Exploring the Literature on Older Women Lived Experiences with Heart Failure

by

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Abstract

The purpose of this paper was to disrupt the biomedical discourse on heart failure. Literature on the lived experiences of older women with heart failure was reviewed from a feminist perspective. The literature review revealed that women's lives are pluralistic and their experiences with heart failure are understood in personal and social contexts. Women living with heart failure seek to understand this complex and chronic syndrome but do not want to abandon their own voices and experiences, ideas, and needs within the biomedical explanation. Recommendations for future research on older women living with heart failure and nursing practice are offered.

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Introduction

During a practicum at a heart function clinic, I discovered that there was a paucity of literature on the lived experience of older women with heart failure. Heart failure, I found, is heavily researched. In addition to cardiology journals, *The European Journal of Heart Failure* and *Heart Failure Reviews* are dedicated to the subject. During my literature searches, I found that the topics most widely addressed encompassed the epidemiology, pathophysiology, and the treatment of heart failure. There were numerous definitions used to describe heart failure which reflect current understandings of the clinical presentations and underlying pathologies of disorders within the larger category of heart failure[1] (Arnold et al., 2006; Chatterjee & Masie, 2007). There were volumes of publications on heart failure dedicated to the diagnosis, investigations, and management of this complex and chronic syndrome. The amount of quantitative research was vast. The anatomy, physiology, and pathophysiology of the heart were continually being described, explained, and emphasized. The diagnosis and investigations were fully and thoroughly suggested and the management and treatments thoughtfully recommended. In contrast, I was surprised by the scarcity of qualitative research. I began to wonder: Where is the person living with and experiencing heart failure? Who was being studied in heart failure? Who was not? Why were some being studied and some not? Why were some included and some excluded?

As I thought about what I had discovered through reviewing the literature in light of my cardiovascular nursing practice and feminist leanings, I wondered, did my focus on

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[1] The Canadian Cardiovascular Society (CCS) defines heart failure as a “complex syndrome in which abnormal heart function results in, or increases the subsequent risk of, clinical syndromes and signs of low cardiac output and/or pulmonary or systemic congestion” (Arnold et al, 2006, p. 23).

the diagnosis and investigation and the management and treatment of heart failure influence my way of being with women with heart failure? Was I failing to provide holistic care for the older woman with heart failure? Was I recognizing her as a person? In other words, what was my way of being with her? Was I practicing how I envisioned being as an advanced practice nurse? I mindfully paused and thoughtfully reflected upon these questions.

Again, I turned to the literature. Gradually, I began to see the person being identified. I continued to wonder: What was it like for people to live with heart failure? Specifically, what was it like for older women to live with heart failure and hear and learn about it in their own words, experiences, and contexts? Why was this not explored? I began to think that information is being missed in the recommendations when people's experiences are not sought out nor described. Then, I happened upon another realization as I reviewed the literature; women—especially older women—were rarely studied in heart failure research. I found this interesting given that in the literature and in practice older women do experience heart failure. I identified a gap in knowledge to guide nursing practice. I wondered if the gap could be related to the dominance of the biomedical discourse in the cardiovascular nursing arena. Thus, I am reviewing the literature on the lived experience of older women with heart failure from a feminist perspective; this will be done with the purpose of disrupting the biomedical discourse on heart failure on women.

Research related to the lived experience of older women living with heart failure is timely and relevant for four reasons: firstly, a paucity of literature exists regarding the experiences of women with heart failure—to date, there are four journal articles published that focus on the experience (Ekman & Skott, 2005; Ekman, Skott, & Norberg, 2001; Martensson, Karlsson, & Fridlund, 1998; Rhodes & Bowles, 2002); secondly, heart failure is a common diagnosis in older women and the Canadian population is aging; thirdly, the incidence[2], prevalence, and mortality[3] of heart failure is on the rise, despite advances in cardiac medicine and surgical techniques (Arnold et al., 2006); and fourthly, heart disease, of which heart failure is a part, is the leading cause of death in women (Heart and Stroke Foundation of Canada, 1996; 2009). Rideout (1986) calls heart failure the final common pathway for all heart diseases. I will be exploring the literature on older women's lived experiences with heart failure from a feminist perspective. For the purpose of my paper, it will be organized into three sections. The first section provides the background of the topic of my paper. This includes statistics on Canada's aging population and the data on the ages on men and women. I will then illuminate how historically men have been the model subjects and frame of reference for cardiovascular research. Subsequently, I will articulate my voice from a feminist perspective and consequently offer a definition of feminism. The second section will commence by presenting a theoretical overview between the experiences of women's health and why it is important for nurses to understand woman's lived experiences. I will also state how researching the lived experiences of older women contributes to nursing knowledge along with its relevance to nursing and nursing theories. I will provide a brief review of the literature on the experiences of older women with chronic health challenges[4, 5]. I will

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[2] Incidence is the frequency of occurrence of any event or condition over a period of time and in relation to the population in which it occurs (Thomas, 1993).

[3] Mortality is the death rate (Thomas, 1993).

[4] The term "chronic health challenge" will be used rather than the terms "chronic illness/illnesses", "chronic disease/diseases", "chronic conditions", or "long-term illness/illnesses". Please note these terms will be used as per the author's original use in the journal article.

then review the literature on older women’s lived experiences with heart failure to determine the current state of knowledge available to nurses. Methodological issues and findings identified in the current research on the lived experiences of heart failure will also be delineated and analyzed from a feminist perspective. In the third and final section, I will provide recommendations for i) future research on the experience of older women living with heart failure and ii) in nursing practice.

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[5] The literature on chronic health challenges is explored for as noted in the previous chapter, heart failure is associated with other co-morbidities.

Section One: Background

Canada’s Aging Population

Demographics in Canada are changing, with the population in Canada aging (Minister of Public Works and Government Services Canada [MPWGS], 2002). In a leading document on this topic, the challenges of an aging population include improving the health, well-being, and independence in the later life of older Canadians (MPWGS, 2002). As the focus of nursing is commonly held to encompass fostering health and improving and supporting well-being, nurses will require ever-increasing knowledge for practice with older people as these challenges arise. It is interesting to note that in the 2006 Census, one in seven Canadians is 65 years of age or older with more than half women, 56% whose proportion increases with age (Statistics Canada – The Daily Tuesday July 17, 2007; 2006 Census: Age and Sex http://www.statcan.ca/Daily/English/070717/d070717a.htm; MPWGS, 2002). Thus, nurses will not only need knowledge to support practice with older people, but will require knowledge specific to caring for older women.

There are three factors responsible for Canada’s aging population: lower fertility rates, the generation of baby boomers, and longer life expectancies. The fertility rate, which averages 1.5 children per woman, has been below the replacement level of 2.1 children per woman since the early 1970s. The generation of baby boomers, as the largest population group, consists of people born between 1946 and 1965. In 2006, this generation ranged between the ages of 41 and 60. In other words, nearly one in three Canadians is a baby boomer. The third factor responsible for Canada’s aging population is a higher life expectancy: 77.7 years for men and 82.5 years for women (Statistics

Canada – The Daily Tuesday July 17, 2007; 2006 Census: Age and Sex http://www.statcan.ca/Daily/English/070717/d070717a.htm).

Thus, more Canadian women are reaching and exceeding the age of 65, and once this age is reached, they have a higher life expectancy and thus their proportions increase. The number of very elderly people aged 80 and older, reached 1 million between 2001 and 2006. In other words, more than 1 in 4 of all seniors were aged 80 or older in 2006; 64.6% of the very elderly were women. Moreover according to the 2006 Census, there were 4,635 people aged 100 or older; and at a ratio of nearly five women for every man. This is significant, as noted earlier, for heart failure is a common diagnosis in older women.

Cardiac Research on Women

Tandon, Hankins, and Le Jemtel (2002) state that women have been under-represented in heart failure research. However, this is changing and women with cardiovascular disease are being recognized and researched. Young (2007) notes that in 1989, the United States held a policy-level conference on women and heart disease; topics included epidemiology, treatment and evaluation of heart disease, educational needs of women, American Heart Association recommendations, and signs and symptoms specific to women. In Canada, the Heart and Stroke Foundation of Canada [HSFC] has moved the women’s cardiovascular health agenda forward; in 1997, the HSFC created blueprints calling for action on the development of reliable data to guide clinical decision-making and pubic health recommendations. In concert with other funding bodies, the HSFC has provided funding to various disciplines to develop knowledge in the area of women, heart disease, and stroke (Young). Thus, research on women and cardiovascular disease has been recognized as a need and this area of research has grown over the last 20 years.

Historically, men have been the model subjects of cardiovascular research. Perry (1994) asserts that all science is derived from a patriarchal tradition. Cardiac disease was deemed as neutral; however, the research was conducted and biased towards men. While cardiac disease was considered gender neutral, it was in fact gender biased, with men's experiences privileged (O'Donnell, Condell, & Begley; 2004). Women represented a small percentage of the total research participants. Moreover, women are constantly compared to the men, as men are regarded as the normative frame of reference. Furthermore, gender analysis was not conducted as a part of the studies (McCormick & Bunting, 2002; O'Donnell et al., 2004; Richardson & Rocks, 2001; Tandon et al., 2002). As a result, the cardiovascular experiences of men are considered "normal," while women are "abnormal" (O'Donnell et al., 2004). Young (2007) observes that several authors have suggested women present symptomatically differently than men; thus women may have cardiac disease but it is not recognized. Because men have been the normative frame of reference, an imbalance has been created in cardiovascular research, including heart failure, with women being excluded in the early years, and more recently underrepresented (McCormick & Bunting, 2002; O'Donnell et al., 2004; Richardson & Rocks, 2001; Tandon et al., 2002). Health care services and practice is informed by research and research has been tailored to men; thus, if women were not included in cardiovascular research then the knowledge that guides practice with this population is questionable. This ideology has been reinforced in research, practice, and education, and calls are being raised to challenge these assumptions (McCormick & Bunting, 2002;

O’Donnell et al., 2004; Stromberg & Martensson, 2003). Reviewing the literature on the lived experiences of older women with heart failure is not only personally relevant; it is also my professional responsibility.

As I read and reflected upon the research literature, I noticed that women were not widely being researched and hence not being represented; moreover, reasons regarding their exclusion were rarely stated. Rodriguez, Appelt, Switzer, Sonel, and Arnold (2008) note that many women were excluded because they did not meet the criteria for the entry into the study. Rather, large clinical trials enrolled younger patients with heart failure and excluded older patients with heart failure, most of whom are women. McCormick and Bunting (2002) and Tandon et al. (2002) observe that older women develop heart disease as a result of estrogen loss during menopause. Alas, it is held that women develop heart disease 10 – 20 years later than men. Men develop heart disease in their fifties, possibly due to falling testosterone levels. McCormick and Bunting argue that being male has never been considered an independent risk factor for heart disease; so why is being a postmenopausal female considered an independent risk factor?

McCormick and Bunting (2002) contend that women were deliberately excluded from research protocols. The reasons are varied and many and include women’s reproductive status, fluctuating hormones, and pregnancy risks thereby making women unpredictable research subjects (McCormick & Bunting). Research was conducted on men with the assumption that whatever the findings, the results would also hold for women. However, the biological and social differences that exist between women and men were not considered. Fortunately, researchers are beginning to focus on the biological distinctions (Redfield, Jacobsen, Borlaug, Rodeheffer, & Kass, 2005; Regitz –

Zagrosek, Brokat, & Tschope, 2007; Tandon et al., 2002); however, the social differences are not being investigated. Moreover, the experience of living with heart failure is not being as readily explored. Costello and Boblin (2004) and Zambroski (2003) contend that little is known about the experience of older people living with heart failure.

A Feminist Perspective

My life and work is reflective of who I am – a woman. I am a daughter to parents who immigrated to Canada, an older sister, a friend, a nurse, a wife, and a graduate student. I am an inquisitor, a nurturer, a novice scholar, and an advocate. As a woman, I am intricately and intimately linked to my topic of interest – women. Parker and McFarlane (1991) assert that feminist research is grounded in women's experiences; while I am not conducting research, my literature review is from a feminist perspective. Women's experiences are pluralistic; in other words, there is no universal woman's experience for women's lives have been shaped by gender (Allan, 1993; Bunting & Campbell, 1990; Chinn, 1995; Doering, 1992; Hall & Stevens, 1991; Hooyman, Browne, Ray, & Richardson, 2002; Kane & Thomas, 2000; Kinser & Lewis, 2005; MacPherson, 1983; Parker & McFarlane, 1991; Webb, 1984). Moreover, gender has been socially constructed; Varcoe, Hankivsky, and Morrow (2007) observe that the term gender is a highly contested term; "gender generally refers to social experiences and differences that arise from the social environment" (Varcoe et al., 2007, p. 12). For the purpose of this paper, the definition of gender will be based on Health Canada's reference:

> Gender refers to the array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to two sexes based on a differential basis. Gender is relational-

gender roles and characteristics do not exist in isolation, but are defined in relation to one another (Greenberger, 2001 cited in Canadian Institutes of Health Research [CIHR], 2007 Gender and Sex-Based Analysis in Health Research: A Guide for CIHR Researchers and Reviewers (http://www.cihr-irsc.gc.ca/e/32019.html#5).

Hall and Stevens (1991) state that feminist research is distinguished by several characteristics. Firstly, research questions are reflective of concerns of a particular group of women; secondly, the purpose of feminist research is primarily for the women being researched rather than the researcher; thirdly, the researcher's history, assumptions, motives, and interests, and interpretations are explicit in the process; and fourthly, multiple realities of women are recognized, valued, and connected to the larger political, social, and economic environments.

As a woman, I have come to learn, and am now conscious, that my perspective influences how I view and understand myself in the world. This realization has been a renewed discovery and acknowledgement. It is an ongoing understanding; verbally articulating my understanding is continuous. In concert with my graduate studies and as a natural extension of my worldview, I think, I reflect, and I wonder about all that I do, what I know, how and why I know, and how this/may way of being and living develops and shapes me as a person and as a woman. This work is complex, full of wonder, and vulnerability. It is not linear; rather it is circular and iterative. In this work, I gain greater personal insight into myself and how I am with others. I am continuously reflecting upon my way of being. Furthermore, my way of being is reflective of who and how I think I am and who and how I want to become.

My assumptions about older women with heart failure are: (a) each woman is respected as a unique and distinct individual and has lead a life with unique and distinct experiences; (b) each woman's experience is derived from the context in which it occurs; the contexts include the personal, social, historical, cultural, political, and the economical contexts. Moreover, the woman may or may not be aware of how the contexts are informing and influencing her; (c) each woman makes meaning and understanding of her experiences with heart failure as she shares and articulates her experiences; (d) the experiences of living with heart failure occur in concert and in context with life as it is being lived; (e) the meanings and understandings will be as unique and distinct as the woman herself as each woman lives in relational and contextual lives; (f) it is a challenge for a woman to verbally articulate her experiences — reflection requires thought, time, patience, and silence. Understanding is embedded with meanings and values and is implicit as well as explicit; and (g) each woman has a voice and needs to know that she has been heard.

I intend to broaden my understanding of the literature on the experiences of older women living with heart failure based on Hall and Steven's (1991) three basic principles of feminism:

1. A valuing of women and a validation of women's experiences, ideas, and needs;
2. A recognition of the existence of ideological, structural, and interpersonal conditions that oppress women; and
3. A desire to bring about social change of oppressive constraints through criticisms and political actions (p. 17).

I will utilize Hall and Stevens (1991) principles when reviewing and analyzing the literature and presenting recommendations for practice and further research. To make the transition from feminist principles to feminist praxis – the practical and specific application of feminist principles to a critique (McCormick & Bunting, 2002, p. 824), I will be applying six questions when reviewing and analyzing the literature. The six questions were formulated by the second author (Bunting, 1997 cited in McCormick & Bunting) from a synthesis of characteristics identified from nursing's feminist literature:

1. Does the research report have a stated or strongly implied purpose of benefiting women?
2. Is there evidence of valuing women and women's experiences, ideas, and needs?
3. Is there an expressed or implied recognition of the structural, interpersonal, and ideological conditions that oppress women?
4. Is there evidence of commitment to social change?
5. Is there a representation of statement of awareness of human diversity?
6. Does the report include a portrayal of women's strengths (Bunting, 1997, p. 526 cited in McCormick & Bunting, p. 824).

In the first section, I have provided the background of my paper. I have included that statistics on Canada's aging population and data on the ages of men and women have been given. I have illuminated how historically men have been the model subjects and the frame of reference for cardiovascular research. Furthermore, I have articulated my voice from a feminist perspective, given a description of feminism, and stated how I will utilize principles of feminism when reviewing and analyzing the literature and presenting recommendations for future research and practice.

Section Two: Theoretical Overview and Literature Review

This section will commence by presenting a theoretical overview between the experiences of women's health and the importance of nurses understanding these lived experiences. I will also detail how researching the lived experiences of older women contributes to nursing knowledge along with its relevance to nursing and nursing theories. I will provide a brief review of the literature on the experiences of older women with chronic health challenges[6, 7]. Then, I will review the literature on older women's lived experiences with heart failure to determine the current state of knowledge available to nurses. I will be analyzing the literature from a feminist perspective. Methodological issues and findings identified in the current research on these lived experiences of heart failure will also be provided.

Understanding the Experiences of Women's Health

It is important that nurses understand the experiences of women's health. As stated previously, to date, men have been the model subjects in research. Thus, women have been understudied; moreover, women have been underrepresented, misrepresented, and even excluded. As a result, research that has been conducted and biased towards men has also been applied to women (O'Donnell, Condell, & Begley, 2004). Alas, while heart failure was considered to be gender neutral, it was gender biased. Men's experiences have been privileged whereas women's experiences have been largely exempted. Therefore, it is important for nurse's to know that women, who

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[6] The term "chronic health challenge" will be used rather than the terms "chronic illness/illnesses", "chronic disease/diseases", "chronic conditions", or "long-term illness/illnesses". Please note that the aforementioned terms will be used as per the author's original use in the journal article.

[7] The literature on chronic health challenges is being explored for as noted in the previous chapter, heart failure is associated with other co-morbidities.

comprise half of the population, have particular experiences and challenges with their health.

Contributing to Nursing Knowledge

Understanding the experiences of women's health contributes to nursing knowledge for two reasons. Firstly, Fawcett (1997 in King & Fawcett) states that the initial component of the structural hierarchy of nursing knowledge is the metaparadigm. Parker (2001) contends that the "metaparadigm is the most abstract level of nursing knowledge and closely mirrors beliefs held about nursing" (p. 5). The metaparadigm identifies the phenomenon of interest to nursing and the relationships between those phenomena. The phenomena of interest to nursing are person, environment, health, and nursing (Fawcett, 1997, Parker, 2001). Person refers to the recipient of nursing and includes individuals, communities, and other groups (Fawcett). Women are inclusive in the metaparadigm of person.

Secondly, a further component in the structural hierarchy of nursing knowledge is theory (Fawcett, 1997 in King & Fawcett). Parker (2001) defines theory in general, reflective, and traditional terms. In general, a theory is "a notion or an idea that explains experience, interprets observations, describes relationships, and projects outcomes . . . [theories] help understand and find meaning from our experience, organize and articulate our knowing, and ask questions leading to new insights" (p. 4). As reflections of understanding, theories "guide our actions, help us set forth desired outcomes, and give evidence of what has been achieved" (Parker cited in Parker, p. 4). By traditional definition, theories are "an organized, coherent set of concepts and their relationships to each other that offer descriptions, explanations, and predictions about phenomena"

(Parker, p. 4). Tomey & Alligood (2002) stress the importance and urgency in using nursing theory within nursing practice, thus promoting the development of nursing knowledge and the development of nursing theory. There are numerous nursing theorists (Paterson & Zderad, 1976; Parse, 1981; 1995, 1998; Watson, 1985, 1988, 2001, 2005) who are committed to understanding the meaning of the lived experiences of health and health challenges. Thus, understanding the experiences of women’s health is important for nurses as these understandings contribute to nursing knowledge.

Experiences of Older Women with Chronic Health Challenges

Heart failure is a chronic health challenge. Thus, a brief review of the literature on older women with chronic health challenges will now be presented. The electronic database, Cumulative Index to Nursing and Allied Health Literature (CIHAHL) was used to identify and locate literature for review. Key words for searching the literature included older women, chronic health challenge, chronic illness/illnesses, chronic disease/diseases, chronic conditions, long-term illness/illnesses, experience and qualitative.

A chronic health challenge is defined as “impairments in function, development, or disease states that are irreversible or have a cumulative effect” (Ogden Burke, Kauffmann, Wiskin, & Harrison, 2000, p. 211 cited in Eastlick Kushner, 2006, p. 59). A chronic condition persists longer than 6 months and may result in partial or complete disability (Potter, Wood, Ross-Kerr, Gilbert, Stephen, & Day, 2006). Older adults experience more chronic conditions — many chronic conditions are associated with aging (Eastlick Kushner; Gilmor & Park, 2006). As noted in the previous chapter, Canadians are living longer. One in seven Canadians is age 65. Gilmor and Park identified that by the age of 65, 77% of men and 85% of women will have at least one chronic health challenge. Thus, living with a chronic health challenge is a reality. Rendering care for women with chronic health challenges is a reality for many nurses.

Giddings, Roy, and Predeger (2007) and Kralik (2002) state that there is a lack of awareness by health professionals of the context in which women with chronic health challenges live. The purpose of Kralik, Brown, and Koch's (2001) paper was to sensitize health care professionals to the experiences of women being diagnosed with a long-term illness. The three authors were a part of three separate inquiries, which explored women's experiences of living with an illness; each author discovered that being diagnosed was a significant event for the women. The authors also found that there was a paucity in the literature about receiving a diagnosis. Kralik (2002) notes that women who live with chronic health challenges are faced with feelings of being overwhelmed, alienated, and without voice within the delivery of health care. Tannenbaum, Nasmith, and Mayo (2003) found that while older women felt that their physical health care needs were being met, their psychological health care needs were inadequately addressed. Ironside, Scheckel, Wessels, Bailey, Powers, and Seeley (2003) also echo this inadequacy; these authors revealed three themes: i) focusing on functional status does not adequately account for the experience of chronic illness; ii) decentering the focus on the treatment of symptoms makes way for equally important discussions of meaning making in the context of chronic illness; and iii) the objectified language of health care may mask how chronic illness is experienced. McDonald and McIntyre (2002) note language carries privilege, power, and knowledge that are valued by a dominant ideology. McDonald and McIntyre contend that women live within complexities of multiple structures, relationships, and ideologies; therefore, health care practitioners need to be reflective of their own complexities and ideologies. Tang and Anderson (1999) suggest that health care providers be reflective practitioners who construct knowledge with women by engaging in dialogue and relation. Several authors (Ironside et al., 2003; Kralik, Brown, & Koch, 2001; McDonald & McIntyre, 2002; Stern, 1996; Tang & Anderson, 1999; Traynor, 2005) assert that women’s voices need to be heard. Kralik et al., (2001) note that nurses are in a key position to listen and acknowledge women’s experiences and concerns, as this is affirming for women diagnosed with a chronic illness.

Lived Experiences of Older Women with Heart Failure

Upon reviewing the literature on the lived experiences of older women with heart failure, four articles were found to be relevant for literature review. The first reading is by Ekman and Skott, 2005; the second reading is penned by Ekman, Skott, and Norberg, 2001; the third reading is authored by Mårtensson, Karlsson, and Fridlund, 1998; and, the fourth reading is written by Rhodes and Bowles, 2002. CIHAHL was used to identify and locate literature for review. Key words for searching the literature included heart failure, adults, older adults, women, experience, qualitative, phenomenology, hermeneutics, and narratives. The criteria (please see Appendix A) for reviewing journal articles included articles written in English, women as the study’s sole participants, and use of a qualitative methodology. The exclusion criteria (please see Appendix A) were journal articles not in English (Barremo, Bruce, Salander, & Sundin, 2008), men as the sole participants (Nordgren, Asp, & Fagerberg, 2007) or men included as study participants (Costello & Boblin, 2004; Ekman, Ehnfors, & Norberg, 2000; Evangelisa, Kagawa-Singer, & Dracup, 2001; Galvao, 2005; Rodriguez, Appelt, Switzer, Sonel, & Arnold, 2008; Stromberg &

Martensson, 2003; Stull, Starling, Hass, & Young, 1999; Yu, Lee, Kwong, Thompson, & Woo, 2007), or if women were not identified as study participants (Albert, 2007; Zambroski, 2003), the methodology was quantitative and/or based on epidemiology, pathophysiology, and treatment (O'Mahony, Sim, Ho, Steward, Buchalter, Burr, 2003; Halm & Penque, 2000; Richardson & Rocks, 2001; Tandon, Hankins, & Le Jemtel, 2002), and if a concept in addition to heart failure was also in the article (Brännström, Ekman, Norberg, Boman, & Strandberg, 2006; Dougherty, Pyper, Au, Levy, & Sullivan, 2007; Falk, Granger, Swedberg, & Ekman, 2007; Gary, 2006; Hägglund, Boman, & Lundman, 2008). The aim of the research of the four relevant readings along with the methodology, participant sample, setting, procedures, findings, and researcher's statement of limitations will now be provided (please see Appendix B).

The first reading is by Ekman and Skott (2005) (Developing clinical knowledge through a narrative-based method of interpretation. *European Journal of Cardiovascular Nursing, 4,* 251 – 256). The aim of their research was to develop clinical knowledge by using hermeneutic phenomenology to gain a deeper understanding of how it is to live with heart failure from a daily life perspective. Hermeneutic phenomenology strives to interpret a text to understand the meaning of the text (Patton, 2002; Schwandt, 2001). An interview was conducted with one 62 year old woman; the setting of the research was not disclosed by the researcher, however, the researchers state that the woman was a participant in a prior research project dealing with the experience of people living with heart failure. The purpose of Ekman and Skott's research was to gain a deeper understanding of how it is like to live with heart failure by interpreting the woman's narrative. The woman was asked to talk about her experiences of living with heart failure

— her story flowed without questions nor comments from the researchers. Her story was tape recorded and transcribed verbatim. The researchers interpreted the textual account of the woman's experience by using Ricoeur's five step analysis: (1) general or naïve reading; (2) distancing; (3) examination of discourse; (4) conjectures and questions; and (5) reflection over the whole. The researchers identified the theme, "struggling to comprehend medical information". The researchers did not identify limitations of their study.

The second reading is penned by Ekman, Skott, and Norberg (2001) (A place of one's own. The meaning of lived experience as narrated by an elderly women with severe chronic heart failure. A case-study. *Scandinavian Journal of Caring Sciences 15*, 60 – 65). The aim of their research, using hermeneutic phenomenology, was to achieve a deeper understanding of the lived experience of being an elderly woman with heart failure. An interview was conducted with a 79 year old woman. When asked about her illness, the woman openly talked about her experience during two occasions: the first narrative took place in her two-room apartment and the second narrative occurred a year later in her nursing home. Both accounts were tape recorded, transcribed verbatim, and interpreted using Ricoeur's five step analysis, as stated above. The researchers identified the theme of 'being at home' and threats to this 'being at home'. The researchers did not identify limitations to their study.

The third reading is authored by Mårtensson, Karlsson, and Fridlund (1998) (Female patients with congestive heart failure: how they conceive their life situation. *Journal of Advanced Nursing, 28*(6), 1216-1224). The aim of their research, using phenomenography, was to describe how female patients with heart failure conceive their situation from a nurse's perspective. Phenomenographic research examines phenomena as they are conceived and increases awareness of the ways a particular phenomenon may be experienced (Marton & Booth, 1997 in Åkerlind, 2005). In other words, the same phenomena may be perceived differently by different people and under different circumstances (Åkerlind). Open, semi-structured interviews that reflected concepts of a holistic nursing perspective were conducted with 12 women between the ages of 65 and 83 years with New York Heart Association [NYHA] functional classification II-IV. To document the degree of the physical limitations and severity of heart failure, the NYHA functional classification is utilized. The NYHA is classed from I to IV and is defined as: NYHA I – no symptoms; NYHA II – symptoms with ordinary activity; NYHA III – symptoms with less than ordinary activity; and NYHA IV – symptoms at rest or with any minimal activity (Arnold et al, 2006). The interview questions that were created were based on nursing's theory holistic perspective and focused on five domains: biophysical, socio-cultural, emotional, intellectual, and spiritual-existential. The setting for the interviews took place in the woman's home with one interview held in the visitor's room in the hospital. The interviews were transcribed verbatim; analysis began by reading each transcript over and over until saturation was reached and similarities and differences were grouped into patterns. A final pattern emerged and resulted in five categories: feeling content, feeling a sense of support, feeling a sense of limitation, feeling anxiety, and feeling powerless. The researchers identified that a limitation of their study was that their results could not be generalized. However qualitative research, of which phenomenography is a part of, is not concerned with issues of generalizability; rather qualitative research is concerned with a holistic understanding, meaning, and multiple realities of a phenomenon (Polit & Beck, 2004).

The fourth reading is written by Rhodes and Bowles (2002) (Heart failure and its impact on older women's lives. *Journal of Advanced Nursing, 39*(5), 441 – 449). The aim of their research, using Husserl's descriptive phenomenology, was to examine and describe the experience of living with NYHA Stage II[8] heart failure from the perspective of women living with it. The intent behind Husserl's descriptive phenomenology is to describe the meaning of an experience from the perspective of those who have had that experience. Four semi-structured interviews were conducted with five women aged 60, 78, 81, and 90 years old and were diagnosed with NYHA Stage II heart failure. The women decided upon the setting of the interviews and most chose to be interviewed at home; one interview took place in a quiet corner of a senior centre. The researchers noted that the setting of the interview allowed the researchers a 'glimpse' of the woman's living environment. The interviews were transcribed verbatim and transcripts were interpreted using Colaizzi's (1978) seven steps: (1) reading and reading the data to gather a sense of the whole; (2) extraction of significant statements and phrases related to heart failure; (3) drawing meanings from the phrases and statements; (4). clustering these meanings into themes; (5) using themes to develop as complete description as possible of the experience of living with heart failure; (6) forming a statement of identification from this description; and (7) verifying this description with the participants in the study. Four

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[8] In 2001, The American College of Cardiology (ACC) and the American Heart Association (AHA) identified four stages of heart failure: Stage A, Stage B, Stage C, and Stage D. The stages are more recent and complement the NHYA classification. Stage A identifies a patient who is at high risk for developing heart failure but has no structural disorder of the heart; Stage B refers to a patient with a structural disorder of the heart but who has never developed symptoms of heart failure; Stage C indicates that a patient with past or current symptoms of heart failure associated with underlying structural heart disease; and Stage D signifies a patient with end-stage disease who requires specialized treatment (Hunt et al., 2001).

themes emerged from the data analysis: acknowledging losses in their lives, accepting the losses, changing their lives, and deepening relationships, with subthemes for each main theme delineated and described. The authors note the similarities between their findings and the findings of the study reviewed above by Mårtensson, Karlsson, and Fridlund (1998) relative to the first three themes of the Mårtensson et al study. The researchers identified that a limitation of their study was that their sample size was small. However qualitative research, of which Husserl's descriptive phenomenology is a part of, is not concerned with issues of sample size; in qualitative studies, the sample is almost always small (Polit & Beck, 2004). According to Polit and Beck, sample size should be determined based on the informational needs of the research; thus a guiding principle in sampling is data saturation—sampling to the point at which no new information is acquired and redundancy is attained.

As previously stated, I will be applying six questions when reviewing and analyzing the four journal articles (please see Appendix C). McCormick and Bunting (2002) assert that research studies that do not claim to be feminist should not be judged by feminist standards. Thus, in respect to the authors of the four journal articles, and in concert with McCormick and Bunting's paper, my intent is not to criticize these readings for not being feminist, nor is it a critique of the quality of the research study. Rather, I will examine the feminist aspects of the researcher's perspective on studies on the experience of women with heart failure. Bunting (1997 in McCormick & Bunting) observes that many nurses researching women may have, consciously or unconsciously, used a feminist perspective in their studies without an explicit statement.

All four of the relevant articles for review (Ekman & Skott, 2005; Ekman et al., 2001; Mårtensson et al., 1998; Rhodes & Bowles, 2002) were unanimous in the purpose of their studies: to gain an understanding of what is like for older women to live with heart failure. None of the articles, however, claimed to have been conducted within a feminist framework. Three of the four studies (Ekman & Skott; Ekman et al.; Rhodes & Bowles) used phenomenology as the methodology. The third reading, from Mårtensson et al,. exercised a phenomenographical approach. The first two readings by Ekman & Skott and Ekman et al., respectively, engaged in Ricoeur's hermeneutic phenomenology perspective. The fourth reading (Rhodes & Bowles) exercised Husserl's descriptive phenomenology. All four of the readings met the first two questions developed from nursing's feminist literature (McCormick & Bunting, 2002): (1) Does the research report have a stated or strongly implied purpose of benefiting women? and (2) Is there evidence of a valuing of women and women's experiences, ideas, and needs? The focus of the first reading (Ekman & Skott) was on developing clinical knowledge through the use of narrative analysis; the authors use the term "her" and "she" to indicate that the knowledge that was developed was from research on a woman with heart failure. The second reading (Ekman et al.) uses the woman's name and the term "patient" interchangeably while the third (Mårtensson et al) and fourth reading (Rhodes & Bowles) uses the term "women," "female patients," and "patients" throughout. All four of the readings used interviews as their research method; thus, the women's experiences, ideas, and needs were directly and explicitly sought. In the first (Ekman & Skott) and second readings (Ekman et al.), the woman was asked to describe her experiences of living with heart failure, and each time, the narrative flowed without prompting or questioning. The third reading (Mårtensson et al) had an interview guide, based on the holistic domains of nursing theory on the biophysical, socio-cultural, emotional, intellectual, and spiritual-existential domains. The fourth reading (Rhodes & Bowles) also had an interview guide, though the interview questions were not disclosed in the articles. Further, the interviews were undertaken where the women spent most of their time.

The research questions and methodology implemented by all of the researchers is appropriate. Mårtensson et al. (1998) approach of phenomenography is appropriate for their research aims at understanding how female patients conceive their situation — phenomenography examines phenomena as they are conceived. Ekman and Skott (2005), Ekman et al. (2001), and Rhodes and Bowles (2002) research question and methodology is also appropriate because the foundational question phenomenology asks is “what is the meaning, structure, and essence of the lived experience of this phenomenon for this person or group of people?” (Patton, 2002, p. 104). A phenomenological approach is most useful when the intent is to understand an experience as it is understood by those who are living with it (Cohen, Kahn, & Steeves, 2000). Phenomenology is an appropriate research method for nursing; the emphasis in phenomenological research is on the meaning of lived experience and nursing strives to understanding those experience as lived (Beck, 1994; Polit & Beck, 2004). Thus, the knowledge produced from phenomenological research contributes to nursing knowledge.

The first two readings (Ekman & Skott, 2005; Ekman, Skott, & Norberg, 2001) use hermeneutic phenomenology as the methodology of their research. The first reading (Ekman & Skott) draws from the experience of a woman living with heart failure. The authors note that the purpose of the interpretation of the narrative was to develop clinical knowledge and to gain a deeper understanding of how it is to live with heart failure from a daily life perspective. The authors assert that knowledge about the illness experience of a patient is needed. The authors advocate that the meanings from the narratives can be used in everyday practice as clinical tools.

The purpose of the second reading (Ekman et al., 2001) was to achieve a deeper understanding of the meaning of the lived experience of being an elder woman with chronic heart failure. The authors observe that research concerning elderly people is based strongly on a biomedical orientation while knowledge of how this population experiences their disease and care that they receive is limited. The authors assert that becoming informed of this populations' illness perspective gives important detail to the knowledge that is necessary to render good care.

The third reading (Mårtensson et al., 1998) uses phenomenography in their research. The aim of this research was to describe how female patients with heart failure conceive their situation from a nurse's perspective. Thus, through the lens of nursing theory and perspective, the women described their experiences of living with heart failure. Ergo, the women living with heart failure were able to describe how they conceived their own situation. Therefore, nursing intervention focused on what the women described their experience to be.

The fourth reading (Rhodes & Bowles, 2002) uses Husserl's descriptive phenomenology as the research design and address the question: how do older women with NYHA Stage II heart failure perceive their own lives? This research aims to examine and describe women's experience of living with heart failure. The authors provide a clear background to their research question. The authors state that they bracketed their beliefs and assumptions derived from experience and the literature and recorded these before the interviews began; identifying and suspending assumptions are key components to Husserl’s methodology.

All four of the readings (Ekman & Skott, 2005; Ekman et al., 2001; Mårtensson et al., 1998; Rhodes & Bowles, 2002) met the third question developed from nursing’s feminist literature (McCormick & Bunting, 2002): (3) Is there an expressed or implied recognition of the structural, interpersonal, and ideological conditions that oppress women? In all four readings, there was an implied recognition. In the first reading (Ekman & Skott), the authors stated that they “had a feeling that the narrator had considerable hardship in her daily life” (p. 253). The authors also noted that different voices were present in the woman’s narrative: the voice of the lifeworld—that being the voice of the life experiences of the woman and her everyday concerns—and the voice of medicine—or medical science which is the dominant discourse. As a dominant discourse, medicine would highlight the pathology, management, and treatment of heart failure and this may oppress women by denying women’s voice and their experiences with heart failure. The second reading (Ekman et al.) identified that the interpretation of being ill with heart failure is made from many different perspectives: from the woman herself and from her caregivers and doctors. As the woman becomes more dependent upon others, she has had to leave her home. Different dimensions of ‘being at home’ and threats to this ‘being at home are expressed. As a result, the woman experiences a homelessness in her own body and a homelessness in her relations with her caregivers. Furthermore, the woman experiences homelessness in spite of, and as a result of, being in institutional care. The woman’s caregivers and doctors, along with the woman having to leave home, are examples of ideological and structural conditions that oppress women. In the third reading (Mårtensson et al.), the women described a sense of limitation, anxiousness, powerless, and guilt for they were unable to fulfill role expectations at work, at home, and in social settings. Moreover, the authors identified that hospitals and general health care routines subject people to feelings of powerlessness. Again, it appears in this article that ideological and structural conditions oppress women. The fourth reading (Rhodes & Bowles) noted that the women in their study expressed concerns maintaining control; this threat came from different sources, ranging from loss of control due to physical symptoms to emotional control to financial constraints of being on a fixed income as retirees. Interpersonal conditions that oppress women are addressed in this reading.

None of the readings met the fourth question developed from nursing's feminist literature (McCormick & Bunting, 2002): (4) Is there evidence of a commitment to social change? The first reading (Ekman & Skott, 2005) refers to an article by Mishler (1984 in Ekman & Skott) and notes that the inclination to transform the patient's life into a medical problem is also a part of a larger, more general social process – a process whereby language expressing an individual's experiences is steeped within a language of instrumental rationality (p. 255). However, this statement does not lead to elaboration or social changes. In the second reading (Ekman et al., 2001), the authors assert that the woman experiences placelessness in the organization of care and this is reflected in the placelessness of her illness experiences. "To deny a patient (a woman) [sic] this place, or to promote a system that does not permit a place for a patients as whole persons, threatens the patient's identity…as well by conveying that there is no place for reflection upon the experience of illness" (Ekman et al., p. 64). However, the authors do not make recommendations to amend this. The third reading (Mårtensson et al., 1998) provides suggestions as to what nurses can do to intervene and break the cycle of women who feel limited and powerless. Alas, the women are not asked what they needed in order to break this cycle. In the fourth reading (Rhodes & Bowles, 2002), the authors identified that the women drew on inner resources of great strength and courage in order to find contentment in their lives. "They discover ways to create productive lives and deeply meaningful relationships, within the boundaries imposed by HF (heart failure) [sic]" (p. 448). Again, there is no discussion as to how the women could be facilitated through living within the boundaries imposed by heart failure, while still creating productive and meaning lives.

Two of the readings met the fifth question developed from nursing's feminist literature (McCormick & Bunting, 2002): (5) Is there a representation or statement of awareness of human diversity? Mårtensson et al. (1998) interviewed 12 women between the ages of 65 and 83 years old; eight women attended elementary school and four women attended college. With regard to martial status, five women were married and seven women were widowed. With regards to socioeconomic status, five women were housewives, four were unskilled workers, and three women were skilled workers. Rhodes and Bowles (2002) interviewed five women aged 60, 78, 81, 84, and 90 and all were Caucasian; no further demographics were disclosed. The remaining readings by Ekman and Skott (2005) and Ekman et al.(2001), interviewed one woman aged 62 and 79 respectfully; however, there were no additional characteristics of the woman revealed. Hall and Stevens (1991) contend that women's experiences are pluralistic and that there is no universal woman's experience because women's lives are not exclusively shaped by gender. “Women’s interpretations, values, interests, and actions can differ dramatically according to sexual orientation, class, race, ethnicity, education, age, and national origin (p. 17).

All four readings met the sixth question developed from nursing’s feminist literature (McCormick & Bunting, 2002): (6) Does the report include a portrayal of women’s strengths? In the first reading, Ekman and Skott (2005) note that the woman experiences conflict when attempting to incorporate her personal experience and her medical diagnosis. While the woman cannot fully incorporate the medical explanation into her own understanding, she does not completely reject the explanation. Rather, she adds her own experiences to the explanation and does not accept being identified according to a medical diagnosis. In the second reading, Ekman et al., (2001) realized that as the woman became more ill with heart failure, she expressed a loss of courage, power, and self-confidence. However, the researchers realized that these losses were not the sole results of the illness; rather, these losses were compounded by the woman’s experience in institutional care. Thus, there are personal contexts and social contexts to consider. In the third reading, Mårtensson et al., (1998) recognized that while the women expressed feelings of limitation, anxiety, and powerlessness, they also experienced feelings of contentment and a sense of support. The researchers recommended nursing interventions to facilitate the women in obtaining a more hopeful perspective by encouraging them to verbalize their feelings and concern; this aids women in acquiring a greater sense of control, competence, and self-esteem. Mårtensson and colleagues delineate what nurses need to do to help women achieve a sense of control: encouraging a hopeful outlook; plan for self-care based on the assessment of the women’s self-identified need for support and information. Further, these authors state that the nurse can contribute to the woman's safety and sense of security by increasing the quantity and quality of family support. In the fourth reading, Rhodes and Bowles (2002) observe that heart failure affects every aspect of the women's lives and yet the women were able to draw on inner resources of strength and courage. The themes that the researchers identified were acknowledging losses in their lives, accepting those losses, changing their lives, and deepening their relationships. So, in spite of losses experienced as a result of having heart failure, the women were able to positively change their lives by creating more productive and more deeply meaningful relationships.

Upon reviewing the four readings through a feminist perspective, I was able to identify the ideological, structural, and interpersonal conditions that oppress women. I have gained an appreciation for the various and complex contexts in women's lives. My understanding of older women with heart failure had been obscured by the dominance of the biomedical discourse. As the researchers in the first reading identified, a woman who questions is not necessarily questioning the medical voice; rather, women do not want abandon their own voices. Women's experiences are pluralistic and I have come to appreciate the depth of that statement. There are multiple realities in women's lives, and for me, this is particularly enlightening. Women lead and live their lives within complex contexts and while I had once known this, I had in fact forgotten it. Reviewing research on older women's lived experience with heart failure has contributed to my nursing knowledge and practice; I now have a deeper understanding of heart failure from the perspective of those who live with this chronic and complex syndrome.

Moreover, upon reflection, I realized that my forgetfulness is due to the engulfing nature of the dominant discourse of medicine—even within my own nursing practice. These four readings remind me to consciously give women time and space. The first reading (Ekman & Skott, 2005) highlighted this for me. In addition, time and space is needed to hear their voices as well as to acknowledge to each woman that I have heard her. I will actively listen to all that the women are saying and not saying and I will not constantly interrupt each woman's personal narrative with a bio-medical interruption. In my nursing practice, I will actively listen and confirm my role as her listener as each woman recalls and considers her experiences and makes meaning of and for herself.

Explaining conditions with a medical diagnosis is not the same as understanding a particular experience of that condition. As the second reading conveys (Ekman et al., 2001), women need a place to reflect upon their experience with heart failure; to deny women this threatens their very identity. The life of the woman must take priority over the nurse's perspective.

The third reading (Mårtensson et al., 1998) reaffirms that women are to be encouraged to verbalize and express their feelings and concerns. The fourth reading (Rhodes & Bowles, 2002) illuminates how strong women are and that they draw from inner resources of great strength and courage. All four of the readings called for further research, as there is a paucity of research literature on older women's experiences living with heart failure from their perspectives.

Section Three: Recommendations

To conclude my paper, I will provide recommendations for: i) future research on the experience of older women living with heart failure and ii) in nursing practice.

Recommendations for Future Research

I would use a feminist perspective to guide my research on experience of older women living with heart failure and disrupt the biomedical discourse. I would uphold the eight criteria of feminist research as identified by Duffy (in Parker & McFarlane, 1991:

1. The principal investigator is a woman.
2. Feminist methodology is used (defined as a research approach characterized by one or more of the following: interaction between the researcher and subject, a non-hierarchical relation between the researcher and the subject, an expression of feelings, and a concern for values).
3. The study has the potential to help the subjects, as well as researchers.
4. The research is focused on the experiences of the woman (defined as having to do with how a woman lives through the topic of the research).
5. The purpose of the investigation is to study woman (not nurses, patients, etc. [sic]).
6. The word “feminist” [sic] of “feminism” [sic] is used in the report.
7. Bibliographic references to feminist literature are included.
8. Non-sexist language is used.

I would also espouse the feminist principles identified by Hall and Stevens (1991). My research would address the six questions identified from nursing’s feminist literature (Bunting, 1997 in McCormick & Bunting, 2002).

There are six recommendations that I would follow in my feminist research. My first recommendation is that I would identify my research as having a feminist perspective; I would include the term “feminist” in the title of my research paper as well as use and make reference to feminist literature. My second recommendation is that I would engage in a non-hierarchical relationship with my research participants by valuing the women’s experiences, values, ideas, and needs; I would strive to recruit a diverse group of women with various values and interests to sexual orientation, class, race, ethnicity, education, age, and national origin. Women who participate in my research will be identified as “research participants.” My research question, “what is the lived experience of older women with heart failure” would drive the research methodology. Therefore, I would employ feminist methodology for phenomenology for the intent of phenomenology is to understand an experience as it is understood by those who are living with it (Cohen, Kahn, and Steeves, 2000). Interviews would be held in a place that the women feel safe in and spend most of their time in. I would listen to the women’s experiences, ideas, and needs. My research would benefit each research participant by drawing on the experiences of being a woman living with heart failure, without privileging their diagnosis and chronic illness. Thus, my third recommendation is that each woman would be given the time and space to share the experiences she chooses to reveal, as well as withhold any information—again, as she chooses. Her experiences would be listened to and acknowledged as heard at the time of the interview. It is essential that each woman’s voice be heard and acknowledged, as well as affirmed. As a fourth recommendation, and in concert with the feminist perspective and phenomenology approach, I would articulate my history, assumptions, motives, and interests, and make my interpretations explicit in the research process. For my fifth recommendation in my feminist research, I would identify the social, historical, cultural, political, and the economical contexts that oppress women. My sixth recommendation is to be mindful of how I translate the results of my research findings. My intent would be to raise the consciousness of professional health care providers, the general public, and women with heart failure. Parker and McFarlane (1991) identified that dissemination and utilization of research findings are political endeavors. My research would state any need for changes in the social, political, and health policies, and practices that affect women and call for political activism. I would make my research available for women and for professional health care providers.

Recommendations for Nursing Practice

There are five recommendations that I would follow in my nursing practice with older women with heart failure. Firstly, I would seek out the woman's voice, actively listen to her, and demonstrate presence and mindfulness in an attempt to view her experiences from her perspective rather than from my perspective. Secondly, I would give the woman time and space to articulate her experiences, ideas, and needs. Thirdly, I would strive to create a safe and caring environment for her so that she may reflect upon her experiences. My fourth recommendation would be to facilitate the woman to achieve a sense of control over her life situation by facilitating her to explore her ideas and needs with heart failure by actively listening, affirming that I have listened, and encouraging her. I would foster hope, facilitate in the planning of her self-care, and support her family by providing them with information and being in frequent contact. My fifth recommendation would be to identify the biomedical discourse and try to disrupt it by acknowledging and appreciating the complex contexts that the woman lives in. I would encourage the woman for her strengths and recognize the relationships she engages in and is a part of.

The intent of my paper was to explore the literature on older women's lived experiences with heart failure from a feminist perspective and disrupt the biomedical discourse. In the first section, I have provided the background of the topic of my paper; this included statistics on Canada's aging population and the data on the ages on men and women. I then illuminated how historically men have been the model subjects and frame of reference for cardiovascular research. Furthermore, I articulated my voice from a feminist perspective and provide a description of feminism. In the second section, I presented a theoretical overview between the experiences of women's health and why it is important for nurses to understand woman's lived experiences. I also stated how researching the lived experiences of older women contributes to nursing knowledge along with its relevance to nursing and nursing theories. I provided a brief review of the literature on the experiences of older women with chronic health challenges. I also reviewed the literature, from a feminist perspective, on older women's lived experiences with heart failure to determine the current state of knowledge available to nurses. Methodological issues and findings identified in the current research on the lived experiences of heart failure have also been delineated and analyzed from a feminist perspective. In the third and final section, I have provided recommendations for: i) future research on the experience of older women living with heart failure and ii) nursing practice.

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Appendix A:

Inclusion and Exclusion Criteria for Reviewing Literature on the Lived Experience of Older Women with Heart Failure

Inclusion criteria:

Journal articles had to be written in English;

Women were identified as the study's sole participants; and

Qualitative methodology was used.

Exclusion criteria:

Journal articles not written in English;

Men were also included as study participants;

Women were not identified as study participants;

Methodology was quantitative and/or based on epidemiology, pathophysiology, and treatment; and

A concept in addition to heart failure was also in the article.

Appendix B:

Journal Articles Relevant for Literature Review on the Lived Experience of Older Women with Heart Failure

Author	Aim	Setting	Participants	Methodology	Procedures
Ekman & Skott (2005)	To develop clinical knowledge by gaining a deeper understanding of how it is to live with heart failure from a daily life perspective	The woman was a participant in a prior research project dealing with the experience of people living with heart failure	One 62 year old woman	Hermeneutic Phenomenology Ricoeur's five step analysis: 1. general or naïve reading; 2.distancing; 3.examination of discourse; 4. conjectures and questions; and 5.reflection over the whole.	One tape recorded interview transcribed verbatim
Ekman, Skott, & Norberg (2001)	To achieve a deeper understanding of the meaning of the lived experience of being an elder woman with heart failure	Interviews took place in the woman's two-room apartment and in a nursing home	A 79 year old woman	Hermeneutic Phenomenology Ricoeur's five step analysis: 1. general or naïve reading; 2.distancing; 3.examination of discourse; 4. conjectures and questions; and 5. reflection over the whole.	Two recorded interviews made at a 1 year interval and transcribed verbatim
Martensson, Karlsson, & Fridlund (1998)	To describe how female patients with heart failure find meaning in their situation from a nurse's perspective	Interviews took place in the woman's home with one interview held in the visitor's room in the hospital	12 women between the ages of 65 and 83 years with NYHA II-IV	Phenomenography Analysis began by reading each interview over and over until saturation was reached and similarities and differences were	Open semi-structured interviews and transcribed verbatim

				grouped into patterns. A final pattern emerged and resulted in five categories	
Rhodes & Bowles (2002)	To examine and describe the experience of living with NYHA Stage II heart failure from the perspective of women living with it	The women decided upon the setting of the interviews and most chose to be interviewed at home; one interview took place in a quiet corner of a senior centre	Five women aged 60, 78, 81, and 90 years old	Husserl's Descriptive Phenomenology Colaizzi's (1978) seven step analysis: 1. reading and reading the data to gather a sense of the whole; 2. extraction of significant statements and phrases related to heart failure; 3.. drawing meanings from the phrases and statements; 4. clustering these meanings into themes; 5. using themes to develop as complete description as possible of the experience of living with heart failure; 6. forming a statement of identification from this description; and 7. verifying this description with the participants in the study	Four semi-strucutured interviews with each woman and transcribed verbatim

Author	Findings	Limitations
Ekman & Skott (2005)	Struggling to comprehend medical information	Not stated
Ekman, Skott, & Norberg (2001)	‘Being at home’ and threats to this ‘being at home’	Not stated
Martensson, Karlsson, & Fridlund (1998)	Five categories: feeling content, feeling a sense of support, feeling a sense of limitation, feeling anxiety, and feeling powerless	Results of their study could not be generalized. However qualitative research, of which phenomenography is a part of, is not concerned with issues of generalizability; rather qualitative research is concerned with a holistic understanding, meaning, and multiple realities of a phenomenon
Rhodes & Bowles (2002)	Four themes: acknowledging losses in their lives; accepting their losses; changing their lives; and deepening relationships.	Small sample size; however qualitative research, of which Husserl’s descriptive phenomenology is a part of, is not concerned with issues of sample size for in qualitative studies, the sample is almost always small

Appendix C:

Feminist Aspects of the Researcher's Perspective on Studies on the Experience of Women with Heart Failure

Author	**Does the research report have a stated or strongly implied purpose of benefiting women?**	**Is there evidence of valuing women and women's experiences, ideas, and needs?**	**Is there an expressed or implied recognition of the structural, interpersonal, and ideological conditions that oppress women?**	**Is there evidence of commitment to social change?**	**Is there a representation of statement of awareness of human diversity?**	**Does the report include a portrayal of women's strengths**
Ekman & Skott (2005)	Strongly implied	Yes	Implied recognition	No	No	Yes
Ekman, Skott, & Norberg (2001)	Strongly implied	Yes	Implied recognition	No	No	Yes
Martensson, Karlsson, & Fridlund (1998)	Strongly implied	Yes	Implied recognition	No	Yes	Yes
Rhodes & Bowles (2002)	Strongly implied	Yes	Implied recognition	No	Yes	Yes