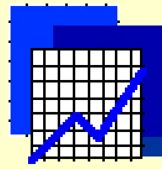

[Back to the Articles of the Month Index Page]

January 2011 Article of the Month

This month's article selection is by Chaplain John Ehman,
University of Pennsylvania Medical Center-Penn Presbyterian, Philadelphia PA.

Groleau, D., Whitley, R., Lesperance, F. and Kirmayer, L. J. "**Spiritual reconfigurations of self after a myocardial infarction: influence of culture and place**" *Health and Place* 16, no. 5 (September 2010): 853-860.

SUMMARY and COMMENT: This qualitative study out of Quebec, Canada offers intriguing observations about connections between the language patients use to make sense of their heart attack and the spiritually transformative experience of the health crisis. The authors argue for close attention to the patients' cultural context but suggest how their location-specific findings may be broadly valuable.

A sample of 39 men and 12 women were interviewed in their homes 1-3 months after their suffering a myocardial infarction (MI). The audiotaped sessions lasted 1.5-2.5 hours, guided by the McGill Illness Narrative Interview Schedule, "a semi-structured ethnographic interview schedule, conceptualized to explore illness meaning, experience and behavior" [p. 854; see also Related Items of Interest, §III, below]. When subjects were asked "if they knew someone who had an illness like their own" [p. 855], they tended to talk about how others' heart attacks were due to risk factors like high cholesterol, hypertension, diabetes or smoking; but, in contrast, they appeared to discount such risk factors in their own cases and instead emphasized the role of *stress* in their crises (e.g., "I had a 'heart like a sponge' [p. 856], illustrating how the heart is symbolically the seat of feeling/emotion). The researchers focus on metaphorical language in patients' narratives of their heart attacks and the effects upon their lives, and here the particular cultural/linguistic context of the participants comes out: for example, in the idiomatic expression of *pris de Coeur* ["taken by the heart"].

> While "*pris du Coeur*" did not correspond to any medical diagnosis, participants explained that *pris du Coeur* mean having an irreversible chronic condition that places important limitations restricting one’s physical activities and geographical mobility. In particular, one who is *pris du Coeur*, cannot engage in activities that would take one away from easy access to hospital services, such as going on a fishing or hunting expedition or spending the winter in a southern country.... [p. 856]

These patients generally made sense of their illness not in biological/medical terms but as a turning point in their lives, and the theme of spirituality emerged as "central to the patients’ narratives and [was] identified as instrumental in post-MI recovery" [p. 853, abstract]. They talked about their MI "as an experience that projected them into a 'state of limbo,' a 'time-out' while at the hospital or at home recovering, where they engaged in prolonged reflection on the meaning and direction of their lives" [p. 856]. Subsequently, these patients expressed a "need for changing the way they perceived their own lives, accompanied by a shift in values, responsibilities and identity" [p. 856]. Their self-perception was of becoming more humanistic, altruistic

and concerned about the collectivegood and, by the same token, more critical of materialism, individualism, and the "'speed of life' aspects of North American society" [p. 856].

> For many, particularly those who lost consciousness at the time of their MI, the illness brought them face to face with death. Many added that it was only through divine intervention that they were brought back to life. Some believed that they were granted redemption because of some unfinished business. The majority of patients explained that their faith in God helped them adapt to their new health situation, made them stronger and gave more meaning to their lives. Also, most prayed to God, the Virgin Mary or a deceased member of the family for protection and good health. [p. 856]

"Overall, most participants noted an intensification of religious and spiritual feelings since their MI" [p. 857].

> Their personal stories of a succession of difficult events that led to the crisis projected by the MI experience were often followed by a profound shift in identity and values. Their narratives situated their MI experience within a web of integrated meanings connecting the spiritual aspect of their lives with values that stepped away from an individualistic definition of self to adopt a more collectivistic position that many were still negotiating for themselves. [p. 857]

Groleau and her colleagues see in the language of these narratives ways that patients have linked their metaphorical sense of the heart with culturally accepted idioms, so that "talk about an MI may serve as an 'idiom of distress,' a culturally acceptable way for people to express emotional distress in an oblique way..." [p. 857].

> That is to say, it is socially acceptable to speak about one's MI and perhaps evoke concern and attentiveness from others. As an idiom of distress, talking about their MI gave some patients the legitimacy and power to negotiate changes in their social roles and responsibilities..., include[ing] new facets of identity. This newly integrated identity, sometimes expressed through the cultural idiom *pris de Cœur* ("taken by heart," "heart-struck"), involved a form of culturally mediated acceptance by the social environment as the patient adapted to their new health status. [p. 857]

The authors go on to explore this experience in light of "rite of passage" phenomena and note also how patients perceived recovery as a symbol of redemption, even in explicitly religious terms [--see pp. 857-858].

To sum up many of their points:

> Some studies have suggested that patients may experience spiritual benefits after an MI such as changes in philosophy of life, values and religious views.... However, to our knowledge no previous studies have explored the relationship between spirituality and connection to others during recovery after an MI. Our results suggest the possibility that having a spiritual life and a renewed connection to others, including spiritual others, such as deceased family members, may act as a source of support for recovery, adaptation and well-being in post- MI. But the form and content of such increased spirituality may vary according to place and local spiritual and religious dynamics. These aspects deserve greater attention from researchers interested in adaptation and well-being after MI. ...Furthermore, by turning our attention to the narratives of patients experiencing an MI and following their subsequent adaptation, we can better understand how post-MI patients interpret their reality through the use of collectively shared spiritual meanings that allow them to renegotiate their identity. [p. 859]

For this reader, the article seems to have several implications for chaplains: First, it highlights the need to understand the metaphorical significance of specific language that patients use to talk about their experience of illness, and that requires a deep understanding of the cultural context of such language. The rich and varied meaning of the *heart* is a fine example. This also reinforces the challenge of working with patients across lines of cultural diversity. Second, chaplains should always consider how idiomatic language can give patients opportunity and permission to talk about emotional and spiritual issues that otherwise might be difficult for

them to bring to voice. What is the potential of a casual colloquialism to harbor a profound expression? Third, when listening to patients' narratives, chaplains should think about how the spatial dynamics of a story may convey an understanding of personal change and transformation. How patients connect the proverbial dots between coming into the hospital, being in a succession of rooms, and preparing to leave can trace a picture of spiritual journey; and discussion of physical limitations on their movement in the hospital and expected restrictions post-discharge can reveal a great deal about meaning-making. Fourth, the study supports the concern that patients may experience a general disconnect between the biological focus of health care and the meaning-making process precipitated in their own lives following a health crisis. Our authors conclude that "health professionals must engage in extended dialogue with patients to explore ideas of the causes of heart disease, its impact on identity, the consequences of facing one's mortality, and connectedness to family and spirituality" [p. 859]; but such a level of engagement may in many instances actually fall to the interdisciplinary involvement of chaplains.

Suggestions for the Use of the Article for Discussion in CPE:

In thinking about the specific cultural context of this research, students should be reminded of the need to be cautious about making generalizations from any study. The particularity of culture/cultures should come up for discussion, and the section of the article that explains in some detail the cultural context of Quebec (pp. 858) emphasizes this. Students may want to consider how language about the heart (and other parts of the body) can be complex. For instance, how might scripture references to the heart be heard differently or afresh by cardiac patients? Also, how might a patient use medical or colloquial language about the heart with double-entendre to convey a deep feeling? The article's emphasis on spatial dynamics may prompt thought about this aspect of patients' stories, and it may raise an issue of how health care settings are often as distinct in their physical structure as they are in their manifestation of particular medical culture.

Related Items of Interest:

I. For more on relationships between spirituality/religion and cardiac disease, see the following recent articles. (For *earlier* articles, see the January 2003 Article-of-the-Month page.)

> Ai, A. L., Peterson, C., Rodgers, W. L. and Tice, T. N. [University of Washington, Seattle]. "**Faith factors and internal health locus of control in patients prior to open-heart surgery**." *Journal of Health Psychology* 10, no. 5 (Sep 2005): 669-676. [(Abstract:) This study explored the relationships between faith factors and internal health locus of control (IHLC) beliefs. Based on a review of different relationships of perceived control, spiritual surrender and faith factors in the liberation, we assumed a multivariate association among them. Using data from two sequential interviews and the Society of Thoracic Surgeons' Adult Cardiac Database, we tested these associations in a final sample of 202 middle-aged and older patients undergoing open-heart surgery. Primary findings from two-step multiple regression analyses supported hierarchical multi-faceted hypotheses. Greater internal control was positively associated with private prayer for coping, an event-specific, 'vicarious' control strategy, but negatively related to subjective religiosity, general faith measure controlling for other confounders, especially cardiac-significant ones.]
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> Ai, A. L., Peterson, C., Tice, T. N., Bolling, S. F. and Koenig, H. G. [Universities of Washington, Seattle]. "**Faith-based and secular pathways to hope and optimism subconstructs in middle-aged and older cardiac patients**." *Journal of Health Psychology* 9, no. 3 (May 2004): 435-450. [(Abstract:) This study was designed to fill gaps in the new field of positive psychology. Using data from two sequential interviews, this study examined the effect of faith-based and secular pathways to hope and optimism among 226 middle-aged and older patients facing a major medical crisis-

cardiac surgery. Structural equation modeling demonstrated that religious faith factors contributed to the agency component of hope and dispositional optimism indirectly through the use of prayer as a coping strategy. Other sociodemographically resourcable factors affected both the agency and pathway components of hope as well as dispositional optimism and dispositional pessimism directly or indirectly through their effects on emotional distress.]

Bekelman, D. B., Dy, S. M., Becker, D. M., Wittstein, I. S., Hendricks, D. E., Yamashita, T. E. and Gottlieb, S. H. [Department of Medicine, University of Colorado at Denver and Health Sciences Center]. "**Spiritual well-being and depression in patients with heart failure**." *Journal of General Internal Medicine* 22, no. 4 (Apr 2007): 470-477. [Erratum appears in vol. 22, no. 7 (July 2007): 1066.] [(Abstract:) BACKGROUND: In patients with chronic heart failure, depression is common and associated with poor quality of life, more frequent hospitalizations, and higher mortality. Spiritual well-being is an important, modifiable coping resource in patients with terminal cancer and is associated with less depression, but little is known about the role of spiritual well-being in patients with heart failure. OBJECTIVE: To identify the relationship between spiritual well-being and depression in patients with heart failure. DESIGN: Cross-sectional study. PARTICIPANTS: Sixty patients aged 60 years or older with New York Heart Association class II-IV heart failure. MEASUREMENTS: Spiritual well-being was measured using the total scale and 2 subscales (meaning/peace, faith) of the Functional Assessment of Chronic Illness Therapy-Spiritual Well-being scale, depression using the Geriatric Depression Scale-Short Form (GDS-SF). RESULTS: The median age of participants was 75 years. Nineteen participants (32%) had clinically significant depression (GDS-SF > 4). Greater spiritual well-being was strongly inversely correlated with depression (Spearman's correlation -0.55, 95% confidence interval -0.70 to -0.35). In particular, greater meaning/peace was strongly associated with less depression ($r = -.60$, $P < .0001$), while faith was only modestly associated ($r = -.38$, $P < .01$). In a regression analysis accounting for gender, income, and other risk factors for depression (social support, physical symptoms, and health status), greater spiritual well-being continued to be significantly associated with less depression ($P = .05$). Between the 2 spiritual well-being subscales, only meaning/peace contributed significantly to this effect ($P = .02$) and accounted for 7% of the variance in depression. CONCLUSIONS: Among outpatients with heart failure, greater spiritual well-being, particularly meaning/peace, was strongly associated with less depression. Enhancement of patients' sense of spiritual well-being might reduce or prevent depression and thus improve quality of life and other outcomes in this population.]

Delaney, C. and Barrere, C. [School of Nursing, University of Connecticut, Storrs]. "**Blessings: the influence of a spirituality-based intervention on psychospiritual outcomes in a cardiac population**." *Holistic Nursing Practice* 22, no. 4 (Jul-Aug 2008): 210-219. [Forty-six patients with cardiovascular disease received a spirituality intervention consisting of music and imagery on a CD created for the study. They were instructed to repeat the intervention on their own at least 3 times a week for the next 4 weeks. Spirituality and anxiety measures were completed at baseline, after the initial intervention and after four weeks. Halfway through the four-week period, researchers telephoned the participants to check on progress, answer questions, and hear of the experiences of the intervention. Participants also were invited to write of their experiences in a small journal to be returned with the third round of measures (self-administered) at the end of the study. Quantitative analysis showed a significant increase in the spirituality score and a significant decrease in the anxiety score between the baseline and the first post-intervention assessments. However, only 24% of the participants continued to the end of the 4-week study period and returned the third set of measures. Analysis of the final data set from the remaining 13 participants did not show a significant further change in spirituality or anxiety outcomes. Qualitative findings (from the telephone and journal data) indicated that most participants' had a highly positive experience of the music and imagery intervention, especially in terms of the relaxation response it engendered. As they repeated the intervention, some also found in it "a deeper meaning behind the words in the imagery script" and an increasing capacity to utilize the exercise to "take their experience to a new level" [p. 217]. Only 5 participants reported that they found no benefits in the intervention, though

others indicated that the time that it took became problematic. (For more on this article, see our August 2008 Article of the Month.)]

Fitchett, G., Murphy, P. E., Kim, J., Gibbons, J. L., Cameron, J. R. and Davis, J. A. [Department of Religion, Rush University Medical Center, Chicago, IL]. "**Religious struggle: prevalence, correlates and mental health risks in diabetic, congestive heart failure, and oncology patients**." *International Journal of Psychiatry in Medicine* 34, no. 2 (2004): 179-196. [(Abstract:) OBJECTIVES: For some people, diagnosis with a serious illness or other adverse life events can precipitate a period of religious struggle. While evidence of the harmful effects of religious struggle is accumulating, less is known about its prevalence or correlates. The aim of this study was to examine the prevalence and correlates of religious struggle in three groups of medical patients. METHODS: Study participants included diabetic outpatients ($N = 71$), congestive heart failure outpatients ($N = 70$), and oncology inpatients ($N = 97$). Participants completed questionnaires which included several measures of religion, including religious struggle, emotional distress or well-being, and demographic characteristics. RESULTS: Half of the total sample (52%) reported no religious struggle, while 15% reported moderate or high levels. In a multi-variate analysis, younger patients ($p < 0.001$) and CHF patients ($p < 0.05$) had higher levels of religious struggle. Those with higher levels of positive religious coping also reported higher levels of religious struggle ($p < 0.01$), while those who attended worship most frequently had lower levels of religious struggle ($p < 0.05$). Religious struggle was associated with higher levels of depressive symptoms and emotional distress in all three patient groups. CONCLUSIONS: While further research is needed to help clarify the sources, additional correlates, and course of religious struggle, the findings in this study confirm the association between religious struggle and emotional distress in these three groups of medical patients. Clinicians should be attentive to signs of religious struggle. Where patient's responses indicate possible religious struggle, clinicians should consider referral to a trained, professional chaplain or pastoral counselor. (For more on this article, see our November 2004 Article of the Month.)]

Koenig, H. G. [Department of Psychiatry and Behavioral Sciences, and Medicine, Duke University Medical Center, GRECC VA Medical Center, Durham, NC]. "**Religion and remission of depression in medical inpatients with heart failure/pulmonary disease**." *Journal of Nervous & Mental Disease* 195, no. 5 (May 2007): 389-395. [(Abstract:) The impact of religious involvement on time to remission of depression was examined in older medical inpatients with heart failure and/or chronic pulmonary disease (CHF/CPD). Inpatients older than 50 years with CHF/CPD were systematically diagnosed with depressive disorder using a structured psychiatric interview. Cox proportional hazards regression was used to examine the effects of religious involvement on time to remission, controlling for covariates. Of 1000 depressed patients identified at baseline, follow-up data on depression course were obtained on 87%. Patients involved in group-related religious activities experienced a shorter time to remission. Although numerous religious measures were unrelated by themselves to depression outcome, the combination of frequent religious attendance, prayer, Bible study, and high intrinsic religiosity, predicted a 53% increase in speed of remission (HR 1.53, 95% CI 1.20-1.94, $p = 0.0005$, $n = 839$) after controls. Patients highly religious by multiple indicators, particularly those involved in community religious activities, remit faster from depression.]

Tartaro, J., Luecken, L. J. and Gunn, H. E. [Department of Psychology, Arizona State University, Tempe]. "**Exploring heart and soul: effects of religiosity/spirituality and gender on blood pressure and cortisol stress responses**." *Journal of Health Psychology* 10, no. 6 (Nov 2005): 753-766. [(Abstract:) The current study investigated gender effects on the influence of self-reported religiosity and spirituality on cardiovascular and cortisol responses to a laboratory stressor among young adults. Participants with higher composite religiosity/spirituality scores, religiosity, levels of forgiveness and frequency of prayer showed lower cortisol responses. Greater composite religiosity/spirituality, religiosity, frequency of prayer and attendance at services were associated with lower blood pressure in males and elevated blood pressure in females. Findings suggest that

spiritual and/or religious individuals may experience a protective effect against the neuroendocrine consequences of stress, though cardiovascular benefits may vary by gender. This work represents an important step in the convergence of multiple realms of research by linking physiological measures with indicators of individual belief systems.]

Vollman, M. W., LaMontagne, L. L. and Wallston, K. A. [Vanderbilt University School of Nursing, Nashville, TN]. "**Existential well-being predicts perceived control in adults with heart failure**." *Nursing Research* 22, no. 3 (Aug 2009): 198-203. [(Abstract:) This study examined the relationship between spiritual well-being (SWB) and perceived control (PC) in adult patients with heart failure (HF). The sample included 75 adults ranging in age from 27 to 82 years. Participants verbally completed study questionnaires in a clinic room selected for privacy. Multiple linear regression results indicated that increased existential spiritual well-being (a subscale of SWB) predicted increased PC. Thus, patients with HF who adjust to personal changes and who also connect with others may develop meaning and purpose in life and may perceive increased control over their heart disease.]

Villagomeza, L. R. [University of South Florida, Tampa, FL]. "**Mending broken hearts: the role of spirituality in cardiac illness: a research synthesis, 1991-200**." *Holistic Nursing Practice* 20, no. 4 (Jul-Aug 2006): 169-186. [(Abstract:) This research synthesis analyzed research on spirituality in cardiac illness from 1991 to 2004 to identify progress, gaps, and priorities for research. Articles were retrieved from PubMed and CINAHL. Twenty-six studies met inclusion criteria. Moody's Research Analysis Tool, Version 2004, was used to analyze studies. Lack of conceptual model and universal definition of spirituality are major knowledge gaps. A proposed conceptual model is presented.]

II. For more on how traumatic experiences may affect spirituality, see the May 2005 Article-of-the-Month page.

III. Groleau and her colleagues used the McGill Illness Narrative Interview to collect their qualitative data. This guide was developed by Groleau (and also current co-author Kirmayer) and presented in the following article in 2006:

Groleau, D., Young, A. and Kirmayer, L. J. "**The McGill Illness Narrative Interview (MINI): an interview schedule to elicit meanings and modes of reasoning related to illness experience**." *Transcultural Psychiatry* 43, no. 4 (December 2006): 671-91. [(Abstract:) This article summarizes the rationale, development and application of the McGill Illness Narrative Interview (MINI), a theoretically driven, semistructured, qualitative interview protocol designed to elicit illness narratives in health research. The MINI is sequentially structured with three main sections that obtain: (1) A basic temporal narrative of symptom and illness experience, organized in terms of the contiguity of events; (2) salient prototypes related to current health problems, based on previous experience of the interviewee, family members or friends, and mass media or other popular representations; and (3) any explanatory models, including labels, causal attributions, expectations for treatment, course and outcome. Supplementary sections of the MINI explore help seeking and pathways to care, treatment experience, adherence and impact of the illness on identity, self-perception and relationships with others. Narratives produced by the MINI can be used with a wide variety of interpretive strategies drawn from medical anthropology, sociology and discursive psychology.]

IV. This month's featured article is from *Health and Place* --a journal with a quite particular focus. To quote the description from the journal's website:

> The journal is an interdisciplinary journal dedicated to the study of all aspects of health and health care in which place or location matters. Recent years have seen closer links evolving between medical geography, medical sociology, health policy, public health and epidemiology. The journal reflects these convergences, which emphasise differences in health and health care between places, the experience of health and care in specific places, the development of health care for places, and the methodologies and theories underpinning the study of these issues.

The journal has only the occasional article that touches upon spirituality, but it may be worth browsing for its distinctive emphasis.

If you have suggestions about the form and/or content of the site, e-mail Chaplain John Ehman (Network Convener) at john.ehman@uphs.upenn.edu .
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