to identify the most frequently eaten foods. Once this information is obtained, healthier ways to prepare those foods can be explored.

Another identified barrier to adherence was financial limitations. It is imperative that the nurse assess the financial ability of older women to purchase medication and food, and identify alternative resources for acquiring the prescribed items prior to discharge. Having this information before discharge enables the nurse to explore other avenues to obtain the needed resources, such as medications provided by drug companies to those unable to pay. By recognizing limited resources and intervening prior to discharge, the nurse plays a vital role in promoting adherence to the prescribed plan and decreasing additional medical intervention related to nonadherence.

An intriguing finding of this study was the insecurity these older women experienced after their MI. Because this insecurity may increase older women's stress after MI, interventions to foster security, such as the medical alert system, should be implemented.

## Summary

This study explored older women's lifestyle changes after MI and provides a foundation for further investigations to assist older women who are at highest risk for morbidity and mortality after MI in making lifestyle changes to prevent further MIs. The results of this study and future research may be used to develop effective interventions to assist elderly women to reduce their risk factors, improve their health, and promote their quality of life.

Table 1.

### Data Analysis of Lifestyle Changes of Older Women after Myocardial

#### Infarction

| Global Categories | Clusters                    | Initial Raw Data  |
|-------------------|-----------------------------|---|
| Physiological     |                             |   |
| Changes           | Decreased energy            | I'm more exhausted; Like the blahs; No energy; I tire out faster.                                 |
|                   | Physical/Cognitive symptoms | I had shortness of breath; I started having pressure; I don't think as clearly; My legs give out. |

#### Health Decisions

and Actions

Process of modifying  
cardiac risk factors  
amenable to change

I'm trying to lose  
weight; We bake now; I  
started walking. I try  
not to worry.

Alterations in activity

I do a little bit and sit  
down; My husband does  
dishes; I double the  
fluid pill.

Change in perspective

I need to take better  
care of me; Maybe things  
are not as important as I  
thought; I need to be  
more serious about  
myself.

Change in compliance/  
adherence

Now I go to the doctor; I  
take my medicine on time;  
I now take medicine like  
they tell me.

Life Outcomes

Related to

Changes

Emotions

I wasn't sure what to do;  
It was just the fear of  
doing; I cry a lot more.

Results of medical  
management/lifestyle

I'm getting better at  
putting cigarettes down;

changes

After heart attack I felt  
better, didn't have that  
shortness of breath; I  
felt better; I'm [now] on  
almost 8 to 9 meds

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Patricia B. Crane, PhD, RN, is an Assistant Professor, School of Nursing, the University of North Carolina, Greensboro, NC.

Jean C. McSweeney, PhD, RN, is a Professor, College of Nursing, the University of Arkansas for Medical Sciences, Little Rock, AR.

Crane, Patricia B.^McSweeney, Jean C.