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Spiritual reconfigurations of self after a myocardial infarction: Influence of culture and place

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ABSTRACT

This study explored illness narratives following a myocardial infarction (MI) in French Canadians. Qualitative interviews were completed using the McGill Illness Narrative Interview with 51 patients following a first MI. Content analysis of interviews suggested that the heart was perceived as a receptacle that contained an accumulation of life's ordeals, negative emotions and family traumas. This resulted in perceived heart strain, which was considered a direct cause of the MI. References to spirituality were central to the patients' narratives and were identified as instrumental in post-MI recovery. Results illustrate how place and culture interact to shape illness experience and recovery trajectories after a life-threatening health event.

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1. Introduction

Cardiovascular diseases remain one of the major causes of hospitalization and death in industrialized countries, as well as in many low or middle income developing countries (ICIS, 2002; Mackay and Mensah, 2004). A study of 29,000 participants in 52 countries found that nine risk factors (dyslipidemia, smoking, hypertension, diabetes, alcohol, obesity, stress, diet and lack of exercise) accounted for 90% of myocardial infarctions (MI) (Yusuf et al., 2004). The management of modifiable risk factors following an MI has become an important focus of clinical communication and tertiary prevention models of care with much attention given by studies to medication characteristics, clinician–patient relationship and psychological factors (Schroeder et al., 2004; Terre, 2007).

Experiencing an MI can be traumatic for many patients and their family, and correspondingly, many studies have also focused on negative psychological reactions such as fear, anxiety, depression and post-traumatic stress disorder (Al-Hassan and Sagr, 2002; Ginzburg, 2006; Shemesh et al., 2006). However, other authors have suggested that responses to life-threatening events are not necessarily negative and may actually result in positive

changes reflecting resilience or post-traumatic growth (Barakat et al., 2006; Hassani et al., 2009; Tedeschi and Calhoun, 2004). These positive responses can contribute to well-being and adaptation to illness (Linley and Joseph, 2004; McBride et al., 1998; Walton, 1999; Woods and Ironson, 1999). Some patients facing life-threatening illness also experience an increase in spirituality or religiosity, which are associated with successful coping with stress (Graham et al., 2001) and with positive global appraisals of well-being (McBride et al., 1998; Woods and Ironson, 1999).

Medical practitioners and educators have become increasingly aware that spirituality constitutes an important component of comprehensive patient care (Clark et al., 2003; Tang et al., 2002). Spirituality has been defined as a construct with multiple dimensions (George et al., 2000) with focus given to one or other dimensions depending on the researcher. Example of these dimensions summarized in a review by Doster and colleagues include: “a way of being in the world, an innate feature of a human being, meaning and purpose in life, interconnectedness between the spiritual person and a higher power and/or other persons, beliefs and values about reverence for life, for human rights and for dignity and the transcendence of self or finiteness of human experience (Doster et al., 2002).” While the number of studies exploring spirituality and well-being among patients with heart disease has increased since 1990 (Doster et al., 2002), studies on post-MI spirituality have tended to use quantitative scales to explore correlations between one or more extrinsic

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constructs of spirituality, and specific health outcomes such as post-MI depression, cholesterol and triglyceride levels (Bekelman et al., 2007; Blumenthal et al., 2007). Although these scales and components of spirituality can be useful to predict health outcomes, some have argued that they ignore other dimensions of spirituality (i.e. forgiveness, mindfulness) that may play an important role in post-MI patient's well-being and health behavior (Blumenthal et al., 2007; Brown and Ryan, 2003; McCullough et al., 2000). Similarly, the theoretical concepts of spirituality implicit in these scales also does not reflect the fact that constructions of spirituality are embedded in various local contexts, and determined by situated factors such as religion, history, politics and cultural models of illness. As such, grounded concepts of spirituality are dynamic, in flux, and change depending on local and global events as well as individual experience (Sacks, 2005; Whitley and Kirmayer, 2008). In other words, *place* matters when conceptualizing and exploring factors such as spirituality.

As an alternative to decontextualized models and measures, others have argued for the use of intrinsic or self-defined constructs of spirituality (Adams-Weber, 1998; Woods and Ironson, 1999) to better understand how spirituality relates to patients' well-being after a myocardial infarction (Doster et al., 2002). Several authors have suggested that future studies on post-MI adaptation should also explore illness representations in order to better understand how context and culture influence adaptation to the illness (Cameron, 1996; Cherrington et al., 2004). There is a paucity of studies that have explored the local cultural representations of illness that go beyond patient's simple attributions of their MI. Moreover, with the exception of Walton (1999, 2002) in the United States, there is also little research that addresses spiritual experience following an MI from the patient's perspective (Cherrington et al., 2004; Havranek, 2001).

The present report is part of a larger study that explores cultural models of illness representations and their relation to treatment adherence and recovery after a first myocardial infarction among patients in Quebec, Canada. In this paper, we focus on issues related to spirituality and recovery, which were a central theme in the patients' illness narratives.

Theoretical background. There is a tendency in health social sciences to assume that attributions that people make about their own diseases are logically coherent and rational (Wong and Weiner, 1981; Young, 1981). Young (1981) argued that people use at least three distinct forms of representations and reasoning when discussing their illness or symptoms: (1) representations based on explanatory models of illness based on causal thinking such as symptom or illness attributions (i.e. "I caught a cold because I wasn't wearing a hat;" "I had a heart attack because I was too stressed;" "I'm depressed because my boss has been harassing me for the past year"); (2) representations based on their own prototypical illness experiences or prototypical experiences of others, which allow comparison to their current illness through analogical reasoning (i.e. "Last year, my uncle and aunt died of lung cancer, so I got scared and decided to quit smoking.") and (3) representations organized in temporal sequences or chain-complexes in which experiences and events are linked metonymically to the present health problem without evoking an explicit causal relationship (i.e. "All my symptoms have to do with my divorce. Everything happened at once. I don't know how they're connected."). Community studies have shown that past prototypical illness experiences and explanatory models are not always idiosyncratic but often refer to local popular theories of health that can influence the adoption of health behaviors and may reflect the underpinnings of the sociocultural context of the narrator (Groleau et al., 2009, 2006a, 2006b; Groleau and Rodriguez, 2009).

2. Methodology

Participants. The study sample was comprised of 51 French Canadian men and women living in the province of Quebec, between the ages of 23 and 70, presenting a range of socio-economic backgrounds and levels of education. Patients were recruited from five hospital coronary care units in the cities of Montreal and Laval. They were purposively selected to represent the following criteria: (1) having experienced a first diagnosed MI during the last three months; (2) born in Canada and (3) self-defining as French Canadian or *Québécois*.¹ Of 60 patients referred to us by clinical or research coordinators of participating hospitals, 57 agreed to participate. The three who refused to participate simply mentioned not having enough time or not being interested. Six of the recruited patients died before their first ethnographic interview could be scheduled, which reduced the sample to 51. Our sample was limited to this cultural community as it represents the majority ethnocultural group in the province. This focus on a single ethnocultural group was chosen to allow us to understand how a specific cultural group configures the post-MI experience. The research protocol and consent forms were approved by the research ethics review boards of the five participating hospitals. All participants read and signed a consent form just before the first interview was conducted.

Procedures. Illness narratives were collected at the patient's home, between one to three months post-MI, using the McGill Illness Narrative Interview Schedule (MINI), a semi-structured ethnographic interview schedule, conceptualized to explore illness meaning, experience and behavior (Groleau et al., 2006).² The interviews lasted between 1.5 and 2.5 h and were conducted between one to three months post-MI by the first author (DG) and a research assistant. The first part of the interview was relatively unstructured, with no time limit imposed, in order to collect patients' illness narratives. The middle part of the interview asked open-ended questions to elicit specific types of reasoning (i.e. illness prototypes to explore analogical reasoning and explanatory models for their MI, to explore causal reasoning). The last part of the interview explored pathways to care and changes in worldview, the section where most patients spontaneously produces a rich spiritual narrative relating to how their MI had changes them.

Analysis. Interviews were audio taped, transcribed verbatim, and transferred to a computer program for coding (nVivo 1999 and Merge for nVivo). We used two types of codes: a predetermined list of conceptual codes corresponding to the structures we explored with the MINI (i.e., explanatory model, prototype, events of a chain complex) (Stern and Kirmayer, 2004) and thematic codes that emerged from the narratives. After the completion of the coding of the first 12 interviews, no new themes emerged. This analytic procedure first aimed at identifying the common explanatory models, prototypes, and types of events of the illness narratives. When the dominant theme of spirituality was identified, we then interpreted the local cultural significance of each of the explanatory models, prototypes and events in relation to the spiritual narrative.

3. Results

The majority of participants were men (39/51) with most of them having 14 years of education or more in total

¹ French Canadians living in Quebec usually refer to themselves as *Québécois*.

² The MINI interview schedule is published in appendix of the article by Groleau et al., 2006.

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