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Abstract

The aim of this study was to elucidate the meaning of the experience of younger people (< 55 years) during their first year following a myocardial infarction. We analyzed 17 interviews using a phenomenological–hermeneutic method. The core theme and central phenomenon was the everyday fight to redress the balance in life, which encompassed an existential, physical, and emotional battle to regain a foothold in daily life. The aftermath of a life-threatening event involved a process of transition while at the same time creating a new meaning in life. Lack of energy and its impact on the complex interplay of midlife combined with unreasonable demands from employers and health care professionals seemed to color the experience of the informants. The knowledge gained in this study can constitute a valuable contribution to overall quality assurance in nursing care and the development of nursing interventions for the cardiac rehabilitation of younger patients.

Keywords

heart health; hermeneutics; illness and disease, life-threatening / terminal; phenomenology; Ricoeur

Despite a number of studies demonstrating a departure from a naturalistic approach focusing on people's experiences following a myocardial infarction (MI), only a few (Allison & Campbell, 2009; Lacharity, 1999) explicitly investigated younger people (< 55 years old), including both sexes. Previous studies appear to have been concentrated on specific phenomena, such as symptoms (Johansson, Swahn, & Stromberg, 2007; McSweeney & Crane, 2000; Sjöström-Strand & Fridlund, 2008), information needs (Decker et al., 2007; Hanssen, Nordrehaug, & Hanestad, 2005), and the recovery process (Hildingh, Fridlund, & Lidell, 2006; Tod, 2008). Other phenomena of focus were stress (Clark, 2003; Sjöström-Strand & Fridlund, 2007), fatigue (Alsén, Brink, & Persson, 2008), lifestyle changes (Condon & McCarthy, 2006), intimate relationships (Arenhall, Kristofferzon, Fridlund, Malm, & Nilsson, 2011; Johansson Sundler, Dahlberg, & Ekenstam, 2009), and the dyadic experience of patients and partners following an MI (Thompson, Ersser, & Webster, 1995; Wang, Thompson, Chair, & Twinn, 2008). Although several of the above-mentioned studies included people of all ages, younger people de facto represented a relatively small proportion of the total. Hence, it is unclear how well these findings actually reflect the experience of younger people following an MI.

It appears reasonable to suggest that today younger people experience a complex and hectic life situation, with obligations such as work and career development, responsibility for underage children, and sometimes for

their own parents. This is supported by Lachman (2004), who described the complex interplay in the everyday life of midlife adults as being linked more to the welfare of others, such as children, parents, coworkers, and family members, than is the case in any other phase of life.

We know that an MI, regardless of age, is likely to add severe distress to everyday life and can result in an uncertain situation (Coyle, 2009; Kristofferzon, Löfmark, & Carlsson, 2007; Ostergaard Jensen & Petersson, 2003). Researchers who depart from a naturalistic approach have revealed that life following an MI can involve the experience of an uncertain and vulnerable everyday situation (Doiron-Maillet & Meagher-Stewart, 2003; Svedlund & Danielson, 2004), and result in feelings of guilt and worthlessness (Svedlund & Axelsson, 2000). However, others have found that life following an MI can entail an unremitting endeavor to achieve normalization (Eriksson, Asplund, & Svedlund, 2009; Svedlund & Danielson).

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Being struck by a life-threatening condition in midlife is likely to have a different effect, for example, than the same condition has on a retired person. Klein and Nathan (2003) concurred, and proposed that the consequences of an MI for family life and occupational activities can be greater for younger compared to older people. It is, however, important to acknowledge that research into life-threatening conditions has also revealed that part of people's experiences, irrespective of age and condition, might actually represent universal human reactions to the often unexpected and ruthless reminder that we all exist between life and death, and that life can be taken away at any point. Although there are similarities in human experiences following a life-threatening event, it is important to firmly base nursing care on general knowledge and the individual's unique perspective.

Research focusing on chronic conditions in middle-aged individuals indicates that our assumptions might be true (Nordgren, Asp, & Fagerberg, 2007). For example, Röding, Lindström, Malm, and Öhman (2003) found that younger individuals (37 to 54 years) who had suffered a stroke felt frustrated because they considered that rehabilitation services did not always recognize that their needs could differ from those of older stroke patients. Hence, it might be relevant to bear in mind that the needs of younger age groups for practical nursing support and interventions might not be identical to those of people closer to retirement or already retired.

To our knowledge, only two studies have explicitly focused on the experience of younger people following an MI (Allison & Campbell, 2009; Lacharity, 1999). Lacharity investigated 12 women aged between 31 and 47 years, whereas Allison and Campbell studied 7 men aged between 32 and 58 years. These researchers found that following an MI, younger women experienced negative effects on family life and younger men regarded suffering an MI as a weakness. There seems to be a paucity of naturalistic investigations of younger women and men following an MI, which makes it difficult to develop cardiac nursing care and appropriate interventions for younger patients. The aim of this study was to elucidate the meaning of the experience of younger people (< 55 years) during their first year following an MI. We conducted the study between May and September 2010.

Method

We used a phenomenological–hermeneutic method developed by Lindseth and Norberg (2004) to interpret interview texts. Lindseth and Norberg were inspired by the theory of interpretation presented by Ricoeur (1976). The method draws on the Western philosophy tradition, combining phenomenology with hermeneutics. Its purpose is to elucidate the meaning of a phenomenon

(Lindseth & Norberg). The point of reference in phenomenological studies is the essence of the meaning itself, not some object outside the realm of meaning. Hence, phenomenologists focus on “the understandable meaning of the experience” (Lindseth & Norberg, p. 146). In Lindseth and Norberg's method, interpretation of the text involves entering the hermeneutic circle via naïve reading, thematic structural analysis, and comprehensive understanding, described as a dialectic movement between a nonmethodic pole (understanding) and a methodic pole (explanation). The aim of a phenomenological–hermeneutic interpretation is to identify truths about the “essential meaning of being in the life world” (Lindseth & Norberg, p. 151). In this study, we collected data by means of narrative interviews (Mishler, 1986) following Lindseth and Norberg's recommendation that this is an appropriate method for disclosing the meaning of a lived experience.

Context

The participants in this study were originally cared for at one of three different county hospital coronary care units (CCUs) in southeast Sweden. The hospitals were located in three towns, each serving a sparsely populated area. The populations of the towns ranged from 128,000 to 234,000 inhabitants. Patients are usually discharged 4 or 5 days after an MI. During their hospital stay, patients, and in some cases relatives, receive from registered nurses (RNs), physicians, and physiotherapists written and oral information packages about MI and how to cope with it. Patients are also offered group exercise training and an education program called the “Heart School,” the aim of which is to increase knowledge of MI and encourage lifestyle changes.

Participants and Recruitment

Seventeen participants (6 women, 11 men) took part in the study and were recruited by purposive sampling (Polit & Beck, 2012) with regard to age, sex, education, and time since MI. Cardiac RNs at the three hospitals recruited the participants based on the following inclusion criteria: (a) aged 55 years or younger, with (b) an initial MI diagnosis within 12 months, (c) an MI diagnosis made on the basis of symptoms and electrocardiographic changes and/or confirmed by an abnormal elevation of cardiac enzyme levels, and (d) the physical and mental ability to participate. The RNs issued 39 invitations and 19 people agreed to take part, although at the time of interview two could not be located. We contacted the remaining 17 by phone. During the call, we informed them about the study and their right to withdraw at any time. A time and place for the interview were arranged. The participants were aged 23 to 53 years

Table 1. Example of Thematic Structural Analysis.

Meaning Unit	Condensation	Theme	Core Theme
We went down there [to my father's] once a week. But since I became ill, we haven't been there quite as often. So now I have [pause, crying] well it was sometime this spring. I got so fed up with everything and broke off all relations with him. I don't want anything to do with him. In order for me to recover [pause] I've told him that I don't give a damn about him right now, I mean I told him straight out. I don't have the strength; I don't want anything to do with him right now. Then occasionally he calls and then, well, I talk to him if he calls me, but I don't call him myself.	Lack of energy has forced me to break off relations with my father in order to recover.	Energy: Constantly lacking	An everyday fight to redress the balance in life

(median = 47, mean = 45). Ten were married, 4 were cohabiting, 3 were single, and 15 had children. Four participants had a university education, 10 a high school education, and 3 a secondary school education. Prior to the MI, 14 participants had blue- or white-collar positions, 1 was self-employed, and 2 were unemployed.

Narrative Interviews

We tested and discussed three broad, open-ended interview questions with a group of people who had suffered an MI. The group concluded that the question most likely to encourage narratives was, "Could you please tell me about your experiences in the period after the MI?" The first author conducted two pilot interviews (not included in the study) to test the suitability of the question before using it. The majority of the interviews took place in the participants' homes but two were conducted elsewhere (workplace, private hospital room). We posed the following probing questions to encourage narration as well as for clarification purposes: What do you mean? Could you please give me an example? Can you tell me more? The interviews were recorded and transcribed verbatim, including pauses, sighs, silences, tears, and laughter. One interview lasted for 27 minutes, and the others varied in length from 54 minutes to 2 hours 20 minutes.

The Phenomenological–Hermeneutic Interpretation

We used the following three methodological steps as part of the phenomenological–hermeneutic analysis: naïve reading, thematic structural analysis, and comprehensive understanding (Lindseth & Norberg, 2004). The analysis involved a continuous dialectical movement between the whole and the parts of the text; i.e., between understanding and explanation. First, the narratives were read repeatedly in an open-minded way (i.e., naïve reading, to grasp the whole meaning, while a naïve understanding was developed). Second, the first author

performed a thematic structural analysis aimed at explaining the parts of and patterns in the text as objectively as possible to validate or invalidate the naïve understanding (Lindseth & Norberg). We then organized the narratives into meaning units; i.e., a sentence, a group of sentences, or a whole paragraph that conveyed the meaning of the phenomenon.

We condensed and abstracted the meaning units, bringing them together in terms of similarities and differences to form the themes and the core theme (see Table 1). All authors compared the themes with the naïve understanding, validating the thematic structural analysis. The analysis was characterized by a back-and-forth movement between the narrative, meaning units, and themes. The third and final step was comprehensive understanding, in which we interpreted the narratives as a whole while taking account of the naïve understanding, the thematic structural analysis, our preunderstanding, and the literature. This step helped to revise, broaden, and deepen our understanding of the text (Lindseth & Norberg, 2004).

Ethical Considerations

We complied with the established ethical guidelines contained in the Declaration of Helsinki (World Medical Association, 2005) and approved by the Regional Ethical Review Board in Lund (Sweden). We obtained verbal and written informed consent from all participants, assured them of confidentiality, and advised them about their right to withdraw at any time without having to state a reason. Because interviews can evoke sensitive issues, a social worker was on standby in case participants needed counseling.

Interpretation and Findings

Naïve Understanding

The narratives elucidated the participants' experiences during the first year following their MI. They described suffering an MI as a traumatic experience, coupled with

abnormal tiredness and the constant presence of emotions such as fear and anxiety. They often experienced everyday life as a range of unreasonable demands that were too difficult to face and handle. Their experiences partly reflected feelings of being under constant threat because of their unreliable body and a permanently altered outlook on life. The participants felt humbled by the experience of receiving a second chance. Suffering an MI could also be experienced as life taking a complete U-turn, i.e., existentially, mentally, physically, and socially, and the participants' narratives described their struggles to recreate their former life.

Thematic Structural Analysis

The structural analysis indicated that the meaning of younger people's experiences following an MI is embodied in five themes: energy: constantly lacking; fear: a constant companion; demands: constantly present; threats: an unreliable body and mind; and outlook: life will never be the same. These themes formed the foundation of the core theme: An everyday fight to redress the balance in life.

Energy: Constantly lacking. This theme revealed that life after surviving an MI often meant overwhelming physical and mental fatigue, which at times was impossible to manage. The participants could no longer perform activities that previously formed a normal part of their life with the same ease or vitality, which had a distressingly large impact on everyday life and the family. One participant stated,

Hard, it was very hard not having the strength. As the children put it, "It's Aunty and fast food." I always loved cooking, but it's frustrating now. So as they [the children] say, "It's lucky that Aunty and pizza parlors are there so we have something to eat."

Constantly experiencing a lack of physical and mental energy led to obvious restrictions; for example, in the ways participants socialized with family and friends. The number of spontaneous outings decreased and activities with their children took place at a slower tempo. All activities had to be properly planned because the participants' physical energy reserves were only sufficient for one activity at a time. A constant lack of physical energy also changed the everyday patterns of running their homes and pursuing their hobbies. In some cases, it had a negative impact on their ability to care for older parents. Mentally, their experience of fatigue could lead to them no longer being able to handle conflicts with their children or exposing themselves for long periods to noisy environments at home or at work. A lack of mental energy also meant that a previously pleasant and happy disposition was now less evident, particularly because

many plans for the future were shelved in light of not knowing what the next day might bring.

The participants also described periods when fatigue completely took over life and affected their ability to cope with even the simplest chores or activities. As one participant commented, "You don't have the strength, Nothing is fun; absolutely nothing is fun. [Pause] You can't make yourself do things as you don't have the strength; you simply feel that everything is shit." At such times, the participants had no choice other than to ask for support and help, thus feeling dependent on family and friends. These situations could also give rise to emotions other than dependency, such as ambiguity and unwillingness to involve friends and family, and they tried as far as possible to handle the situation themselves.

Fear: A constant companion. Within this theme, the participants' constant awareness of their fear became obvious. Suddenly and unexpectedly, the notion of the fragility of life could strike them. Becoming aware of one's mortality and the realization that a future was not guaranteed could result in fear of suffering another—this time fatal—MI.

Their fear of death was closely linked to the fear that dying would mean being unable to fulfill their parental responsibilities toward their underage children. They also feared not seeing their children grow up and being unable to participate in their life plans and dreams. There was obvious fear and concern about their children's health and the possible risk that the children could also end up with an MI in the future. Their efforts to prepare for an unpredictable future included drawing up a will and reviewing their life insurance. One participant stated,

I have come to realize that I'm no longer immortal. . . . It has been the biggest thing to switch [pause] from living life as immortal to suddenly realizing that you. [Pause] Shit, I wasn't so damned far from being on the wrong side and leaving it all, the children and everything. I never imagined that I would suffer an MI. . . . And that's why I've started the thing with a will, something I would never have considered before. That's not something [pause] you should need to think about when you're thirty-five years old.

Ever-present fear could also be the result of not receiving straight answers about why they had been stricken. The participants felt that they had received no information about how to prevent a recurrence. Being on sick leave could create a feeling of insecurity as well as fear of financial destitution. To survive, some participants had to borrow money from relatives or even sell personal possessions. They also feared not being able to perform their job with the same level of efficiency. Those who were unemployed at the time of their MI also feared being less attractive on the labor market.

Another source of anxiety was the fear of physical exertion, particularly in relation to marital duties. The participants described the negative impact of fears of being unable to perform sexually and fear of resuming a normal sex life, which could lead to a feeling of worthlessness. Emotions and needs were present but the fear of being incapable of handling the physical exertion occasioned by sexual intimacy led them to suppress such emotions and needs. A participant stated,

I was of course afraid that I would have another heart attack and feared doing certain things. . . . Well, I was afraid to have intercourse so to speak. . . . At the beginning, there was this fear of exerting myself and stuff like that, followed by the fear of not being able to get an erection.

Demands: Constantly present. It became clear how everyday life appeared to close in on the participants as a result of various demands from employers, the Swedish Social Insurance Agency (SSIA), and health care professionals. All these demands, many of which meant less time to recover and rehabilitate, added more stress to a life situation in which the participants were already struggling to feel solid ground beneath their feet. Sometimes, employers were responsible for the participants' experiences by demanding a return to work before they felt ready, instead of providing support and assistance.

Threats of redeployment or dismissal resulted in a feeling of being at the mercy of the employer and her or his attitude, and not having the strength to stand firm and argue one's case, which caused great uncertainty and pressure. In some cases, participants were powerless when the SSIA demanded that they return to work early. One participant stated,

It was not possible for me to remain on sick leave for as long as I needed because I would have risked losing my job, and there's this thing about the sickness benefit coming to an end and you being deemed fit to go back to work and things like that. . . . I didn't feel very well, and thought that I was not taken seriously by my employer or the SSIA.

The participants had the impression that the SSIA rules were applied without taking account of individual circumstances. Because of their persistent lack of energy and constant demands, they were unable to state their case and thus complied with decisions despite feeling "depreciated." Furthermore, they experienced that the SSIA, employers, and health care professionals did not always provide the same information.

The health care professionals, including the cardiac rehabilitation team, provided several follow-up visits, educational sessions, and physical training programs. The

participants considered it stressful and demanding to combine these activities with family life, work commitments, and the physical and mental consequences of an MI. They saw them as a rigid standard package, not coordinated in terms of when or where they took place, and at the same time constituting a pressure to attend several days a week during working hours. Thus, they perceived the activities proposed by the health care professionals as more or less mandatory, uncoordinated demands as opposed to a genuine offer of services.

They also reported that no one on the cardiac rehabilitation team actually asked what they needed and what was most important for them at that particular time. For example, they considered the physiotherapist-led training classes more suitable for older people and not tailored to a younger patient group. One participant said,

These information sheets are always sent to someone who has suffered a heart attack, and regardless of whether or not there is a need, they offer you a fixed number of cardiac training sessions. You receive notification to attend this meeting and that meeting. . . . I was first told to see a nurse, and the next day an appointment was arranged for me to see the occupational therapist. They should try to coordinate it somehow, so that I can have time to relax at home. I shouldn't have to rush there and back, driving thirty to thirty-five miles.

Threats: An unreliable body and mind. The participants described the experience of no longer being able to trust their body, particularly because their heart could stop without warning; thus, they began seeing their body as unfamiliar and weak. These experiences meant that the participants were constantly on guard and read their body signs carefully, resulting in a fear of being alone. Choosing to be in places where people were nearby, with easy access to an ambulance, and remaining in regular contact with relatives and friends were strategies to cope with such experiences. One participant said, "I had to be in places where other people were nearby and where it was easy for the ambulance to reach me should something happen."

The participants also indicated that their MI had left them with a number of physical and mental problems, including impaired sleep, nightmares, and a fear of dying in their sleep, which added to their constant fatigue and had a negative effect on everyday life. Temporary cognitive problems such as forgetfulness, difficulty spelling, and difficulty concentrating—even on familiar things—affected their work and private life, adding to the feeling of stress. They also had sudden, strong mood swings, including irritation and anger about issues that would not have worried them before the MI, which led to feelings

of remorse, guilt, and lack of trust in their body. The participants avoided discussing their problems for fear of losing their job or being considered strange, while at the same time struggling to trust their body again and return to normal. A participant stated,

Now at the blink of an eye, I get mad about nothing, just like that [snaps his fingers]. Today I get upset about things that I would not even consider getting angry about before. This naturally affects our relationship. She [wife] gets a lot of crap for the things I do, and I get irritated and snub her.

Outlook: Life will never be the same. This theme represented the realization that life had changed dramatically and that the situation would continue for an indefinite period. The participants regarded the MI as a warning that made them aware of the very thin line between life and death. It took a long time to come to terms with what had happened. Acquiring knowledge about possible cause and effect allowed an opportunity to move forward, even if it meant a different kind of everyday life to the one they had previously. However, receiving no knowledge of cause and effect made it difficult to focus on what to prioritize. A life-threatening condition could also weaken self-confidence and evoke a sense of being categorized as ill at a fairly young age. One participant stated, "I always considered myself healthy, fit, and able to take action when necessary. So I feel that the MI has shaken my confidence."

The narratives also revealed a constant struggle to comply with healthy lifestyle changes, such as the dietary modifications and physical activities required following an MI. Professional support seemed to be a critical factor to make the lifestyle changes successful. However, the narratives indicated inadequate support, with the result that goals set by the participants were not always achieved. A desire was expressed to meet with the physiotherapist alone for individual advice and support, although some participants stated that a personal trainer was preferable to the cardiac rehabilitation team physiotherapist. However, their new outlook had the added bonus of a more accepting view of life and their fellow human beings.

Seizing life and enjoying living for the moment could involve a change of priorities in terms of what was valuable in life. One participant remarked,

You value your life today, and it is important to do the things you find enjoyable and ignore the rest. . . . That is probably the most important lesson: to live in the here and now and make the most of what you have.

The participants no longer prioritized risk taking, material possessions, or working life, all of which had been

very important to them before the MI. Instead, they valued the opportunity to spend quality time with family members and felt deeply grateful for their second chance in life.

Comprehensive Understanding and Reflections

The findings of this study suggest that the experience of younger people (< 55 years) after an MI can be interpreted as an everyday fight to redress the balance in life. After a life-threatening event, life can become a daily physical, emotional, and existential battle for a secure foothold. Everything that had been taken for granted was now endangered, especially as a result of the realization that the former lifestyle would never return. We interpreted the core theme, an everyday fight to redress the balance in life, as a central phenomenon colored by the experience of these younger people. In addition to the battle to regain a secure foothold, the core theme also encompassed experiences that we believe might be unique to younger people, such as a constant lack of mental and physical energy that seriously impaired everyday life. Their lack of energy, together with their experience of unreasonable demands on the part of employers, health care services, and in particular the SSIA, seemed to impact on their lives after an MI in a particularly negative way.

The interpretation is that for younger people, the period after an MI is marked by a fundamental life transition in which their everyday existence is characterized by a struggle to regain a foothold. According to Meleis, Sawyer, Im, Messias, and Schumacher (2000), it is possible to describe major life changes as a shift from one state to another—a process of transition. This process can result in a changed perception of health, new meaning, and a sense of control. Among other things, the participants' struggles to find new ways of living with the consequences of an MI reflected this process. Some participants were still influenced by the uncertainty of an unreliable body and mind, as well as their experiences of mental and physical fatigue and fear, whereas others had reached a state of reorientation and stability. It therefore seems as if the transition process can facilitate the quest for a new meaning in life and make it possible to face new challenges. This is in line with Meleis et al., who stated that in all transitions there is a need to achieve a sense of balance in life, and that the transition process ends with a new beginning or a period of stability.

Other researchers have previously described the struggle to establish a secure foothold in everyday life following an MI. Kristofferzon et al. (2007) revealed that former MI sufferers struggled to strike a balance between problems and resources to regain control, redefine normality,

and learn to live with the limitations imposed by the MI. Bergman and Berterö (2003) found that even though an MI is a negative event, certain positive experiences could also occur, such as feeling a zest for life and a desire to seize life in the here and now. To offer adequate support it is important for health care professionals to understand and be aware of this transition process. Our interpretations revealed that in combination with their experience of going through a key life transition, these younger people also searched for a new, personal meaning in life.

The participants' narratives to some extent exude a sense of threat, suffering, anxiety, and fear. They struggled to live in the present and maintain a positive outlook on the future. This was illustrated by prioritizing new values in life, such as enhancing their physical health through lifestyle changes, attempting to live for the moment, becoming more moderate in life, and spending more time with their families. Our findings are consistent with Frankl (1964), who claimed that regardless of the circumstances, life has meaning, even in times of distress and illness. Meaning can assist individuals to endure and survive the most unfavorable conditions and can also promote, improve, and help them to cope with adaptation during the recovery period.

Endowing life events with meaning facilitates the individual to define her or his values in life, thus making her or him better able to cope with and understand the current crisis. Baldacchino (2011) found that an MI appears to trigger a reevaluation of priorities and the meaning of life. Gaining new meaning in life; changing one's life values, such as improved relationships (Svedlund & Danielson, 2004); and being given a second chance (Eriksson et al., 2009; Kristofferzon, Löfmark, & Carlsson, 2008) following an MI have been previously described and correspond with the findings of the present study. The search for meaning is an individual and existential process that requires time. Health care professionals should be able to support patients in this endeavor.

Another part of the struggle to regain balance in life was the presence of obvious mental and physical exhaustion that resulted in physical, cognitive, social, and emotional restrictions. Although fatigue is common in this patient group regardless of age (Alsén et al., 2008; Appels, 2004; Brink, Karlson, & Hallberg, 2002; McGowan et al., 2004), we suggest that following an MI it might have a particularly debilitating impact on the experience of life among people in midlife. Prior to the event, the participants in this study all led extremely busy and complex lives, filled with work, young children, family, leisure activities, and so forth. This suggests that their daily physical and emotional exhaustion was particularly distressing, not only for themselves but also for those around them.

Health care professionals need to be observant, because fatigue can be a key symptom of depression (Irvine et al., 1999). Depression following an MI is associated with an increased risk of mortality (Dickens et al., 2008; Frasure-Smith, Lespérance, Juneau, Talajic, & Bourassa, 1999), as well as difficulty adhering to behavior and lifestyle recommendations (Ziegelstein et al., 2000). Consequently, we must pay greater attention to the presence of fatigue and its negative influences on the everyday life of younger people during cardiac rehabilitation. This can facilitate identification of the individuals concerned and ensure that they receive the necessary nursing interventions and support. The findings of this study demonstrate the necessity for cardiac nurses to listen to younger people and participate in interventions that help them to deal with their experience of fatigue, thus increasing their chances of regaining a secure foothold.

The most pertinent finding to emerge from this study, which we interpreted as unique to this age group, was how the participants constantly struggled with what they felt were unreasonable demands from employers, the SSIA, health care professionals, and even the cardiac rehabilitation team. This demonstrates that the care of younger people must not be based exclusively on routines but that RNs should take individual circumstances into account. As the participants in the present study reported, such routines can be experienced as more demanding than supportive and allow less time for recovery and rehabilitation, thus adding more stress to the life situation. RNs working in cardiac care have a responsibility to support patients and coordinate care initiatives with other health care professionals (Fridlund, 2000).

It is well known that participation in exercise-based rehabilitation leads to reduced mortality in patients with coronary heart disease (Heran et al., 2011). More than ten years ago, Wieslander and Fridlund (2001) highlighted the necessity of adapting cardiac rehabilitation to the needs, attitudes, age, and family situation of the affected individual. This is especially important in younger people, because Yohannes, Yalfani, Doherty, and Bundy (2007) highlighted younger age as a predictor of early dropout from cardiac rehabilitation. Additionally, Thompson and Clark (2009) revealed in a review that two of the reasons patients do not receive cardiac rehabilitation could be family commitments and work obligations.

Findings from the present study provide health care professionals and authorities with a plausible reason as to why routine care does not work; i.e., why younger people might drop out of cardiac rehabilitation. It is therefore important to raise awareness among health care professionals about the necessity to not be demanding and instead be supportive by tailoring the care and cardiac rehabilitation to a younger person's situation as well as

involving the individual as a collaborative partner. Health care professionals should apply person-centered care systematically and consistently, as it can contribute to improved concordance between the care provider and patient on treatment plans and increase patient satisfaction (Ekman et al., 2011). This is particularly important, as person-centered care is one of the six identified core competencies of health care professionals (Cronenwett et al., 2007; Swedish Society of Nursing, 2010).

Methodological Considerations

According to Morse, Barrett, Mayan, Olson, and Spiers (2002), there is a need for rigor in all phases of the research process, as well as verification strategies for its enhancement in a qualitative inquiry. Variation in the demographic characteristics of the study group resulting from the participants being recruited from three different CCUs and the inclusion of both women and men might have led to richer narratives. We carried out the interviews during the first year following an MI and chose this timeframe in light of the fact that 30% of MI patients in Sweden are readmitted to hospital at least once during the first year (Henriksson, 2011). In the interviews, the participants appeared to speak freely and honestly about what mattered to them, and some indicated that they had “not told anyone about this before.”

In this study, the interpretation was based on our roles as RNs and nursing science researchers, as well as our experiences and understanding of younger people following an MI. When gathering and analyzing the data, we constantly reflected on and questioned the first author’s preunderstanding of the context (6 years’ experience as a cardiac RN) so as to remain open to the data and provide as accurate an account of the phenomenon as possible. Such reflexivity helped the first author to remain in this mode. According to Lindseth and Norberg (2004), the researcher must have sufficient preunderstanding to be able to grasp the essential meaning of the text.

We avoided the weakness of taking the participants’ statements for granted and disregarding important statements. The interviewer used probing questions and summarized what had been said to check that her understanding was correct. According to Lindseth and Norberg (2004), a strategy for ensuring trustworthiness in the analysis process is inherent in the comparison of the naïve understanding, structural analysis, and comprehensive understanding that takes place in the dialectical movement between the whole and the parts.

Throughout the study, critical reflection and regular discussions took place between all authors to ensure trustworthiness. The first author led the thematic structural analysis, the second author independently read the emerging thematic structural analysis, and the third

author assumed the task of questioning analytical assumptions and the proposed themes. During this process, no disagreements or contradictory interpretations arose, although there was discussion about how best to label the themes. As argued by Ricoeur (1976), there is always more than one probable interpretation of a text, but in this case all authors agreed that the findings presented were the most credible understanding of the narratives. We used quotations to illustrate the participants’ views, thus giving the reader the opportunity to judge the interpretation and trustworthiness of the study (Benner, 1985). Although transfer of the findings to other contexts requires recontextualization of the results (Ricoeur, 1991), they can still be applicable in a context similar to that in this study.

Conclusion

Findings from this study contribute knowledge and a deeper understanding of the meaning of younger people’s experiences following a myocardial infarction. The core theme of an everyday fight to redress the balance in life reflects the battle to obtain a secure foothold despite constant threats and demands. Participant experiences were interpreted as a transition process with a search for meaning, thus leading to balance in life as well as new values and priorities. The transition process and search for new meaning might be a universal human reaction to life-threatening events. Hence, the findings of this study suggest that certain elements of younger people’s experiences following an MI might not be unique. However, their physical and mental exhaustion were interpreted as having the potential to exert a major impact on their complex everyday life, which not only affected them negatively but also their underage children and others close to them.

Our interpretation was that their draining experiences of constant demands from employers, the SSIA, health care professionals, and the cardiac rehabilitation team were specific to this younger age group. When planning care and cardiac rehabilitation, RNs should acknowledge that following an MI, younger people might have different needs compared to older individuals. Providing person-centered care might be one way to address this issue. In this study, we demonstrated that further investigations are needed on how younger people experience the care they receive following an MI and how RNs can best care for them in their new life situation.

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References

- Allison, M., & Campbell, C. (2009). "Maybe it could be a heart attack . . . but I'm only 31": Young men's lived experience of myocardial infarction—An exploratory study. *American Journal of Men's Health*, 3(2), 116-125. doi:10.1177/1557988307308519
- Alsén, P., Brink, E., & Persson, L. (2008). Living with incomprehensible fatigue after recent myocardial infarction. *Journal of Advanced Nursing*, 64(5), 459-468. doi:10.1111/j.1365-2648.2008.04776.x
- Appels, A. (2004). Exhaustion and coronary heart disease: The history of a scientific quest. *Patient Education and Counseling*, 55(2), 223-229. doi:10.1016/j.pec.2003.09.008
- Arenhall, E., Kristofferzon, M.-L., Fridlund, B., Malm, D., & Nilsson, U. (2011). The male partners' experiences of the intimate relationships after a first myocardial infarction. *European Journal of Cardiovascular Nursing*, 10(2), 108-114. doi:10.1016/j.ejcnurse.2010.05.003
- Baldacchino, D. (2011). Myocardial infarction: A turning point in meaning in life over time. *British Journal of Nursing*, 20(2), 107-114. Retrieved from <http://www.british-journalofnursing.com/>
- Benner, P. (1985). Quality of life: A phenomenological perspective on explanation, prediction, and understanding in nursing science. *Advances in Nursing Science*, 8(1), 1-14. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Bergman, E., & Berterö, C. (2003). 'Grasp life again': A qualitative study of the motive power in myocardial infarction patients. *European Journal of Cardiovascular Nursing*, 2(4), 303-310. doi:10.1016/S1474-5151(03)00098-7
- Brink, E., Karlson, B. W., & Hallberg, L. R. (2002). Health experiences of first-time myocardial infarction: Factors influencing women's and men's health-related quality of life after five months. *Psychology, Health & Medicine*, 7(1), 5-16. doi:10.1080/13548500120101522
- Clark, A. M. (2003). "It's like an explosion in your life . . .": Lay perspectives on stress and myocardial infarction. *Journal of Clinical Nursing*, 12(4), 544-553. doi:10.1046/j.1365-2702.2003.00740.x
- Condon, C., & McCarthy, G. (2006). Lifestyle changes following acute myocardial infarction: Patients perspectives. *European Journal of Cardiovascular Nursing*, 5(1), 37-44. doi:10.1016/j.ejcnurse.2005.06.005
- Coyle, M. K. (2009). Over time: Reflections after a myocardial infarction. *Holistic Nursing Practice*, 23(1), 49-56. doi:10.1097/01.HNP.0000343209.56710.2a
- Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., & Warren, J. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55(3), 122-131. doi:10.1016/j.outlook.2007.02.006
- Decker, C., Garavalia, L., Chen, C., Buchanan, D. M., Nugent, K., Shipman, A., & Spertus, J. A. (2007). Acute myocardial infarction patients' information needs over the course of treatment and recovery. *Journal of Cardiovascular Nursing*, 22(6), 459-465. doi:10.1097/01.JCN.0000297391.11324.0f
- Dickens, C., McGowan, L., Percival, C., Tomenson, B., Cotter, L., Heagerty, A., & Creed, F. (2008). New onset depression following myocardial infarction predicts cardiac mortality. *Psychosomatic Medicine*, 70(4), 450-455. doi:10.1097/PSY.0b013e31816a74de
- Doiron-Maillet, N., & Meagher-Stewart, D. (2003). The uncertain journey: Women's experiences following a myocardial infarction. *Canadian Journal of Cardiovascular Nursing*, 13(2), 14-23. Retrieved from <http://www.cccn.ca/content.php?doc=21>
- Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., & Stibrant Sunnerhagen, K. (2011). Person-centered care—Ready for prime time. *European Journal of Cardiovascular Nursing*, 10(4), 248-251. doi:10.1016/j.ejcnurse.2011.06.008
- Eriksson, M., Asplund, K., & Svedlund, M. (2009). Patients' and their partners' experiences of returning home after hospital discharge following acute myocardial infarction. *European Journal of Cardiovascular Nursing*, 8(4), 267-273. doi:10.1016/j.ejcnurse.2009.03.003
- Frankl, V. E. (1964). *Man's search for meaning: An introduction to logotherapy*. London: Hodder & Stoughton.
- Frasure-Smith, N., Lespérance, F., Juneau, M., Talajic, M., & Bourassa, M. G. (1999). Gender, depression, and one-year prognosis after myocardial infarction. *Psychosomatic Medicine*, 61(1), 26-37. Retrieved from <http://www.psychosomaticmedicine.org/>
- Fridlund, B. (2000). Cardiac care: Nurse's role today and tomorrow. *Scandinavian Journal of Caring Sciences*, 14(4), 209-210. doi:10.1080/028393100300006780
- Hanssen, T. A., Nordrehaug, J. E., & Hanestad, B. R. (2005). A qualitative study of the information needs of acute myocardial infarction patients, and their preferences for follow-up contact after discharge. *European Journal of Cardiovascular Nursing*, 4(1), 37-44. doi:10.1016/j.ejcnurse.2004.11.001
- Henriksson, C. (2011). *Coronary heart disease and early decision making, from symptoms to seeking care: Studies with focus on pre-hospital delay in acute myocardial infarction patients* (Doctoral thesis). Uppsala University, Faculty of Medicine, Uppsala, Sweden. Retrieved from uu.diva-portal.org/smash/get/diva2:432646/FULLTEXT02
- Heran, B. S., Chen, J. M., Ebrahim, S., Moxham, T., Oldridge, N., Rees, K., & Taylor, R. S. (2011). Exercise-based car-

- diac rehabilitation for coronary heart disease. *Cochrane Database of Systematic Reviews* (Online), 7, CD001800. doi:10.1002/14651858.CD001800
- Hildings, C., Fridlund, B., & Lidell, E. (2006). Access to the world after myocardial infarction: Experiences of the recovery process. *Rehabilitation Nursing*, 31(2), 63-69. doi:10.1002/j.2048-7940.2006.tb00127.x
- Irvine, J., Basinski, A., Baker, B., Jandciu, S., Paquette, M., Cairns, J., & Dorian, P. (1999). Depression and risk of sudden cardiac death after acute myocardial infarction: Testing for the confounding effects of fatigue. *Psychosomatic Medicine*, 61(6), 729-737. Retrieved from <http://www.psychosomaticmedicine.org/>
- Johansson, I., Swahn, E., & Stromberg, A. (2007). Manageability, vulnerability and interaction: A qualitative analysis of acute myocardial infarction patients' conceptions of the event. *European Journal of Cardiovascular Nursing*, 6(3), 184-191. doi:10.1016/j.ejcnurse.2006.08.003
- Johansson Sundler, A., Dahlberg, K., & Ekenstam, C. (2009). The meaning of close relationships and sexuality: Women's well-being following a myocardial infarction. *Qualitative Health Research*, 19, 375-387. doi:10.1177/1049732309331882
- Klein, L. W., & Nathan, S. (2003). Coronary artery disease in young adults. *Journal of the American College of Cardiology*, 41(4), 529-531. doi:10.1016/S0735-1097(02)02861-9
- Kristofferzon, M.-L., Löfmark, R., & Carlsson, M. (2007). Striving for balance in daily life: Experiences of Swedish women and men shortly after a myocardial infarction. *Journal of Clinical Nursing*, 16(2), 391-401. doi:10.1111/j.1365-2702.2005.01518.x
- Kristofferzon, M.-L., Löfmark, R., & Carlsson, M. (2008). Managing consequences and finding hope—Experiences of Swedish women and men 4-6 months after myocardial infarction. *Scandinavian Journal of Caring Sciences*, 22(3), 367-375. doi:10.1111/j.1471-6712.2007.00538.x
- Lacharity, L. A. (1999). The experiences of younger women with coronary artery disease. *Journal of Women's Health & Gender-Based Medicine*, 8(6), 773-785. doi:10.1089/152460999319101
- Lachman, M. E. (2004). Development in midlife. *Annual Review of Psychology*, 55, 305-331. doi:10.1146/annurev.psych.55.090902.141521
- Lindseth, A., & Norberg, A. (2004). A phenomenological hermeneutical method for researching lived experience. *Scandinavian Journal of Caring Sciences*, 18(2), 145-153. doi:10.1111/j.1471-6712.2004.00258.x
- McGowan, L., Dickens, C., Percival, C., Douglas, J., Tomenson, B., & Creed, F. (2004). The relationship between vital exhaustion, depression and comorbid illnesses in patients following first myocardial infarction. *Journal of Psychosomatic Research*, 57(2), 183-188. doi:10.1016/S0022-3999(03)00610-X
- McSweeney, J. C., & Crane, P. B. (2000). Challenging the rules: Women's prodromal and acute symptoms of myocardial infarction. *Research in Nursing and Health*, 23(2), 135-146. doi:10.1002/(SICI)1098-240X(200004)23:2<135::AID-NUR6>3.0.CO;2-1
- Meleis, A. I., Sawyer, L. M., Im, E.-O., Messias, D. K. H., & Schumacher, K. (2000). Experiencing transitions: An emerging middle-range theory. *Advances in Nursing Science*, 23(1), 12-28. Retrieved from <http://journals.lww.com/advancesinnursingscience/pages/default.aspx>
- Mishler, E. G. (1986). *Research interviewing: Context and narrative*. Cambridge, MA: Harvard University Press.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 13-22. Retrieved from <http://ejournals.library.ualberta.ca/index.php/IJQM/index>
- Nordgren, L., Asp, M., & Fagerberg, I. (2007). Living with moderate-severe chronic heart failure as a middle-aged person. *Qualitative Health Research*, 17, 4-13. doi:10.1177/1049732306296387
- Ostergaard Jensen, B., & Petersson, K. (2003). The illness experiences of patients after a first time myocardial infarction. *Patient Education and Counseling*, 51(2), 123-131. doi:10.1016/S0738-3991(02)00196-9
- Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins.
- Ricoeur, P. (1976). *Interpretation theory: Discourse and the surplus of meaning*. Fort Worth, TX: Christian University Press.
- Ricoeur, P. (1991). *From text to action: Essays in hermeneutics II*. London: Athlone.
- Röding, J., Lindström, B., Malm, J., & Öhman, A. (2003). Frustrated and invisible—Younger stroke patients' experiences of the rehabilitation process. *Disability and Rehabilitation*, 25(15), 867-874. doi:10.1080/0963828031000122276
- Sjöström-Strand, A., & Fridlund, B. (2007). Stress in women's daily life before and after a myocardial infarction: A qualitative analysis. *Scandinavian Journal of Caring Sciences*, 21(1), 10-17. doi:10.1111/j.1471-6712.2007.00433.x
- Sjöström-Strand, A., & Fridlund, B. (2008). Women's descriptions of symptoms and delay reasons in seeking medical care at the time of a first myocardial infarction: A qualitative study. *International Journal of Nursing Studies*, 45(7), 1003-1010. doi:10.1016/j.ijnurstu.2007.07.004
- Svedlund, M., & Axelsson, I. (2000). Acute myocardial infarction in middle-aged women: Narrations from the patients and their partners during rehabilitation. *Intensive and Critical Care Nursing*, 16(4), 256-265. doi:10.1054/iccn.2000.1516
- Svedlund, M., & Danielson, E. (2004). Myocardial infarction: Narrations by afflicted women and their partners of lived experiences in daily life following an acute myocardial infarction. *Journal of Clinical Nursing*, 13(4), 438-446. doi:10.1111/j.1365-2702.2004.00915.x
- Swedish Society of Nursing. (2010). *Svensk sjuksköterskeförenings strategi för utbildningsfrågor [Swedish Society of Nursing's strategy for educational issues]*. Bromma, Sweden: Author. Retrieved from <http://www.swenurse.se/Publikationer-Remisser/Publikationer/Utbildning/Svensksjukskoterskeforenings-strategi-for-utbildningsfragor-ute/>

- Thompson, D. R., & Clark, A. M. (2009). Cardiac rehabilitation: Into the future. *Heart, 95*(23), 1897-1900. doi:10.1136/hrt.2009.173732
- Thompson, D. R., Ersser, S. J., & Webster, R. A. (1995). The experiences of patients and their partners 1 month after a heart attack. *Journal of Advanced Nursing, 22*(4), 707-714. doi:10.1046/j.1365-2648.1995.22040707.x
- Tod, A. (2008). Exploring the meaning of recovery following myocardial infarction. *Nursing Standard, 23*(3), 35-42. Retrieved from <http://nursingstandard.rcnpublishing.co.uk/>
- Wang, W., Thompson, D. R., Chair, S. Y., & Twinn, S. F. (2008). Chinese couples' experiences during convalescence from a first heart attack: A focus group study. *Journal of Advanced Nursing, 61*(3), 307-315. doi:10.1111/j.1365-2648.2007.04529.x
- Wieslander, I., & Fridlund, B. (2001). Cardiac rehabilitation efforts for patients with ischaemic heart disease—A 5-year comparative review in five counties in western Sweden. *Coronary Health Care, 5*(1), 16-24. doi:10.1054/chee.2000.0106
- World Medical Association. (2005). *World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects*. Retrieved from <http://www.wma.net/en/30publications/10policies/b3/>
- Yohannes, A. M., Yalfani, A., Doherty, P., & Bundy, C. (2007). Predictors of drop-out from an outpatient cardiac rehabilitation programme. *Clinical Rehabilitation, 21*(3), 222-229. doi:10.1177/0269215506070771
- Ziegelstein, R. C., Fauerbach, J. A., Stevens, S. S., Romanelli, J., Richter, D. P., & Bush, D. E. (2000). Patients with depression are less likely to follow recommendations to reduce cardiac risk during recovery from a myocardial infarction. *Archives of Internal Medicine, 160*(12), 1818-1823. doi:10.1001/archinte.160.12.1818

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