

BECKONING THE HEART:
A GUIDED AUTOBIOGRAPHICAL APPROACH TO UNDERSTANDING WOMEN'S
RECOVERY FOLLOWING MYOCARDIAL INFARCTION

by

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Abstract

As cardiac research specific to women slowly emerges from the field, there is increasing evidence that women's experiences following myocardial infarction are different from men's (Boogard, 1985) and that younger women may be faced with different developmental challenges compared to their older female counterparts (LaCharity, 1997, 1999).

This study explored how women constructed their experience of recovery following a myocardial infarction (MI). Action research using Guided Autobiography (GA) provided the methodology for addressing the research question: How do women under the age of 55 years, construct their experience of recovery following myocardial infarction? Guided autobiography was utilized as the research tool or method for gathering the research data.

Five women, between 48 and 53 years of age, who experienced MI within the past 3 years, voluntarily participated in a 7-week GA group with other female cardiac patients where they engaged in a weekly reflection and writing practice. Six autobiographical themes were used to guide participant's written accounts. A follow-up session was conducted approximately 8 weeks following the completion of the group to address issues of research validity.

Data sources in this study primarily comprised of participant's autobiographies, audio and videotapes of the research sessions and the researcher's field notes. Research sessions were transcribed verbatim and analyzed according to Berg's (1995) method of content analysis. Six common themes emerged across research sessions including a) the experience of loss, b) living with uncertainty, c) changes in self-concept, d) personal needs and self-care, e) care and support, and f) taking care of others.

Study findings contribute to the growing body of literature specifically dedicated to exploring women's experiences of MI and recovery. Findings also demonstrate the value of utilizing Guided Autobiography as a clinical intervention to facilitate emotional recovery in women following a significant cardiac event such as MI. Other implications for health-care providers are discussed.

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The time will come
When, with elation,
You will greet yourself arriving
At your own door, in your own mirror,
And each will smile at the other's welcome.

And say, sit here. Eat.
You will love again the stranger who was yourself.
Give wine. Give bread. Give back your heart
To itself, to the stranger who has loved you.

All your life, whom you ignored
For another, who knows you by heart.
Take down the love letters from the bookshelf,

The photographs, the desperate notes,
Peel your own image from the mirror.
Sit. Feast on your life.

(D. Walcott, n.d.)

CHAPTER ONE

Be patient toward all that is unsolved in your heart and try to love
the questions themselves like locked rooms or books
that are written in a foreign tongue. (R.M. Rilke, n.d.)

Introduction

Coronary heart disease (CHD) is currently the leading cause of illness, disability, and death among Canadian women (Statistics Canada, 2002). In 1999, almost 20,000 women died as a result of heart disease. Myocardial infarction (MI) or heart attack, the major medical emergency of the cardiovascular system, accounted for almost half of these deaths. Only recently has this 'silent epidemic' begun to receive more public attention or media coverage despite the fact that mortality rates from MI in women are doubled in comparison to women dying from breast cancer (Statistics Canada, 2002).

Historically, cardiac illness has been viewed as an affliction specific to middle-aged men. This misconception is partially attributed to the fact that heart disease and MI occur, present more severely, and result in death at an earlier age in men than women (Kannel, as cited in Packard, 1992). In addition, misleading information from health care professionals and the media have suggested that MI predominantly manifests with textbook symptoms occurring only in men. Despite the prevalence rates in women, most of the research regarding various aspects of heart disease and MI is based primarily on studies conducted on men (Benson & Arthur, 1997; Jenson & King, 1997). Women have either been excluded from or dramatically underrepresented in most cardiac research.

While a paucity of cardiac research has been solely devoted to examining women, even fewer psychosocial studies have been conducted in the area of recovery following MI (Boogard & Briody, 1985; Fleury & Cameron-Go, 1997). Moreover, little distinction has been made between groups of younger and older women (LaCharity, 1997, 1999). Consequently, little is known about younger women's recovery experiences.

Research that has examined adjustment to MI and included samples of women has mostly relied on descriptions of narrow constructs (see Keckiesen & Nyamathi, 1990) and is not conducive for portraying women's lived experience. The development of recovery services and support programs specific and germane to women is an area that has yet to be explored.

In more recent studies, social support has been implicated as a significant factor in women's recovery from MI (Benson & Arthur, 1997; Moser, 1994). Despite these findings, there is little evidence that therapeutic resources exist for younger women following MI outside of conventional rehabilitation programs which focus on physical recuperation. In general, women have rarely been asked the necessary questions that will more fully illuminate their specific

needs for psychological treatment and care. Given the magnitude of this health concern for women, the importance of conducting research that specifically highlights women's experience and knowledge of their subjective experience of recovery from MI is critical.

With a progressively aging population, it is inevitable that greater numbers of women will suffer from ailments of the heart, including MI. Subsequently, it is important that health professionals develop a better understanding of the recovery process in women following MI. For counsellors working with female heart patients, it is important they be aware of the potential challenges and difficulties that may arise during their recovery and their subsequent needs for support.

The Research Question

The research question that was asked was: How do women under the age of 55 years, construct their experience of recovery following myocardial infarction? Within the framework of action research, a guided autobiography group created the context in which women engaged in a process of reflection and writing and shared their life histories and recovery experiences with other female cardiac patients. This small group context was conducive for women's expression of voice and the development of an individual and co-constructed dialogue reflecting their meaning making processes related to MI recovery. Moreover, the lived experience of the group process served to comprise an important component of their recovery experience. This study also explored the suitability of using guided autobiography as a method of research with female heart patients.

The Bridge between Counselling Psychology and Medicine

The contributions of Counselling Psychology in health care are multifold and have an important place within the biopsychosocial model of disease. Given that chronic illness (e.g. cancer, heart disease, and stroke) currently represents the greatest threat to health, the impact of biological, psychological, and social factors in the origins of the illness process is critical (McRae and Smith, 1998).

Departing from a biomedical perspective, which focuses on the biological origins of disease, the Counselling Psychologist's lifespan approach explores personal meaning making and views the individual in a more holistic manner, thus emphasizing the subjective nature of experience and the world of the individual (e.g. psychological, social, emotional, and spiritual factors). Health is explored in the context of the individual's location in the life cycle as well as in their lifestyle and relationships (Woolfe, 1996). In this sense, the lifespan approach addresses problems in everyday living and is particularly useful given the enduring nature of chronic illness and the interaction between disease processes with normal developmental processes.

Historically, Counselling Psychology has been largely excluded from the realm of

medicine as social workers, clinical psychologists, and psychiatrists have dominated the field. The work of these mental health professionals has aligned with the medical model and tended to focus on assessment, case management, and the prescription of medication rather than psychotherapy or counselling. In contrast, the shift from a biomedical to a biopsychosocial model of disease provides a natural link between Counselling Psychology and medicine. The current study demonstrates how research and practice in these areas can be bridged within the context of studying heart disease in women.

Personal Perspective on Women's Cardiac Recovery

While I have not personally been diagnosed with heart disease or myocardial infarction, there are several factors that have led to my interest in conducting this research. These include my experience of working in health care within the culture of cardiac health, interests in the lived experience of illness, feminist beliefs and values, and my own life experience of health and evolving understanding of wellness from an integrative perspective.

Having worked in health care for many years, my exposure to hospital culture has deepened my understanding of the individual experience of heart related illness, and of issues and concerns that emerge while hospitalized. I have also come to understand the importance of creating opportunities for ill persons to talk about their illness experiences. Kleinman (1988) emphasizes the importance of "empathic witnessing" or the commitment to help a sick person facilitate the telling of their illness story, thus enabling them to give value to their illness experience.

Although health care professionals do not typically provide patients with openings to share personal histories and meanings associated with their illness experience (beyond the reiteration of symptom history) as part of standard care, sick people will often seek out opportunities to do so. As a cardiology technologist, I have witnessed countless patients trying to engage almost anyone (including housekeeping staff and food service workers) in a dialogue about how their illness came to be, the severity of their symptoms, or the fact that they had never previously been hospitalized.

Over the years, I too have listened to heart patients tell their stories of feeling devastated by their diagnoses and prognoses, demoralized by hospital routines, of being silenced and misunderstood by doctors and family members, and stories of loss, grief, and uncertainty about the future. I have also heard stories of heroic medicine, gratitude, human kindness and hope. Many of these stories surfaced through informal conversations with patients, as well as through interviews I conducted with women hospitalized with heart attacks as part of my Masters research (Bowers, 1996). Emerging from these interviews were stories about women's

struggles of surviving a potentially life threatening health crisis while already facing life altering decisions and transitions. Each participant recognized the value in talking with other women about their experience of heart disease as well as other aspects of their lives. To date, few resources to meet this need have been available to women.

Since conducting my Masters research, I have found it increasingly difficult to separate my role as a technologist from my training as a counsellor and researcher. Consequently, while performing diagnostic heart tests, I have often slipped into these latter roles as I informally collect data through observing, asking questions, offering empathy, and theorizing about the experiences of those with whom I am working. Beyond wondering about individual processes of meaning making surrounding the illness experience, I have often reflected on the degree to which sick people feel seen and understood by their health care providers.

I conduct my work through a feminist lens that views the experience of being heard and understood, and of being valued and validated, as a fundamental component of the healing process. Given that my work as a counsellor involves facilitating support, emotional healing, meaning making, communication and relationship building, and the exploration of existential concerns, I understand that much of this work is foundational within the context of experiencing illness. Healing, in this sense, attends to all parts of the individual, not just their physical self. Woodman (personal communication, May 2001) distinguishes between 'curing' and 'healing' in that the individual may be cured of her or his illness via medicine's curative approach without becoming whole. In contrast, wholeness speaks to the importance of bringing together the healing of women's bodies and their emotional, psychological, and spiritual selves.

My experience of working in health care has left me with a deep sense of dissatisfaction and frustration with medicine's narrow views on health, the domination of bodily or medical knowledge, and the extent to which women's health has been medicalized and often underrepresented in terms of research and gender specific care. As a feminist, I understand that women are systemically oppressed in our society, and in general, have less power and authority than comparably situated men. Medicine has played an active role in perpetuating some aspects of women's oppression as bodies become a symbolic field for the reproduction of dominant values and conceptions (Crawford, 1984, as cited in Sherwin, 1998).

In conducting research in the area of women and health, it is essential to look at the values and assumptions implicit in medicine's attitudes towards women. For example, women continue to be discouraged from trusting and listening to their bodies and intuitive knowledge, encouraged instead to rely on "expert" knowledge that shapes what we are capable of knowing. Dismissing women's bodily knowledge concerning their hearts could be deadly given the

accumulating evidence that women differ from men in terms of the presentation of cardiac symptomology.

At the same time, women have historically been instrumental in effecting political and social change and creating alternative visions of women's health including the development of female-specific services and resources outside of mainstream medicine. Smith (1987) suggests that women have the power to change the ways we interact with the medical system and the ways we learn about the lived experience of being ill:

Women have developed alternatives for women, which have been radical both in providing for a woman a place to begin from her knowledge of her own body and also representing a radical departure from the professional forms of social relations in which knowledge is appropriated and controlled by 'experts' (p. 53-54).

A common theme emerging from my previous research (see Bowers, 1996), current cardiac literature related to women and MI, and from conversations with other health professionals and female heart patients, is that there is a lack of emotional support for women recovering from cardiac illness. Consequently, in continuing with my vision for creating alternative health resources for women, I have developed my earlier research and more fully explored women's MI recovery within a supportive women-centered context.

Consequently, five women, ages 48 to 53, participated in an 8-week research group using guided autobiography to reveal how they constructed the experience of recovery within 3 years of having a heart attack. Their stories and reflections are presented in Chapter Four.

The Organization of the Dissertation

In Chapter One, I present the topic of the current study, women's recovery from myocardial infarction, and provide some background demonstrating the significance of this issue. I also briefly discuss how the shift from a biomedical to a biopsychosocial model of disease provides a natural link between counselling psychology and medicine in terms of both research and practice. As well, I present an overview of my research question and discuss my personal perspectives on women's cardiac recovery. I conclude with this summary of the organization of the dissertation.

Chapter Two examines the relevant research literature beginning with an overview of the women's health movement and illustrating how the lack of attention to women's cardiac health is embedded within the larger story of how medicine has historically contended with women. This provides a context for understanding women's history of exclusion from cardiac research. I then examine various factors related to myocardial infarction in women and review a body of qualitative research that explores cardiac recovery in women.

Chapter Three describes action research (Sumara & Carson, 1997) using guided autobiography (Birren & Deutchman, 1991) as the methodological framework for conducting the study. As well, I discuss the format of the research and the selection and recruitment of participants, participant profiles, data collection, data analysis, and issues of validity.

Chapter Four presents the findings of my research. I wanted to present these findings in a way that paralleled the unfolding of each research session. Consequently, recovery themes were described and presented by week, followed by women's autobiographies and group dialogue using a multilayered representation. Finally, I provided an analysis and interpretation of each session including self-reflections on group process. The chapter ends with the elucidation of six themes that emerged from looking across the weekly sessions.

Chapter Five offers a discussion of the research findings within the context of the six recovery themes and previous research. As well, secondary findings unique to younger female MI patients are discussed. I explore the implications of using guided autobiography for health care providers and discuss study limitations. Finally, I present some personal thoughts on conducting this research project.

CHAPTER TWO

Literature Review

Each woman responds to the crisis that...*illness*... brings to her life out of a whole pattern, which is the design of who she is and how her life has been lived. (A. Lorde, 1997, p.7)

Introduction

In this chapter, I will review the relevant literature in the area of women's recovery from myocardial infarction thus providing a background and rationale for the current study. Literature searches were conducted using MEDLINE, CINAHL, Dissertation Abstracts, and PsychINFO on heart disease, myocardial infarction, cardiac rehabilitation, models of recovery, and psychological responses with women in the research subject category from the 1980's through May 2004.

I begin with a brief overview of the development of women's health-care, which provides a natural segue to examining the exclusion of women from cardiac research. I will then examine myocardial infarction and the impact of this event on women. Research examining recovery from MI will also be reviewed. Particular attention will be given to recent qualitative studies examining the subjective experiences of women.

A Brief History of the Development of Women's Health-Care

The lack of attention to women's cardiac health is embedded in the larger story describing how medicine has historically contended with women and their health and health-care. The fact that women have been under-researched, misdiagnosed, and overlooked in their treatment, reveals the status of cardiac care currently available to women. Moreover, women's exclusion from research in this area parallels greater systemic concerns involving issues of power, ownership, and voice, and which reveal the androcentric bias evident in medical practice and biomedical research. Having a sense of this history provides the context for understanding the obstacles that have prevented women from receiving gender specific cardiac care and highlights the importance of conducting the current study.

The Foundational Work of the Women's Health Megamovement.

Weisman's (1998) book entitled *Women's Health Care: Activist Traditions and Institutional Changes* delineates the historical development of the women's health megamovement as a series of five waves of public attention to women's health and bodily issues extending across the past two centuries in the United States. These waves of attention have also coincided with cycles of social movement including changes in existing gender role ideologies, heightened women's rights activism, and important developments in the medical profession and health-care system. Specific themes emerged during each wave as

predominantly middle-class women organized to improve the state of all women's health by addressing diverse health issues and countering the domination of primarily male physicians, legislators, and mainstream culture. The results of women's efforts led to renegotiating the meaning of women's health in terms of changes in health-care delivery, policy, and the relationships between women and health-care providers (Weisman, 1998).

Key Issues in the History of the Women's Health Movement.

In the Popular Health Movement of the early 1800's, women began to distribute health information and create public forums to talk about health and bodily issues with other women. Conflict emerged between male physicians practicing midwifery, and women who were traditionally responsible for childbirth, and the health of women and their families (Weisman, 1998).

By the late 1800's, conceptions of 'women's health' as denoting primarily reproductive functions, had emerged as ideas about biological determinism and differences between the sexes gained prominence. Dominant medical theories suggested that women's reproductive organs were central to their overall physical and mental health, while prevailing gender ideology defined maternity as a woman's primary social function and moral purpose, and helped to further legitimize medicine's focus on reproduction for the next century (Smith-Rosenberg, 1985). Public policy, such as campaigns to prohibit abortion and contraception, helped to strengthen the link between reproduction and women's health, and were heavily supported by male physicians as declining fertility rates posed economic threats (Weisman, 1997). Key issues in this wave of the health movement focused on the efforts of female physicians to define their distinctive expertise in women's health and their professional role in medicine as more women gained access to medical training (Weisman, 1998).

During the Progressive Era, extending into the 1920's, all of women's reproductive functions were being transformed into medical services as a result of physician's entrepreneurial interests and efforts to frame these as preventive health-care (Weisman, 1998). While women's health advocates were divided between supporting either maternal and child health programs or sexual and reproductive rights, both groups continued to equate women's health with reproductive functions. During this time, conflicts had emerged between private physicians and new services (e.g. birth control clinics and prenatal care) established for women by public health nurses and female reformers (Weisman, 1998).

The Women's Health Movement of the 1960's and 1970's presented the first major challenge to the medical profession's view of women's health by broadening their health concerns beyond the scope of reproduction. The dominant theme in this wave was women's shared experience of feeling a lack of control over their bodies. In response, women argued for

the right to make informed decisions about all aspects of their health-care (Weisman, 1998).

Problematic was the fact that the medical profession was male-dominated and viewed as "treating women in a condescending manner, withholding information, overusing surgery, prescribing risky drugs, and devices, medicalizing women's reproductive functions, and reinforcing sexual stereotypes by encouraging reproduction over pregnancy prevention" (Weisman, 1998, p. 72). Most notably, activists strongly criticized medicine's gate keeping authority to control women's reproductive lives by regulating access to abortion and contraception services (Weisman, 1997), use of untested drugs such as thalidomide and diethylstilbestrol (DES) prescribed to pregnant women often without their knowledge and which led to miscarriages, birth defects, and reproductive disorders in offspring (Johnson & Fee, 1994); and inappropriately informed consent procedures including one-step biopsy/mastectomy procedures (Weisman, 1997). Women's efforts in directly challenging medical authority profoundly impacted women's health-care and led to the legalization of abortion, health education campaigns, the creation of alternative health services (e.g. women's health centers, abortion services, and birthing centers) which competed with mainstream care, and the large influx of women into medical schools during the 1970's (Weisman, 1997).

Another significant legacy of this movement were the guidelines implemented by the Food and Drug Administration (FDA) in 1977 that barred women of childbearing potential from participating in clinical research (until adequately safe information could be derived from animal and early clinical studies) in response to the outcry of the DES and thalidomide disaster (FDA, as cited in Vidaver, Lafleur, Tong, Bradshaw, & Marts, 2000). In essence, these protectionist policies eliminated all premenopausal women from medical research, thereby ensuring that the approval of new drugs, devices, and interventions studied from that point forward was based almost solely on studies of men or possibly postmenopausal women or both. As Dresser (1992) noted, "in the name of potential protection for potentially pregnant women and their fetuses, all women [had] lost opportunities to improve and extend their lives" (p. 25).

While the first three waves of the health megamovement centered on public awareness of women's health issues and information, competition and legitimacy issues around health professionals, and issues of reproduction, fertility, and abortion, it was not until the latter half of the 1900's that issues regarding biomedical research and access to treatment began to more obviously shape the direction of women's cardiac health services.

In the most recent wave of the health movement, advocacy groups in the early 1990's argued that women's health had been neglected with respect to research and care, and demanded equity in access to the benefits of medical research and treatment (Weisman, 1998). Given the broad emphasis on women's health throughout the lifespan, specific claims

suggested that women's health had been studied much less than men's; women had been excluded or underrepresented in large research projects resulting in large gaps of knowledge and inadequate treatment; research on women had focused too narrowly on the reproductive concerns of younger women while neglecting the health of older women, and that not enough women were primary investigators in health research funded by the government (Weisman, 1997, 1998).

In contrast to previous health movements, efforts to shape the women's health agenda were made from within the system by women in positions of influence (e.g. in medicine, government, health organizations) who sought to influence government policies in terms of funding medical research specific to women's health, the inclusion of women as research participants in clinical studies, reforms in medical education and training, programs to encourage women to become primary investigators in health research, and improvements in health service delivery to women (Weisman, 1997, 1998).

Key accomplishments also included the creation of government offices and branches dedicated to the coordination of women's health activities (LaRosa & Pinn, 1993). The work of these offices have been groundbreaking in terms of facilitating the policy changes advocated by feminists and which eventually helped change the face of the women's health research agenda in the United States.

For example, in 1990, the Society for Women's Health Research, working in conjunction with the U.S. government, requested that the General Accounting Office (GAO), a branch of the National Institutes of Health (NIH), investigate the progress of previously established guidelines for the inclusion of women in federally funded biomedical research (Vidaver et al., 2000). The GAO reported that the research model for the "typical 70kg man" was alive and well and that there was little evidence that the NIH had implemented earlier policy guidelines (Greenberger & Marts, 2000, p. 463).

Consequently, the Society played a significant role in drafting subsequent legislation, which established the Office of Research on Women's Health (OWHR), a NIH office designed to co-ordinate and monitor efforts to improve women's health research, and put the requirement for the inclusion of women and minority groups in all federally funded research studies, and for analysis of clinical trial data by subpopulation, into law (Greenberger & Marts, 2000). Endeavors such as the Women's Health Initiative, a massive research project addressing the major cause of death, disability, and frailty among middle-aged and older women, demonstrated the newly emerging strategic commitment of the NIH to make women's health a priority (Healy, 1991).

Interestingly, during these same years, the FDA published its new guidelines for studying and evaluating gender differences in drug trials, thus replacing the 1977 protectionist policy that excluded most women of childbearing potential from clinical trials (FDA, as cited in Baylis, 1996). [Significant to the FDA's decision was the work of AIDS activists who challenged protectionist policies regarding access to experimental drugs thus modeling a language and political strategy useful to feminists in pursuing the women's health agenda (Johnson & Fee, 1994)]. Women's access to the benefits of biomedical research and women-centered medical treatment and care continues to remain a central concern in the women's health-care agenda of the 21st century.

Summary

As the institution of health-care became more formalized and male-dominated, gender-based tensions emerged questioning who had the authority to define and control health-care practices (Weisman, 1998). The dissension surrounding these concerns in one wave of the health movement often set the stage for activist efforts in the next.

What becomes evident throughout this history is that women have not been passive recipients of medical control (Weisman, 1998). As powerful consumers, they provided a key market of health services and products, and instigated important changes in medical practice. As health-care providers, women have repeatedly demonstrated their commitment to generate new services and organizations to meet the health needs of women not adequately addressed by mainstream providers. Despite these successes, gender continued to play a fundamental determinant in terms of prevailing conceptions of women's health and health-care.

More specifically, Weisman (1998, p. 4) suggests that health-care has never simply been the rational application of biomedical science or technology to the problems of the body. Instead, it is a negotiated social arrangement for providing personal services that are perceived to be needed and appropriate by providers, consumers, insurers, and policymakers, all of which reflect social and cultural values and beliefs, and incorporate dominant social and power interests.

In this sense, the male domination of the health-care system, including medical practice and biomedical research; the concentration of money and power among men; and the problems women report with access and appropriateness of health-care has reflected an "androcentric bias," thus focusing on the bodily experiences and diseases of men, and either neglecting those experiences of women or narrowly construing them in terms of reproduction (Rodin & Ickovics, 1990).

Moreover, masculinist models of health have repeatedly served an ideological purpose by masking the social constructions of health, making them appear natural (Baylis, Downie, &

Sherwin, 1998; McCormick, Kirkham, & Hayes, 1998). For example, the white male became the prototype of the human research subject, and male health became the norm against which definitions of women's health are made. In the case of cardiac research and care, male norms have been used to judge what is appropriate and necessary for women.

Current Status of Women's Inclusion in NIH Research

In a recent survey of articles, published in four major medical journals between 1993 and 1998, Vidaver et al. (2000) explored whether the NIH guidelines, requiring the inclusion of women in clinical research, is currently reflected in the scientific literature. Findings suggest that although the majority (about 80%) of NIH funded studies included women as study participants, only a small percentage (25-33%) of studies that included women analyzed data by gender. In both cases, these figures had not improved significantly over the 5-year period. While this situation may be improving, the data demonstrates that the policies for inclusion of women in biomedical research have not yet been fully implemented.

The importance of including women in clinical research and conducting gender-based data analysis is essential to understanding the impact of disease states and clearly has implications for treatment and patient care. Vidaver et al. (2000) suggest "until potential differences in response to treatment and interventions between women and men are adequately addressed, we cannot be satisfied that sex-specific adverse events are unlikely to occur" (p. 503). Moreover, they recommend increased awareness and monitoring of recruitment and retention of women in clinical research and for the consistent practice of conducting analysis of data by gender.

Women's Health in Canada

While the Canadian history of women's health-care has been significantly less documented than that of the United States (US), it appears that Canada is moving in the direction of developing clinical research policies that serve women's health interests as well as men's. Baylis (1996) argued that when US policy makers enacted policies addressing gender equity in clinical research several years ago, a strong backlash was observed in Canada and managed to diminish some of the force of these policies. More specifically, this backlash fuelled ongoing debates about the facts of exclusion and the need for inclusion of women in research, and reflected a resistance and distrust of what is often perceived as a female-biased feminist agenda (see Baylis, 1996).

Despite this resistance, policies and guidelines supporting gender inclusion and the presence of underrepresented groups in Canadian research began to emerge in greater force towards the latter part of the 1990's (see Baylis, 1996; Baylis et al. 1998). Moreover, the development of federally funded programs of research including five Centers' of Excellence for

Women's Health, located across Canada, and the recent and timely development of the Canadian Institutes of Health Research (CIHR) hold considerable promise in terms of strengthening policy-focused research on women's health in this country.

The Exclusion of Women from Cardiac Research

The demands for equity in access to biomedical research and appropriate treatment and care for women have been distinctly existent in the area of heart disease as claims challenging women's exclusion and under representation from clinical trials were clearly identified during the most recent wave of the women's health movement. In a review of studies beginning in the 1950's, Thomas and Braus (1998) suggest that early cardiac studies either excluded women entirely, included women in their study populations but omitted them from data reports, or added women to their study populations after the studies had been conducted for some time.

Despite the magnitude of this health concern in women, the preponderance of information regarding the etiology, incidence, management, and rehabilitation of heart disease has been conducted almost exclusively on male populations (Healy, 1991; Wenger, Speroff, & Packard, 1993). In attempts to expose this gender disparity, several well-known studies of cardiovascular disease were identified and widely publicized, during the 1990's, as key examples of federally funded projects that did not produce data that was generalizable to women (Mastroianni, Faden, & Federman, 1994). Each of these studies has had widespread influence on the treatment and prevention of heart disease for both genders, despite the fact that women were excluded as study participants (Healy, 1991).

For example, the Multiple Risk Factor Intervention Trial (MRFIT) was designed to determine the efficacy of risk modification in 12,866 men, aged 35-57, who were at high risk for developing heart disease because of elevated serum lipids, hypertension, and cigarette smoking (The MRFIT Group, 1977). The Coronary Drug Project (CDP), was a randomized, controlled clinical trial developed to evaluate the efficacy of various lipid influencing drugs on prolonging the lives of men, aged 30-64, with a prior history of heart disease (Meinert, 1986 as cited in Mastroianni et al. 1994). Similarly, the Physicians' Health Study (PHS) was a randomized, controlled trial, designed to test whether aspirin in low doses reduced the risk of myocardial infarction among 22,071 healthy male physicians (Steering Committee of the Physicians' Health Study Research Group, 1989). Investigators in these studies claimed that the exclusion of women as research participants was based on their perception that heart disease was an illness primarily afflicting middle-aged men, and in the latter study, that few middle-aged female physicians with heart disease existed when the study was conducted in the early 1980's (Mann, 1995).

The Baltimore Longitudinal Study of Aging (BLSA), a community-based study of normative aging, issued a report entitled "Normal Human Aging" based on data comprised of over 1,000 men (Shock et al., 1984). Interestingly, the title of the monograph implicitly equated 'normal' with a 'male' perspective, demonstrating how women's experience becomes camouflaged under the generic category of human. Despite the fact that women represented the majority of the elderly population, no women were included as study participants during the first 20 years of Baltimore trial. Moreover, when risk factors for heart disease were assessed, several years into the study, investigators had difficulty drawing conclusions related to women. Arguments defending the male-only design point to a time, approximately two decades ago, where a perceived epidemic of heart disease among middle-aged men was prevalent (Healy, 1991; Mann, 1995). Other experts disputing the charge that cardiac research has neglected women have cited various arguments for justifiably excluding women from clinical trials. For example, the participation of women has been associated with unwarranted research costs, difficulties with recruitment and/or maintaining participation, complications and disruptions in research protocols (e.g. due to hormonal fluctuations), and protectionist measures (Baylis et al., 1998; Mann, 1995).

Despite these claims, Healy (1991) advises that the legacy of this early cardiac research must still be recognized. Namely, that the impact of these studies has represented "decades of sex-exclusive research that has reinforced the myth that coronary heart disease is a uniquely male affliction and has generated data sets in which men are the normative standard" (p. 275). As well, health stereotypes about women including beliefs that 'women somaticize their emotional problems,' and that 'women just don't get heart disease' further contributed to physician's failure to recognize heart disease as a serious condition in women (Dresser, 1992).

The consequences of excluding women from cardiac research is that the data necessary for making choices regarding prevention and treatment for women are unavailable and must be extrapolated from data collected on men, despite physiological and psychosocial gender differences that may exist (Baylis et al. 1998; Healy, 1991). This has inevitably led to biased standards of care and the failure to fully consider aspects of heart disease that are specific to women.

While efforts of the last wave of the women's health movement have played a fundamental role in altering government and funding policy leading to greater initiatives in women's health, the "androcentric" history of cardiac research has resulted in a scarcity of medical knowledge about heart disease in women until recent years. In this sense, the social scaffolding that supports various societal beliefs about gender ideology and health has made it challenging for women to become visible within the domain of cardiac health.

Myocardial Infarction

"The experience of [MI] is typically sudden, frequently without forewarning, often dramatic, usually distressing, and almost always life-threatening" (Byrne, 1990, p. 369). In this sense, individuals often shift from feeling well to feeling sick very quickly. MI occurs when an obstruction in one of the coronary arteries prevents sufficient oxygen to supply the heart resulting in the death of a portion of the heart muscle (American Heart Association, 1996).

Denial is commonly documented among individuals first recognizing cardiac symptoms (Byrne, 1990), which are often attributed to other illnesses such as gastrointestinal conditions (e.g. heartburn), flu, or arthritis. As well, various symptoms of MI can also mimic features of anxiety or panic (American Heart Association, 1996).

While symptoms of MI may be non-existent, mild, or severe, the most classic manifestation is a pressure, squeezing, fullness or pain in the center of chest, which may radiate to the shoulder, neck or arms. Accompanying indicators may include sweating, shortness of breath, nausea or vomiting, and a sense of impending doom or imminent death (American Heart Association, 1996).

The time from the onset of MI symptoms to diagnosis and treatment is essential in terms of minimizing heart damage. Diagnosis of acute MI is based on the individual's clinical history, electrocardiograph findings, and the measurement of cardiac enzymes found in the blood (American Heart Association, 1996). While immediate medical interventions typically revolve around the restoration of adequate blood supply through the coronary arteries, the standard treatment for MI may include drug therapy, medication, risk factor reduction, stress management, and cardiac rehabilitation (Beery, 1995; Wenger, 1992).

Women and Myocardial Infarction

Current literature increasingly suggests that the expression of MI differs in women than in men (Chiamvimonvat & Sternberg, 1998). The Framingham heart study is widely recognized as a leading longitudinal study of sex-specific information concerning coronary and cardiovascular disease incidence as well as the impact of multiple risk factors on disease occurrence in both women and men (see Murabito, 1995). Although a full review of this material is beyond the scope of this study, an overview of some of these features will provide a background from which to explore women's MI experiences and needs.

Age of Onset.

Age is a prominent feature in the onset of heart disease in women as initial cardiac symptoms tend to be delayed, on average 10 years later for women than for men (Lerner & Kannel, 1986; Wenger, 1999). Wenger (1999) suggests that one in eight or nine (American) women aged 45-65 have clinical manifestations of CHD, in contrast to one in three women older

than 65 years of age. Data from the Framingham study suggests that MI, as the principal manifestation of CHD, is less common in women than in men, as women typically present initially with angina pectoris or chest pain (Kannel as cited in Packard, 1992; Wenger, 1999). While the incidence of MI is lower in women than in men across all ages (below 85 years), this gender difference narrows significantly above age 65 as MI becomes a serious health concern for elderly women (Statistics Canada, 2002). Data from Statistics Canada indicated that in 1999, almost 800 Canadian women died from acute MI between the ages of ~25 and 64 compared to almost 11 times this number at ages 65 to 85+ years.

Framingham data also suggests that MI is more likely to be fatal in women than in men, and that mortality rates in the first month and year also tend to be higher in women (Kannel, as cited in Packard, 1992). As well, post-MI morbidity, rates of re infarction, and the presence of silent and unrecognized MI, appear to be higher among women (Maynard, Martin, et al. 1992; Wenger, 1992, 1999).

In an extensive review of the literature, Nohria, Vaccarino, and Krumholz (1998) concluded that the advanced age of women was the most significant factor contributing to their decreased survival following MI compared to men. Nohria et al. also suggested that gender-related differences were less related to intrinsic characteristics of coronary disease in women than to a variety of factors associated with female sex including a greater incidence of cardiac risk factors, decreased efficacy of therapeutic modalities, and a tendency toward the under use of treatments in women relative to men. Similarly, Wenger (1999) attributes women's poorer prognosis to a greater occurrence of cardiac complications following MI (e.g. shock, heart failure, recurrent chest pain) and to the prevalence of co-morbidities (concurrent medical conditions such as arthritis, diabetes, or cancer) often observable in older women.

Risk Factors.

While risk factors for heart disease include behaviors, lifestyle patterns, and genetic characteristics, it is the combination of these factors that serve as predictors for the development of MI. Understanding "the social context of women's experiences is central to risk reduction efforts" (Fleury, Keller and Murdaugh, 2000. p. 968). Wenger (1999) suggests that a number of social factors including lower socioeconomic status (e.g. education, occupational status, marital status, parenthood and income) and the social roles that women hold may influence their understanding and appreciation of their health as well as their ability to engage in risk prevention or reduction. More specifically, women's "otherness orientation" plays a pivotal role in how they the way that they prioritize and adopt health enhancing actions (see Fleury et. al, 2000; King & Arthur, 2003; Hawthorne, 1993).

Although the major risk factors for MI in women are similar to those found in men, and include age, hypertension, hypercholesterolemia, smoking, obesity, diabetes, and physical inactivity (Peberdy & Ornato, 1992; Wenger, 1999), risk factor epidemiology appears to differ between the sexes (Centers for Disease Control as cited in Wenger, 1999; Murabito, 1995). Eaker (1989) contends that when studying women and disease, it is essential to also consider factors related to environment and psychological milieu.

Follow-up data from the National Health and Nutrition Examination Survey (NHANES) demonstrates that while hypertension and obesity imparts a comparable relative risk for women as for men, diabetes is a far more serious risk attribute for women (Centers for Disease Control as cited in Wenger, 1999). NHANES data also suggests that smoking represents a greater relative risk in women than men, while hypercholesterolemia is a somewhat greater risk in men than women (Centers for Disease Control as cited in Wenger, 1999).

Female specific risk factors for MI, such as the use of oral contraceptives (OC), have also raised serious concerns. Research in this area has demonstrated mixed findings but suggests that the degree of risk appears to be influenced by dosage, preexisting cardiac risk factors, and especially the presence of cigarette smoking (see Rosenberg, Palmer, Rao & Shapiro, 2001). Natural and surgical menopause (following hysterectomy), resulting in estrogen depletion, is also associated with the increased development of heart disease in women. Current research is challenging previously held beliefs that hormone-replacement therapy (HRT) is cardio protective for menopausal women, given the increasing incidence of cardiovascular events in certain groups of older women following the first few years of use (McNagny & Wenger, 2002). Up until now, data in this area has been primarily based on observational studies and clinical trials in primates (Stampher & Colditz; Adams, Laplan, Manuck et al. as cited in the Writing Group, 2002).

Most recently, the Writing Group (2002) for the Women's Health Initiative published startling findings of the first randomized primary prevention trial of postmenopausal hormones. One component of the study comparing estrogen and progestin with placebo was unexpectedly terminated as results demonstrated women's increased risk of breast cancer, heart disease, stroke, and pulmonary embolism. Further study findings suggested that taking estrogen alone may be safer in women with hysterectomies.

While available research demonstrates comparable benefits of risk factor reduction in both women and men, less attention has been devoted specifically to women in this area over the past three decades compared to men (Wenger, 1999).

Symptom Presentation and Diagnosis.

In women, the clinical presentation of MI symptoms often differs from the classic

descriptions expressed by men. The range of women's symptoms can include pain in other locations other than the anterior chest, such as the lower jaw and teeth, arms, shoulders, back and abdomen (Sullivan et al. 1994). Women also report a greater incidence of general weakness, palpitations, dyspnea, presyncope, fatigue sweating, nausea or vomiting as chest pain equivalents (Eaker, Packard, Wenger, Clarkson, & Tyroler, 1988; Maynard, Litwin, Martin, & Weaver, 1992). As well, women experience more silent MI's than do men and nearly half of women's MI's are unrecognized (Lerner & Kannel, 1986).

Medicine has often referred to these differences in women as "atypical," thus perpetuating earlier misconceptions that heart disease is a 'male' illness and the norm against which women's experiences are defined. Consequently, women's coronary symptoms have often been misdiagnosed and attributed to non cardiac origins (including psychiatric indicators thus portraying women as 'overly sensitive' or 'neurotic') during initial medical evaluations (see Murdaugh, 1990).

The lack of early diagnosis of MI symptoms in women has also been attributed to beliefs about the cardio protective nature of estrogen in premenopausal women, thus causing health professionals (and the general public) to discredit women's presentation of angina symptoms to causes other than heart disease. Given that noninvasive cardiac tests have lower accuracy in women (Hung et al. 1984), which can result in improper diagnosis and treatment, Chiamvimonvat and Sternberg (1998) argue that women should be investigated more thoroughly than their male counterparts.

Increasing evidence also suggests that physicians pursue a less active or aggressive approach to the diagnosis and management of heart disease in women compared to men (Seils, Friedman, & Schulman, 2001). More specifically, several studies have demonstrated that women are less likely to be referred for coronary angiography and revascularization procedures (Ayanian & Epstein, 1991; Cochran, 1992) including coronary bypass surgery (Steingart et al. 1991) despite symptomology of similar or greater severity, thus suggesting a potential gender bias in the delivery of cardiac care.

Help Seeking Behavior.

Survival from an acute MI is closely related to the individual's ability to promptly seek treatment following the onset of symptoms. Life-threatening arrhythmias are typically the cause of death in those individuals with MI who are unable to receive rapid medical assistance (American Heart Association, 1996). Consequently, the effectiveness of cardiac injury reducing drug interventions depends on their rapid administration, which ideally occurs within 90 minutes after symptom onset (International Study of Infarct Survival (ISIS-3) as cited in Dempsey, Dracup and Moser, 1995).

In general, the literature reports a persistent delay in treatment seeking behavior among women compared to men following the onset of cardiac symptomology (Jensen & King, 1997; Moser & Dracup, 1993). While women's conditions may be more serious at the time of hospital admission, their eligibility for drug therapies may be seriously compromised as a result of this delay.

In a study that explored the psychosocial processes by which women decide to seek care for symptoms of MI, Dempsey, Dracup, and Moser (1995) found that although women immediately perceived their pain as abnormal, they tended not to acknowledge its serious nature until self-treatment and other coping strategies failed to improve the situation. Dempsey et al. suggested that several factors contributed to this delay including women's tendency to attribute symptoms to benign or non cardiac causes (even when participants had a history of MI), concerns about inconveniencing or worrying family members or friends, and women's hesitation to involve others in their personal health matters. Women in this study recognized the threat to their well-being and sought treatment only after symptoms remained constant or increased in severity. Perceived low risk for CHD coupled with the nonspecificity of initial symptoms may also delay women's treatment seeking behavior (LaCharity, 1999).

In summary, while cardiac literature has historically defined men's experience of MI as 'typical,' recent studies examining cardiac illness in women increasingly demonstrate that gender differences exist across various clinical features. These differences represent the starting place from which to better understand women's needs for care and recovery following MI. (For a more comprehensive discussion regarding gender differences and MI, see Charney, 1999; Chiamvimonvat & Sternberg, 1998; Julian & Wenger, 1997).

Impact of MI

Physical illness and medical treatment can be highly distressing, particularly in the case of a potentially life threatening event. The onset of myocardial infarction may occur unexpectedly or after ongoing illness hence leading to changes in both the individual and family members (Fleury & Moore, 1999). As patients must advance through a process of coping and adjustment to their illness, so must family members as they too are often thrust into the position of navigating multiple challenges, albeit from a different perspective.

While MI is characterized as an acute illness event, it is generally indicative of a larger disease process. Consequently, various aspects of an individual's physical, emotional, psychological, and/or spiritual functioning/self may be impacted.

Bury (1982) contends that "illness, and especially chronic illness, is precisely that kind of experience where the structures of everyday life and the forms of knowledge which underpin them are disrupted" (p.169). This disruption may call for a restructuring of self in terms of who

one is, and what one is able to do. May (1977) also refers to the "dissolution of self" to describe the extent to which illness can challenge an individual's sense of meaning and human integrity.

Frank (1991) suggests that "the loss that accompanies illness begins in the body then moves out until it adversely affects the relationships connecting that body with others" (p.36). Similarly, Shuman (1996) refers to a "hierarchy of loss," to describe loss associated with chronic illness by the degree of injury or harm that it causes a person or family. More specifically, Shuman suggests that individuals living with chronic illness undergo various physical, emotional, and cognitive losses that may dramatically limit their ability to express or carry out important aims, values, projects, or roles and which may result in potentially undermining a personal or family identity, narrative, or life story. If grave enough, Shuman suggests these losses may culminate in a loss of self, severe moral injury, or the elimination of any possibility of a good life. He concludes that the degree to which the experience of loss moves along this pathway will impact the degree of individual suffering.

The stressors associated with MI are diverse and will vary depending on their meaningfulness to the individual, the severity of the event, and the individual's location within the trajectory of the cardiac illness experience. In addition to the disbelief and shock often characteristic to the acute phase of MI, patients (and family members) often experience a range of emotions before and after diagnosis including anger, worry or fear, frustration, guilt, helplessness, and emotional exhaustion (Miracle & Hovekamp, 1994; Titler, Cohen, & Craft, 1991). For example, individuals may feel anxious or fearful about the often dramatic and painful nature of cardiac symptoms, losing physical control (e.g. over bodily functions) or at the prospect of dying. Others may perceive becoming ill as an inconvenient intrusion or interruption in their busy life and may worry how work or family will manage in their absence (Bowers, 1996).

The experience of hospitalization can also be highly distressing given the constant reminders of illness and mortality, the often disquieting nature of medical examinations and treatment procedures, the frequent sense of unfamiliarity, loss of autonomy and control, boredom, and often a perceived lack of adequate emotional support (Cohen & Lazarus, 1979; Fleury & Moore, 1999). As well, the lack of privacy often inherent to coronary and/or critical care units, frequently results in patients witnessing sights and sounds associated with other patient's suffering and/or treatment.

Fleury and Moore (1999) also suggest that the experience of feeling uninformed while hospitalized can be distressing for both heart patients and their families. Receiving satisfactory information and effective communication from health-care professionals has been widely cited in the health literature as an important prerequisite to patient satisfaction (Bensing, 2000; Hall,

Irish, Roter, Ehrlich, & Miller, 1994; Weisman & Teitelbaum, 1985). Subsequently, the needs of both patients and family members during the acute phase of MI may be similar and include the need for information, emotional support, and an understanding of the patient's prognosis (Moser & Dracup, 1993).

The most common and expected psychological consequences following MI are anxiety and depression (Byrne, 1990; Croog, 1983; Fielding, 1991) however most psychosocial research in this area has also focused predominantly on men. MacKenzie (1993) identified perceived loss of control and reduced positive affect as primary components of psychological distress following MI in women.

For hospitalized MI patients, anxiety may fluctuate over time depending on the perceived seriousness of the particular challenge faced during their immediate illness experience. More specifically, anxiety may be higher after the onset of increasingly severe symptoms when the threat to life is the greatest, prior to diagnosis, and again before leaving the hospital when constant medical care and cardiac monitoring must be relinquished (Byrne, 1990). The shift towards depression is more likely to move towards clinical significance further into the process of recovery when the individual has had sufficient time to comprehend the seriousness of her illness and threat to life, and the potential for future incapacity (Byrne, 1990; Fielding, 1991).

Psychological distress following MI may also result from the potential threat to or changes in one's bodily integrity, functional capacity, sense of well-being, self-concept and life roles, values and beliefs, social and occupational functioning, financial security, significant relationships, spousal and familial cohesiveness, commitments and future plans (Cohen & Lazarus, 1979; Kleinman, 1988; Pollin, 1995). Pollin (1995) argues that an ill person's psychological equilibrium is threatened not just by the fear of multiple losses, but of the anticipation of unknown changes in one's life.

Other factors shaping a person's affective and behavioral response to MI and their experience of recovery may include preexisting life stress, personality factors, and the degree and quality of social support (Byrne, 1990). As well, sociocultural factors including social economic status; values and beliefs about what comprise health, illness, and disease; perceptions and understanding about bodily symptoms and functioning, and beliefs about treatments and/or healing customs will impact an individual's experience of illness, treatment and recovery (Loustau and Sobo, 1997).

To illustrate, women suffering from MI must also contend with the consequences of androcentric perceptions about cardiac illness in terms of accessing care, resources, and/or educational materials that are inclusive and relevant to women. The extent to which MI impacts various aspects of a woman's physical, psychological, emotional, cognitive, and social self is

evident. Moreover, to better understand a woman's illness experience it is important to consider the cultural, socioeconomic, and political context in which she exists. While medicine primarily focuses on ameliorating the physical distress associated with MI, psychological, emotional, and spiritual healing and care must also take place to help each individual move towards wellness. In this sense, there is a distinct need for informed health care professionals, including Counselling psychologists, to work as part of an interdisciplinary team that understands and supports the emotional healing of women with heart disease.

Social Support

Evidence suggests that social support, and in contrast, social isolation, are associated with CHD morbidity and mortality. Chesney and Darbes (1998) suggest that individuals who are socially isolated are more likely to become depressed and engage in harmful health behaviors than those with adequate social support networks. In turn, depressed mood and deleterious health behaviors are a significant predictor of mortality in women and men following MI. Consequently, the provision of social support is a fundamental component of recovery however, it is important to examine the quality of social support provided to women. While (heterosexual) marriage might be construed as the epitome of social support, it is not clear that this arrangement provides the same health benefits for women as it does for men.

In a study that examined 246 post-MI patients, Young and Kahana (1993) found that women, including those who were married, received less assistance with household tasks and meals than men, where both had a history of MI. At one year post MI, the relative risk of death for married women compared to men (when age was controlled for) was 3 times the risk observed in men. In the context of women recovering from MI, social relationships including marriage may not necessarily be an ideal substitute for social support (Chesney & Darbes, 1998). Consequently, a significant recovery intervention for women following MI may include seeking sources of positive emotional support which may be found with other female heart patients.

Cardiac Rehabilitation

Accumulating evidence suggests that cardiac rehabilitation (CR) is an essential component of the treatment and recovery of patients with cardiac illness. The stated goals of CR are focused on assisting participants achieve a more complete recovery and return to optimal levels of medical, physiological, vocational, and psychological functioning following a significant cardiac event and to prevent the progression of underlying cardiovascular disease (Fleury & Cameron, 1997; King & Teo, 1998). To accommodate these goals, hospital and community based programs typically provide multifaceted services including prescribed exercise, education, behavioral and lifestyle interventions to enhance risk factor reduction and

stress management to facilitate coping with the disease process (King & Teo, 1998). Despite the availability of CR services, only a small percentage of women who experience cardiac events, including MI, are referred to or vigorously encouraged by physicians to participate in these programs (Ades, Waldmann, Polk & Coflesky, 1992; Halm, Penque, Doll, & Beahns, 1999). Moreover, women have historically demonstrated greater nonattendance and dropout rates compared to men in cardiac rehabilitation programs (Hamilton, 1990).

More recent studies examining women's participation in cardiac rehabilitation suggests that various features of conventional programs are not necessarily meeting women's needs (see Moore, 1996; Limacher, 1999). In one study, Moore (1996) examined participation factors influencing women's program attendance. Study findings suggested that women wanted more social interaction during exercise, peer group support, and encouragement and emotional support from staff.

An all female cardiac rehabilitation program was developed in Ontario during the late 1990's that blended features of conventional (male focused) rehabilitation with various features specific to the identified needs of women (e.g. including modified exercise, emphasis on safety and monitoring, small classes and group participation, and personalized goal setting). The appearance of the facility was also designed to appeal to women's taste and includes attention to color, comfortable seating and a meeting area that encourages socializing (Unsworth, personal communication, December 22, 2000). Preliminary findings examining the effectiveness of this program have demonstrated that improvement in the functional capacity and the compliance of women was significantly higher compared to similar historical data (Sternberg, Chiamvimonvat, Unsworth, & Price, 1999). Sternberg et al. concluded that some women experience greater benefits from a female-specific cardiac rehabilitation program.

Women and Recovery From MI – Qualitative Research Review

Qualitative studies exploring women's subjective experiences of significant cardiac events began to emerge in the field of nursing during the mid 1980's. Departing from traditional research that had either excluded or underrepresented women, nursing investigators introduced research methods that focused on asking questions that would better portray how women experienced cardiac illness. Consequently, these studies have contributed to a small, yet growing body of knowledge specific to women. In the following section, I will review several of these studies.

In a ground-breaking study, Boogard (1984, 1985) used semi-structured interviews to compare the rehabilitation (recovery trajectory) of 10 women and 10 men, aged 25-55, following MI. Her research demonstrated that women's experience of MI recovery at 3 and 6 months differed significantly from men's in terms of return to physical activity, psychosocial factors

including mood and relationships with family members. Within 1 week of hospital discharge, women reported engaging in higher levels of exertion than men, including light housework . Most of the women did not perceive these activities as work, nor did they consider this to be potentially harmful to them. In contrast, post-discharge activities for men included resting, relaxing, and walking. By week four, half of the men were participating in organized walking and rehabilitation programs, while women tended to increase their level of housework .

Study findings also indicated that while both women and men reported feeling depressed following MI, about half of the women described feelings of guilt related to their inability to carry out housework in their usual manner particularly when family members performed these chores for them. As well, these women were likely to resist receiving help from others (Boogard, 1984, 1985)

As a pioneer in the field, Boogard (1984, 1985) was the first researcher to use qualitative methods to explore gender differences post MI, and to capture women's subjective experience in the context of their roles and relationships. She concluded that health professionals need to be sensitive to the potential challenges and difficulties faced by women recovering from MI and to incorporate knowledge of women's needs into rehabilitation programs and educational guidelines geared to facilitate optimal recovery in women. Although these recommendations were made over 15 years ago, few changes have been made in terms of developing programs of cardiac care that specifically attend to the recovery needs of women. Boogard has been cited extensively in much of the qualitative research that has emerged since her work was published.

Focusing specifically on women, Dunn (1985) conducted a phenomenological study to examine their experience of MI between 2 and 14 weeks following hospital discharge. The core theme that emerged from the data and captured the essence of women's experience of MI was loss. In addition to reporting multiple losses, women also reported feelings of guilt in relation to giving up their household roles. Moreover, they had difficulty putting themselves first when conflict erupted between competing home and family demands, and their own health status and rehabilitation. Interestingly, women in this study did not identify physical rehabilitation as a means to gain control over their perceived sense of losses.

Consequently, Dunn (1985) recommended that nursing care for women with MI focus on interventions to address the grief and loss associated with MI, increase social support, attend to patient and family education needs, and help women anticipate normal physical and psychological responses to MI. As well, Dunn recommended the importance of developing cardiac rehabilitation programs that address the specific needs of women by focusing on support in adjunct to physical recovery.

Also using phenomenology, Bowers (1996), interviewed 10 women, ages 40-75 years, still hospitalized with MI to understand how they made sense of this potentially life threatening event. Study findings demonstrated the emergence of nine common themes, several of which were consistent with Dunn's (1985) work and subsumed under Dunn's framework of loss (including illness awareness, feeling emotionally overwhelmed, and the sense of fear and worry). Given that women were located in the acute phase of their illness, they identified other significant themes including difficulty asking for and receiving help from others, and the need for information, and care and support. All of these factors were influenced by the quality of care they received by health providers and family and friends. Almost all of these women demonstrated an interest in participating in a supportive group process with other female cardiac patients undergoing a similar experience.

In a study similar to Dunn's (1985), Benson, Arthur, and Rideout (1997) explored the experiences and concerns of 14 women, aged 39-87, within 6 months of their first MI using phenomenological methods. Data was collected through the use of focus groups and open-ended questions as women were encouraged to tell their story of the events during and after MI. Women identified four major factors that hindered their process of recovery from MI. These included their lack of contact, support and validation from other women with heart disease, perceived gender differences in the treatment received from health professionals compared to male counterparts, aspects of health care delivery (including the lack of female specific health information and inadequate follow-up following hospital discharge) and role tensions with family members (Benson et al., 1997).

Study participants also outlined specific support strategies thought to facilitate their recovery including greater instrumental support at home, follow-up phone calls from health professionals following hospital discharge, and access to a cardiac resource liaison within the community or participation in support group specifically for women.

A major strength of this study was the valuable descriptions women provided about their MI experiences and the identification of specific strategies aimed at supporting their recovery (Benson et al. 1997). A potential study limitation was the use of a sample of convenience where the age of women spanned almost 50 years. Given that the developmental and cohort differences for women in their forties and eighties vary greatly (see Bowers, 1996), researching a sample of participants closer in age, may provide more specific information regarding the recovery needs of younger and older women.

LaCharity (1999) explored the experiences of 11 premenopausal women, ages 31-47 years, using in depth interviews, between 4 months and 11 years after receiving a diagnosis of CHD. Most of these women were mothers and all were working full-time. While study findings

demonstrated that premenopausal women shared many of the same concerns as postmenopausal women (see LaCharity, 1997), several themes unique to this younger group emerged from the interviews.

More specifically, women had dramatic misconceptions about their potential risk for developing CHD based on the perception of various age related factors and their failure to recognize their symptoms as cardiac in nature. As well, women emphasized the importance of returning to paid employment based on motivating factors such as financial considerations and a sense of personal identity and meaning associated with their careers (LaCharity, 1999). This challenges previous research suggesting that women return to work less often than men following a significant cardiac event (see Boogard, 1984; Chirikos and Nickel, 1984). Women in these studies tended to be considerably older than those in the present research. Unlike their older cohorts, most study participants participated in organized cardiac rehabilitation programs and often requested greater access to evening classes in order to better accommodate their work schedules and allow for spousal assistance with child care. Consequently, some of these women reported raising small children which contributed to their difficulties in focusing on their health needs. Despite working full-time, women in this study also ascribed much of their identity to their household and caretaking responsibilities and tended to associate feelings of guilt and low self-esteem with a decreased ability to perform these roles (LaCharity, 1999).

LaCharity (1999) also found that women reported significant concerns about returning to sexual activity due to the fear of recurring cardiac symptoms which often led to conflict with their male spouses. Moreover, women expressed dissatisfaction with the lack of sexual information and counselling received from their care providers despite feeling satisfied with the care and education surrounding their diagnosis. These findings are consistent with earlier research that suggests women tend to receive inadequate sexual counselling following MI and are less likely to resume sexual activity, compared to men, following a cardiac event (Baggs & Karch, 1987; Boogard, 1984; Papadopoulos, Beaumont, Shelley, & Larrimore, 1983). While return to sexual activity has been a well established indicator of recovery from MI in men, women have typically been excluded from this area of research.

Finally, key factors influencing premenopausal women's ability to cope with their diagnosis included adjusting to positive lifestyle changes, 'bypassing negative emotions,' restructuring priorities including an emphasis on values and issues of 'importance,' and focusing on their perceived strengths including social and spiritual support and acknowledging limitations imposed by their illness. Participants acknowledged that accepting the CHD diagnosis led to getting back to as normal a life as possible (LaCharity, 1999).

Based on these findings, LaCharity (1999) offered several important recommendations for addressing the needs of younger women with heart disease. These included comprehensive education initiatives for health professionals surrounding the expression and presentation of cardiac symptoms in women, aggressive risk factor education and assessment in women, rehabilitation programs that are sensitive to needs of younger working women and a more proactive involvement of nurses in making referrals to CRP's and sexual education and counselling for all aged women with cardiac illness. As a group, study participants strongly advocated for the formation of support groups for younger women to share similar concerns and experiences. LaCharity recommendations are fully supported in the current research.

More recently, Arthur, Wright and Smith (2001) conducted an innovative study using participatory action research (PAR) to develop and implement community-based communication and psychoeducational support to women living with heart disease. Two groups of 7 and 9 women, between 46 and 76 years of age, who had a recent MI, angina, coronary angioplasty, or bypass surgery, met monthly for 5 months as both recipients of support and co-participants in the research design process. Through group discussion, personal reflection and evaluation, these women collaborated with the researchers/group facilitators to help create a program they believed to be most beneficial to women living with heart disease.

In general, Arthur et al. (2001) observed that women's 'expression of suffering,' was facilitated through the relationships established with each other and the group facilitators. Two common issues emerged from both groups including the stress of living with heart disease and associated family pressures such as coping with emotional reactions. In this sense, women felt better understood emotionally by their support group peers than by family and friends who they perceived to be protective and less comfortable with their expressed emotional pain.

Secondly, women identified a deficit in both institutional and community based health care in the treatment of women with heart disease. Consequently, they expressed the need for greater emotional support from health professionals, disease and treatment information, and better communication with physicians. While women supported traditional cardiac rehabilitation programs, they felt their recovery would be enhanced in settings that better addressed their emotional and coping needs (Arthur et al. 2001). Arthur et al. concluded that women's primary rehabilitative need following a significant cardiac event may be support from other female heart patients and that these support needs may persist beyond the in-hospital phase of recovery or the typical duration of a CRP.

This study demonstrated the value of providing a support intervention for women living with heart disease. Despite the short duration of the project, participants established a therapeutic bond with other participants and the facilitators that supported their expression of

emotional pain and may have been supportive in terms of living with this heart disease. Moreover, using a research methodology that invited women to collaborate as co-researchers encouraged their use of voice and dialogue thus resulting in a rich articulation of women's experiences and needs in this area. In this sense, Arthur et al.'s (2001) study was also important in terms of challenging dominant medical research paradigms which typically position researchers as 'expert' and historically have not recognized the specific needs of female participants. In terms of study limitations, little information was provided about what constituted the "program" that was developed. As well, few details were provided about the participants and the potential diversity of experience evident between patient groups (e.g. experiential differences between having surgery and a percutaneous cardiac intervention).

Several qualitative researchers have used grounded theory to explore women's illness and recovery experiences. For example, Johnson and Morse (1990) examined the process of adjustment in 7 women and 7 men following their first MI. Based on their study findings, Johnson and Morse developed a theory of adjustment focusing on the progression through four major stages including the initial threatened loss of control, coming to terms with the MI, reestablishing control after MI, and recovery. The overriding task of regaining a sense of control and the role of individual perceptions was considered fundamental to the adjustment process. Subthemes, reflecting strategies and responses directed towards regaining control at each stage were also identified.

Aside from these major findings, Johnson and Morse (1990) reported that female participants tended to minimize their illness symptoms and return to their homemaker roles sooner than was deemed medically safe, thus perpetuating the belief that housework is not real work. Most of these women described feeling protective of their homemaker and mothering roles, and felt uncomfortable receiving support from family members. Consequently, they were careful not to interrupt or offset family routines in order to make personal lifestyle changes. In contrast, the majority of the men in the study considered the modification of their lifestyles to be a joint venture between themselves and their spouses. These findings are similar to other research in this area (see Boogard, 1984, 1985; Dunn, 1985).

While Johnson and Morse's (1990) work was innovative and one of the earliest qualitative models exploring the MI adjustment process, a few limitations should be noted. The degree to which gender differences, demographics or the social context of participants influenced adjustment was not clearly explored. As well, little discussion was provided about the possibility of there being an overlap or integration of stages within the adjustment process.

Also using grounded theory, Fleury, Kimbrell, and Kruszewski (1995) proposed a 3 stage theory of women's recovery following an acute cardiac event, including MI. Within a

support group format, 13 women between the ages of 42 and 78, met weekly for 9 months and discussed individual experiences and concerns related to their illness. The study was conducted as a mutually collaborative endeavor as women served as partners in the research process and identified topics for group meeting discussions.

Fleury et al. (1995) identified 'healing' as the basic social psychological process that explained women's struggle through the uncertainty surrounding their cardiac event and as a means for negotiating personal transition, moving towards new levels of self-organization and personal growth, and creating positive health patterns. Moreover, they suggested that the process of healing comprised of three primary stages including surviving, originating, and patterning balance.

The surviving stage consisted of five categories including the questioning of personal beliefs, reevaluating self, recognizing temporality, searching for meaning, and seeking meaningful connections with others. During this stage, women experienced intense physical and emotional disruption associated with changed views of self and of their world. In exploring how they had chosen to live their lives, women also questioned previously held values and beliefs. They examined their self-worth in the context of personal loss and a greater awareness of mortality. The search for meaning provided a framework to guide change and for understanding healing. Fundamental to women's efforts at seeking connection with others was the communication of feelings and stories related to cardiac experiences.

In originating, women began to integrate aspects of the uncertainty and change associated with their illness by creating new patterns of living, defining self expectations, and perceiving the world. Fleury et al. (1995) identified four categories inherent to originating including seeking self, redefining priorities, finding strength, and building bridges. More specifically, women continued to reexamine previously held values and beliefs as they contemplated alternative definitions of self, possibilities for personal growth and changes in health behavior. As well, they discovered and began to trust their physical and emotional abilities which reflected their efforts at creating an environment supportive of their changing selves. In this stage, women confirmed that the support group format and mutually understanding relationships with other women served to meet their needs by providing a forum to discuss concerns, interpret their illness experiences, support personal growth and set goals for changes in health behavior.

In patterning balance, the final stage of 'healing,' women attempted to move past the challenges and uncertainty related to their cardiac event and towards a new image of themselves including a sustainable lifestyle and health behavioral changes. The four categories associated with patterning balance included creating challenge, celebrating possibilities,

accepting self, and empowering others. More specifically, women reviewed personal goals and contemplated alternative approaches to living that focused on creating purpose and meaning in their lives beyond their illness. As part of more fully accepting themselves, women demonstrated self care and nurturance by respecting and believing in themselves and by remaining flexible in terms of self expectations. In this stage, women also expressed the hope that sharing their struggle and experience of healing would serve to guide and support other women in their process of healing.

Fleury et al. (1995) concluded that an understanding of women's recovery process is essential to the development of cardiac rehabilitation interventions for women. She further suggests that the healing process is encouraged through assisting women to identify and access needed support throughout the rehabilitative process. More specifically, the study highlighted the importance of encouraging women to communicate their experiences and their needs for closeness, and to express feelings related to personal loss, fear and uncertainty in a safe environment such as in a women's support group.

A major strength of Fleury et al.'s (1995) study is that women served as collaborating partners in the research process and were encouraged to identify topics for group meetings, provide feedback and clarification about emergent themes and the research process itself. The group dialogue allowed for individual questioning and critical reflection, hence directing the exploration of and more fully portraying the richness of women's experience. Moreover, the power of the support group format was evident as these women continued to meet long after data collection and analysis were complete.

In a more recent study, Murray, O'Farrell and Huston (2000) used focus groups and a grounded theory framework to explore the experiences, feelings and needs of two groups of 8-10 women, younger than 60 years and older than 60 years, within the context of their heart disease during the pre-diagnosis, in-hospital and recovery period. Several themes were identified within both groups. For example, all participants reported difficulties recognizing their symptoms as cardiac in nature and almost a third of this group recounted being initially misdiagnosed by a physician.

During the recovery period, both groups of women reported memory and sleep difficulties and felt overprotected by family members. Women over 60, many of whom had other health concerns, described a sense of 'resiliency' and their need to return to previous levels of functioning. In contrast, younger women construed their illness as a serious life disruption and focused on expressing emotions and seeking support. All participants felt that talking with other women who had heart disease would be beneficial (Murray et al., 2000).

Based on these findings, Murray et al. (2000) highlighted the need for public education

campaigns that more effectively distributed current information on women's heart health; rehabilitation programs and research that address the emotional aspects women's illness experience; and a great availability of support and counselling services for partner's and/or family members. This was one of few studies in the literature that compared older and younger women and their needs and experiences following a significant cardiac event. Understanding these differences will help to develop recovery resources that are more relevant to different aged groups of women.

A few researchers have conducted qualitative research specifically on elderly women's experience of heart disease. To illustrate, LaCharity (1997) used descriptive methods to gain further insight into the experiences of postmenopausal women following a diagnosis of heart disease. In depth interviews were conducted on 12 women, ranging in age between 53-76, between 4 months and 16 years after their diagnosis. Nine of these women had experienced MI. Women discussed their diagnosis in terms physical and emotional effects, managing lifestyle changes, support systems, and their ability to adapt or cope with the diagnosis itself.

More specifically, LaCharity (1997) found that participants expressed adverse emotions such as fear, towards the various unknowns (e.g. test results, recurring symptoms and further injury, and returning home) and guilt, when unable to fulfill their care provider roles and towards the perceived impact of their illness on their families. Women tended to manage lifestyle changes by adjusting their performance of household and employment duties and avoiding heavy work, dividing tasks into smaller steps, and learning to accept help from others.

While participants mostly praised the support received from family and friends, they reported receiving mixed support from spouses and physicians. Dissatisfaction with spousal support focused on the absence of emotional expression, failure to discuss difficult issues, and a lack of participation in healthy lifestyle changes. Similarly, women perceived physician's lack of information as being unsupportive, and the provision of information as a measure of physician support. In contrast, an important component of the support women received from friends involved sharing their diagnosis and illness experiences, particularly with those also diagnosed with CHD (LaCharity, 1997).

In general, LaCharity (1997) concluded that women with heart disease need greater support to facilitate their emotional adjustment. Consequently, she advocated for spousal education through the development of support groups to teach men about the seriousness of heart disease in women and how to better support their wives emotionally through communication enhancement training. LaCharity also suggested that helping women to explore spirituality and existential concerns related to mortality, and teaching them how to prioritize their health might help them move towards greater acceptance of their illness. All of these

recommendations have clear implications in terms of the development and delivery of ongoing therapeutic groups for women. This is clearly an area where Counselling psychologists can utilize their therapeutic and group facilitation skills to implement a patient wellness and care program.

Using grounded theory, Helpard and Meagher-Stewart (1998) explored the meaning that elderly women attached to their illness, early convalescence at home, and social support needs following an acute cardiac event including MI. Eight women, ranging in age from 61 and 87 years were interviewed at home using a semi-structured format, 2 and 4 weeks after hospital discharge. Findings from this study informed the development of a theoretical model of women's illness experience.

They identified 'finding a voice' as the core variable and social process utilized by participants while struggling to find a 'new self' and way of life following a cardiac event. As women attempted to balance traditional values associated with their homemaker roles and regain a sense of control and stability, they were faced with the difficult task of disentangling their voice from the voice of others (often referred to as a 'battle' or 'fight') while communicating their individual perceptions and lived experiences of illness (Helpard & Meagher-Stewart, 1998).

Inherent in women's struggle for a new 'self,' participants experienced a complex blending and resolution of conflicts related to the impact that living with loss, conforming to traditional roles and societal expectations, and the need for respect and self-enhancement had on their sense of identity, obligation and enjoyment of life. In order to 'blend the gaps,' these women used various cognitive, behavioral, affective strategies and goal oriented plans to recreate a sense of stability in their lives and emerge with a 'new voice' more reflective of their values, experiences, and current needs and identity (Helpard & Meagher-Stewart, 1998). This suggests that individuals are changed through the experience of a life-threatening illness.

Study findings also demonstrated that women's identification with their traditional homemaker and caregiver roles positively influenced their adaptation to early home convalescence, coping strategies, and sense of well-being. While resuming their roles allowed participants to exert personal control and regain a sense of stability and identity, this also represented an obstacle to following the rules of early convalescence, focusing on their individual needs and expressing their inner voice (Helpard & Meagher-Stewart, 1998). This role conflict for women has been previously documented in several studies (see Boogard, 1984; LaCharity, 1999; Johnson & Morse, 1990). Hawthorne (1993) suggests that women's 'otherness' orientation is responsible for the uniqueness of women's recovery and may be related to women's inability to deal openly with their suffering within the family.

In terms of social support, participants reported valuing the emotional support received from significant others as it positively influenced their sense of self esteem and personal growth following their illness event. Interestingly, over half of these women stated that they did not receive positive emotional support in their marriages. This finding supports LaCharity's (1997) recommendation for spousal education and communication training programs in order to better support women with heart disease.

Based on these findings, Helpard and Meagher-Stewart (1998) emphasized the importance of providing 'individualized' information and care to elderly women with heart disease, greater awareness of the inherent value of establishing therapeutic relationships with elderly patients through nursing practice, and assessing the quality of women's social relationships as support in recovery. They also advocated for further research to better understand the impact of women's caregiving roles on illness recovery and in the development of methods to facilitate social connections and emotional support amongst elderly women with heart disease.

A strength of this study was the researcher's conception of the illness experience as being transformative, fluid, and connected to the process of individual meaning making. Consequently, these descriptions are more useful in constructing the wholeness of an individual's experience in contrast to stage theories that are characterized by more clearly delineated movement through phases of recovery (see Johnson & Morse, 1990). Moreover, I resonated with women's task of finding their voice as an element of their illness and experience and which takes healing beyond the realm of physical recuperation.

Lastly, Tobin (2000) proposed a stage theory of recovery in older women following MI. Also using grounded theory, unstructured interviews were conducted with 12 women, ranging in age from 60-80 years, approximately 8 weeks following hospital discharge. Data analysis revealed the core variable in women's recovery process was 'getting back to normal' (or normal with some modifications) as participants envisioned that recovery was the 'resumption of their customary roles and responsibilities and making adjustments necessary to move on with life' (p.17). Tobin suggested that these women progressed through four interrelated stages including accepting what has happened, establishing boundaries, making adjustments, and reestablishing normality. Although Tobin provides a description of the various recovery stages, she suggests the time needed to move through this process varies between individuals.

The initial stage, accepting what has happened, comprised of two categories including confronting mortality and looking for a cause. During this acute stage of illness, women experienced a range of emotions in their attempts to come to terms with their MI as they begin to realize the life threatening nature of the event and question why this has happened to them.

Tobin (2000) observed that women often returned to this stage when faced with physical or emotional setbacks.

The second stage, establishing boundaries, depicted women's first encounter with the imposed limitations of MI and initial efforts at managing their shaken confidence. This stage consisted of three categories including encountering limitations, accepting limitations, and reducing insecurities. More specifically, women had to determine what they could and could not do before establishing boundaries for activities. Accepting limitations imposed by their illness and compliancy in following activity boundaries were integral factors in the process of 'getting back to normal.' Tobin (2000) observed that women who accepted their limitations and were compliant with boundaries were optimistic about recovery, whereas others who struggled with accepting limitations tended to be pessimistic. Women used strategies such as seeking reassurance, acquiring information and practicing caution to help cope with their fear of recurrent symptoms and the resumption of daily activities.

Tobin (2000) viewed the third stage, making adjustments, as the focal point in the recovery process as women either adjusted to the limitations imposed by their illness and reestablished a sense of normality in their lives or were unable to successfully make adjustments ('master this stage') thus impeding recovery. Three strategies were associated with making adjustments and included testing the waters, monitoring self, and weighing costs and benefits. In returning to activities, women graduated from simple to more complex tasks based on their level of comfort and pain. Tasks that could not be performed comfortably often led to lifestyle adjustments. Becoming more attuned to the needs of their bodies helped inform women's activity decisions as did evaluating whether lifestyle adjustments led to positive changes in their health status. Tobin suggested that the quality of support received from others in this stage was an influential factor in facilitating or inhibiting women's progress towards recovery.

Women progressed to the fourth stage, reestablishing normality, after 'successfully mastering' stages one through three. Redefining normal and resuming independence were the essential tasks in this final stage. To progress in their recovery, women were faced with accepting unchangeable limitations imposed by their MI and knowing their capabilities. Women reported accepting these changes more readily when they could adjust their self-expectations and not view their inability to perform certain tasks as limitations. In this sense, women redefined normal when they could return to previous activities with some modifications and when they felt less impacted by physical symptoms. Moreover, women's independence was marked by their ability to complete tasks and participate in chosen activities without fear or worry.

The strength of Tobin's (2000) theory is that it attempts to capture the meaning of the MI experience for menopausal women. As well, it highlights the importance of a progressive resumption of activity despite women's inclination to quickly resume their homemaker roles following hospital discharge (see Boogard, 1985; Dunn, 1985). Tobin also emphasizes that graduated learning needs to exist in each phase of the recovery process which has clear implications for cardiac care specific to women.

A few limitations in Tobin's (2000) study were also noted. Given the critical role of 'acceptance' in the process of recovery, there was little discussion about how this was achieved by these women. As well, there was little elaboration on how social support was facilitative to promoting 'mastery' in the recovery stages.

Summary of Literature

In this chapter, I have reviewed qualitative studies that explored women's subjective experiences of recovery or adjustment to significant cardiac events including MI. Several recurrent themes have emerged including descriptions of women's recovery as being a transformative process, fluid, and connected to individual meaning making (in contrast to descriptions based on narrow constructs evident in male dominated research); the identification of commonalities and differences between younger and older women with heart disease and specific implications for support needs and care resources; the continued need for education programs to better inform the public and health care professionals about cardiac illness in women; the unique phenomena of women's recovery which often include ongoing tensions between balancing care roles, needs for support, and compliance with convalescent guidelines; and women's need for greater emotional support during cardiac recovery including opportunities for contact with other women with heart disease.

Moreover, the literature has highlighted the value of using qualitative methods to portray women's illness experiences and demonstrates a trend towards the inclusion of participants as collaborators in the research process, thereby addressing issues of power, evident in most medical research, and drawing upon women's voices and self/bodily knowledge within the context of a safe and supportive environment. Consequently, the current research uses a collaborative methodology to explore how women below the age of 55 years construct their experience of recovery following MI.

CHAPTER THREE

Methodology

The act of writing, itself, is an evolution; from the Latin *Volvere, volvi, volutum*, to roll. The unrolling of the secret scroll, the thing suspected but not realized until present. (Winterson, 1995, p. 160)

This qualitative study explored how women, under the age of 55 years, constructed their experience of recovery following myocardial infarction. A 6-week group process, including an introductory and follow-up session was conducted over the course of 3 months. Grounded in the practice of Action Research (AR) (Maguire, 1987) and Guided Autobiography (GA) (Birren & Deutchman, 1991), the individual and collective experiences of six participants were examined for emerging themes and structures that described how these women understood their recovery from a significant cardiac event.

Research Design

The primary focus of this study was to explore how women constructed their experience of recovery following MI. A qualitative approach was used to guide the study and was selected as the most suitable means to construct and portray detailed accounts of women's recovery experiences from their own frame of reference and view of social reality (MacMillan & Schumacher, 1993).

Denzin and Lincoln (1994) suggest that qualitative research is concerned with making sense of or interpreting phenomena based on the meanings and processes that people bring to their experience. Participants had the opportunity to further understand their recovery process through individual reflection and through the sharing of personal stories and experiences within a small group with other female survivors of MI.

Action Research

Action research provided the methodology for addressing the research question: How do women, under the age of 55 years, construct their experience of recovery following a myocardial infarction? Guided autobiography was utilized as the research tool or method for gathering the research data.

Action research has been a distinct form of inquiry since the 1940's when Lewin was credited with introducing the term through his work in social psychology, as he transferred the experimental approach of the natural sciences to the social sciences in order to understand critical social problems and bring about social action and change (Hart & Bond, 1995). Since Lewin, the practice of action research has widely evolved and has been used to explore issues in the areas of organizational change, community development, education, and nursing (Hart & Bond, 1995).

Action research is located under the umbrella of participative inquiry methodologies and has often been used interchangeably with terms such as 'participatory research,' 'participatory action research,' and 'co-operative inquiry.' Despite the various definitions and approaches to conducting action research that have emerged across disciplines, common principles tend to exist. For example, Heron (as cited in Reason, 1993) suggests that the participative worldview generally "see[s] human being[s] as co-creating their reality through participation: through their experience, their imagination and intuition, their thinking and their action" (p. 324). In this sense, action research is construed more as a philosophy and a process facilitating the creation of knowledge, rather than a specific methodology or design (McGuire, 1987).

In my reading of the action research literature, I was most inspired by the collection of essays presented in Sumara and Carson's book Action Research as a Living Practice (1997) and drew upon their definition to guide the current study:

Educational action research practices are particular ways of living and understanding that require more of the researcher than the 'application' of research methods. A lived practice that requires that the researcher not only investigate the subject at hand but, as well, provide some account of the way in which the investigation both shapes and is shaped by the investigator (Sumara & Carson, 1997, p. xiii).

Sumara and Carson's definition acknowledges the importance of the living experience of the researcher and the production of self knowledge within her relationship to the research process. In this sense, the action researcher must:

...find ways in which to represent not only the conclusions of inquiry, but as well, the path of thinking and inquiry that had led to these conclusions. This does not mean merely reporting a set of methodologies that were followed. It means showing the connections between the researcher and the subject of the inquiry (Sumara & Carson, 1997, p. xvi).

Typically, most action research approaches are comprised of three integrated research activities including action, investigation, and education (Maguire, 1987). Extensive collaboration and a mutual process of education is required between the researcher and the individuals within a community who, through shared discussion and interaction, develop skills in collecting, analyzing, and utilizing information related to the identified problem. Stuart (1998) suggests that action research projects often use a wide variety of types of data and methodologies for data analysis.

In this research, women in various stages of recovery from MI were identified as the community group under investigation. Although these women may not have been oppressed in

social, economic, or educational terms, female heart patients continue to be in general, subordinated by the medical profession. This is evident in the lack of research that specifically addresses various aspects of women's experience, information and availability of cardiac services and resources that are germane to women, and the gender bias evident in medical treatment (see Ayanian & Epstein, 1991; Beery, 1995).

As action research enables marginalized groups to gain power and voice, women diagnosed with MI had the opportunity to construct their own dialogue and their understanding of recovery, while contributing to the development of a program of research and care that may serve to support other women with heart disease. Participants played an active role in the research process, rather than acting as passive informants, as they engaged in decision making related to data collection methods, theme selection, group guidelines, curriculum modification, and session scheduling.

Moreover, women's participation in the Guided Autobiography group also served to achieve the goals of Action Research (action, investigation, and education) by the very nature of the group process itself. More specifically, engaging in private and deep reflection on personally important historical and emotional events evoked greater awareness for the individual and for other group members as experiences and stories were constructed and shared within the group. Emerging from the experience of sharing personal stories also came the expression of voice, development of trust and provision of support to others, creation of group membership, information exchange and problem-solving, building of friendships, the development of coping strategies, goal setting and behavioral change.

Procedures

The research was conducted at the YWCA, a women's community service agency, located in downtown Vancouver, BC, where I currently rent office space for my private counselling practice. My decision to utilize this setting was based on convenient accessibility of the location and proximity to public transportation, as well as the YWCA's longstanding mission to foster social change through public education to improve the status of women. Approval for this study was obtained through the University of British Columbia ethics committee following acceptance of the research proposal.

Criteria for Study Inclusion.

McMillan and Schumacher (1993) describe purposeful sampling as seeking information rich key informants for in-depth study. Similarly, to be eligible for participation in this study, volunteer women were required to meet all of the following inclusion criteria: (a) diagnosed with MI within the past 36 months, (b) between the ages of 30 and 55 years, (c) medically well enough to attend the group, (d) possessed unimpaired cognitive functioning with an ability to

understand the nature of the study, (e) fluent speakers and writers of English, (f) demonstrated a willingness and ability to commit to the activities required for participation in the Guided Autobiographical group format (e.g. interested in group process, attend all group meetings, complete written assignments and share writing within the group) and (g) provided informed consent for participation in the study.

Birren and Deutchman (1991) emphasize that Guided Autobiography groups are not considered to be 'therapy.' Consequently, this research group was not appropriate for women who were looking for supportive therapy. Although none of the women I interviewed for the study indicated they were looking for supportive therapy, I was prepared to direct those who were to more suitable resources if necessary,

Participant Recruitment.

The process of recruiting volunteer research participants took approximately 8 weeks as they were located through three primary sources including the cardiac rehabilitation programs at two local hospitals and a radio interview with a local journalist who highlighted the nature of the study thus encouraging women to volunteer. Five women were recruited through cardiac rehabilitation programs and one woman volunteered as a result of the radio interview.

Information letters (see Appendix A) advertising the study were distributed to several community locations including Jewish Family Services, The YWCA, The Heart and Stroke Foundation, and The University of British Columbia Nursing Faculty, but did not attract potential research participants.

The following steps more clearly outline the process of recruitment:

Hospital 1

- Contacted 4 cardiologists, a cardiac social worker, cardiac psychologist, and cardiac research coordinator to discuss study and provide participant information letters to forward to potential participants.
- Contacted Medical Director of the cardiac rehabilitation program to discuss study and request endorsement of study.
- Adapted study participant information letter to fit with Medical Director's letter of endorsement (see Appendix B). Revised letter printed on hospital letter head.
- Consulted with two primary nurses in CRP who have direct contact with all enrolled participants. Both nurses indicated their interest in the study and willingly agreed to forward the information letter to women that fit the study inclusion criteria. Potential participants provided permission to have the researcher contact them directly.
- Nurses also reviewed previous CRP patient files and mailed information letters to potential participants. Women either contacted the researcher or received follow-up

telephone contact from clinic clerk and provided permission to have researcher contact them directly to further discuss the study.

- Contacted women for brief telephone interview (see Appendix C). Four women were recruited through this program.

Hospital 2

- Discussed study with director of CRP who readily expressed his interest in the research. Received name of program coordinator/nurse to contact regarding recruitment.
- Consulted with rehabilitation program coordinator/nurse who agreed to forward the study information letter to current and former program participants who fit the inclusion criteria.
- Program coordinator forwarded names of potential participants including contact information to the researcher. Contacted women for brief telephone interview (see Appendix C). One woman was recruited through this program.

Radio Interview

- Contacted local radio journalist to discuss the project and to request an interview to facilitate participant recruitment amongst the general public.
- Journalist conducted a brief interview with the researcher focusing on the research purpose, study requirements and researcher contact information. The interview was aired the following week. One woman was recruited for the study as a result of the interview (K. Gretsinger, CBC Radio, September, 12, 2003).

Participants.

In total, 13 women demonstrated an interest in obtaining more information about participating in the study. Of these individuals, 6 women met the criteria for study inclusion and agreed to participate in the research. Reasons for not participating in the study included women either living out of town or not being able to commit to the time requirements, often due to demanding work schedules.

At the onset of the study, the participants comprised 6 volunteer women. One participant decided to withdraw from the research following the second week. In follow-up telephone contact, she described having difficulty managing current levels of anxiety and felt overwhelmed participating in the group. She also reported struggling with the writing assignments. Consequently, five women remained in the study as participants. This number fits closely with Birren and Deutchman's (1991) recommendation of limiting enrollment in Guided Autobiographical groups to six members.

Description of Participants.

While the age of participants in this study was relatively homogeneous, their individual health circumstances and life situations were considerably varied. More specifically, six European North American and one Middle Eastern participant was between 48 and 53 years of age and reported having a single MI which for most had occurred within 8 months of participating in the study. While some participants reported additional health concerns, all of the women reported varying degrees of cardiac symptomology. Most of the women had undergone diagnostic cardiac procedures and all but one had been enrolled in cardiac rehabilitation (see Appendix H).

The following descriptions outline a brief profile of each participant:

Bev.

Bev was most recently diagnosed with MI approximately two and a half months before the onset of the research group. At 53 years of age, she described herself as happily married with two adult children, both of whom have recently returned home to live. Family and friends play a central role in Bev's life. While she acquired a college education, Bev chose stay home with her children until they were much older before returning to work. In the last several years, she has been involved in various entrepreneurial ventures.

Bev reported other health concerns including high blood pressure and weight control. Following her MI, her angiography procedure was positive requiring angioplasty and the insertion of stents. Since her MI, she has experienced infrequent cardiac symptoms. She self-referred to a cardiac rehabilitation program and reported having difficulty relating to the other participants who were much older. She is currently on cardiac medications. While Bev identified having a very strong familial and social support network, she was motivated to join the study because she felt it would be "valuable talking with other younger women with MI."

Helen.

Helen reported having her MI 3 years ago at the age of 48. She identified having no cardiac risk factors outside of family history and described herself as always being healthy and physically active. Helen's angiogram revealed normal coronary arteries and she has little understanding of why she had a MI. She experiences infrequent and vague cardiac symptoms and continues to take cardiac medication. Helen did not attend cardiac rehabilitation stating that she was already leading a healthy lifestyle when she had her MI.

Helen was divorced at age 32 and has one daughter from her marriage who is 22 years-old and who lives at home. She is currently not partnered. Helen has a graduate education and currently divides her time as a classroom teacher and a fine arts coordinator in her school district. She described having a very full life comprised of a successful and busy career, various

artistic and musical hobbies, and her social network. Helen joined the research group hoping to experience a "greater understanding of her experience" and a "sense of group collaboration in meeting with other women close to her age who have had MI."

Arlene.

Arlene, at age 52 years, had her MI 7 months prior to the onset of the research group. She believes that it occurred as a result of complications from her diabetes (Type I), stating that she has never experienced chest pain. Arlene experienced heart failure following her MI and has struggled with other health concerns including fibromyalgia, and previously Guillain-Barre syndrome. She underwent cardiac catheterization with angioplasty and stents. Arlene has found that participating in a diabetes support group, and more recently cardiac rehabilitation, to be highly beneficial. Arlene was previously married and divorced in her twenties. She has two adult daughters and grandchildren. While currently not partnered, she reports having solid familial and social support. Arlene has been highly successful as an entrepreneur; she is currently employed as an administrative assistant. Her motivation for joining the study was to "gain knowledge and talk with other women who have had MI."

Sarah.

Sarah is a 48 year old woman of Persian decent. She emigrated from her country of origin 5 years ago and is currently upgrading her education at a local college. Sarah experienced her MI 5 months prior to the beginning of the study, while commuting on public transportation. She described her experience of "not being helped" by other commuters and the paramedics as being more traumatic than her actual heart attack. Sarah underwent cardiac catheterization requiring angioplasty and stents. She frequently experiences angina requiring Nitroglycerin, and reports other health concerns including depression, high cholesterol, and lupus. Sarah was recently enrolled in cardiac rehabilitation and currently sees a cardiac psychologist. She reports having little social support outside of living with a very supportive family friend. Moreover, she has no family living locally. Sarah agreed to participate in the study based on her "desire and commitment to help others with heart disease" and "her need to talk about her [MI] experience."

Sally.

At 48 years of age, Sally had her MI 4 months prior to participating in the research group. She reported previous health problems including pericarditis, peripheral vascular disease, and arthritis. While hospitalized with MI, Sally underwent cardiac catheterization requiring angioplasty and stents. She currently experiences cardiac symptoms including chest heaviness and is managing ongoing depression. Sally is enrolled in a cardiac rehabilitation program which she has found beneficial. While currently not working, Sally is a hairdresser and

has been employed in retail business. She describes having some familial and social support. Her interest in participating in the study stemmed from her need for "support and not being alone" and to contribute to "information for the medical community."

Margaret.

Margaret reported having her MI a year and a half earlier at age 48. She was adamant about not having any cardiac risk factors outside of being a long standing and heavy smoker. She had been hospitalized for 9 days and had undergone a cardiac catheterization which did not demonstrate the presence of heart disease. During the procedure, she had a coronary spasm which was thought to be the cause of her MI as well as a dangerous arrhythmia. Margaret participated in cardiac rehabilitation but did not complete the program. She is currently working at several part-time jobs and lives alone with her three cats. She felt participating in the study would provide her with much needed support and information about her MI experience.

Guided Autobiography

Guided Autobiography is defined as a "semi-structured, topical, group approach to life review" that facilitates an understanding of how past life experiences and events have evolved over the course of one's lifetime (deVries, Birren, Deutchman, 1995, p. 166). Expanding from life review, Birren developed Guided Autobiography in his work with older adults to promote successful adaptation to aging (Birren & Hedlund, 1987). More recently, Birren and Deutchman (1991) recommend using Guided Autobiography with other groups facing significant life transitions, disability, health concerns, and for those seeking greater self understanding and acceptance.

The process of Guided Autobiography has two stages. Groups typically include five or six participants and a group facilitator, with meetings typically scheduled for a minimum of two hours over varied durations (Birren & Deutchman, 1991). Each participant is required to write a two-page autobiographical story in 'solitude' on a pre-selected life theme and then read their story within the context of the small confidential group setting. After each reading, group members are encouraged to share personal reactions, impressions, thoughts or feelings evoked by listening to other member's stories. Birren and Deutchman suggest that the 'developmental exchange' or mutual sharing of personally important and meaningful information and experiences is a powerful feature of the Guided Autobiography process.

The nine life themes explored in Guided Autobiography represent issues central to the life course and may elicit powerful recollections of experience and related feelings. These include: a) the history of a major branching point in one's life, b) family history, c) career or major life work, d) the role of money in one's life, e) health and body image, f) loves and hates in one's life, g) sexual identity, sex roles, and sexual experiences, h) experiences of death, and

ideas about dying and other losses, and i) beliefs and values that provide meaning in life (Birren, 1987). Birren and Deutchman (1991) suggest that alternative themes may be added depending on the purpose of the group.

In conjunction with each life theme, specific 'sensitizing questions' are distributed to participants to promote recall and reflection, and to further clarify the importance of significant life experiences. In this sense, the Guided Autobiography process encourages 'creative and divergent thinking' about one's life (deVries, Birren & Deutchman, 1995).

While Birren and Deutchman (1991) emphasize that Guided Autobiography is not designed to be used as formal therapy, positive outcomes have been observed among participants in both research and practice. These have included a sense of increased personal power and importance, recognition of past adaptive strategies and application to current needs and problems, reconciliation with the past and resolution of past resentments and negative feelings, resurgence of interest in past activities or hobbies, development of friendships with other group members, greater sense of meaning in life, and the ability to face the end of life with a feeling that one has contributed to the world (Birren & Birren, 1996, p. 288).

Although the purpose of using Guided Autobiography in the current study was to explore how younger women construct their recovery following MI, it was the researcher's hope that participants would also benefit from participating in the group process with other female cardiac patients particularly given the physical, mental, and emotional upheaval often associated with experiencing a significant cardiac event.

For the purposes of this study, Birren and Deutchman's (1991) GA theme format was adapted to more suitably explore aspects of women's experience of recovery following MI. Accordingly, guiding themes and sensitizing questions relevant to this group were developed. Due to the emergent nature of participatory action research, the final grouping of themes and questions did not emerge without a collaborative discussion with study participants during the second group meeting. At this time, participants were asked to review the proposed themes and determine whether these were suitable and relevant to the group. While a few women suggested that the issue of "money" be added as a theme, this topic was subsumed under an already existing theme – 'Major Life Work.'

Revised Guided Autobiographical Themes.

Based on my understanding of the cardiac literature and experience working as a cardiac health professional and clinical counsellor, the primary facilitator's experience conducting Guided Autobiography and Life Review groups, and the research participant's discussion and input, the final selection of revised GA themes included the following (see Appendix F for descriptions of themes and sensitizing questions):

- Theme 1: Your Health and Experience of MI and Recovery from MI
- Theme 2: Your Major Life Work and Recovery from MI
- Theme 3: Significant Relationships and Recovery from MI
- Theme 4: Self Care: Dealing with Stress and Personal Needs during Recovery from MI
- Theme 5: Your Experiences and Ideas about Death and Recovery from MI
- Theme 6: A Personal Story of My Recovery from MI

Data Sources

The sources of data in this study included telephone and initial interviews with participants, women's written accounts of the six weekly GA themes, video taped accounts of women's participation in the GA group, and the researcher's field notes and journal entries. A more detailed account of the data sources will be further discussed below.

The first source of data consisted of a brief telephone interview (see Appendix C) and initial interview (see Appendix D) that were conducted with each potential participant prior to beginning the group. The purpose of these interviews was to describe the research project and clarify requirements for participation, screen women for study eligibility, answer questions about the research, outline confidentiality and obtain informed consent, and begin developing rapport with each participant. Relevant demographic and health information was also obtained. The interviews were comprised of both open and close-ended questions.

The second source of data was participant's written autobiographical stories based on the adapted GA themes. Using Birren and Deutchman's (1991) GA guidelines, the group was instructed to prepare two pages on each theme to be read during the next meeting. Participant's writings were collected after each group meeting and then photocopied and returned the following week.

The third data source included video taped accounts of women's participation in the Guided Autobiography group. Adler and Adler (1994) suggests that videotaping data offers several advantages including the ability to 'freeze' interactions for reexamination, review multiple observers, and capture behavioral nuances. In contrast, Mishler (1986, p.48) emphasizes that "the initial record--audio or videotape or running observation—is itself only a partial representation of what 'actually' occurred." While my preference was to use the videotape format to document participant's linguistic and nonlinguistic communication, and to further enhance my understanding of group process, it was important to discuss recording options with participants.

Consequently, women were asked, during the initial interview and again during the first group meeting, whether they had any concerns about being video taped during the research sessions. The group collectively agreed to be video taped as well as audio taped (as back-up).

Lastly, my own field notes and journal entries, recorded before, during, and after the completion of the fieldwork, served as the fourth method of data collection. Richardson (1994) recommends that four categories be considered when writing field notes in order to 'nurture the researcher's voice' (p. 526). These categories include: 1) observational notes to document concrete and detailed accounts of process and content; 2) methodological notes to record the details of how to collect 'data,' methodological concerns, issues, questions, and information; 3) theoretical notes including hunches, hypotheses, and critiques of thinking, actions, observations, and alternative explanations, and finally, 4) personal notes to explore uncensored feelings towards content and process issues, relationships with participants, doubts, and satisfactions which can lead to better understanding how these affect claims to knowledge.

My personal notes took place in the form of a research journal. Richardson (1994) suggests that the research journal becomes "a historical record for writing a narrative of the self." This journal was created while developing the research proposal and has been used to record descriptive and reflective notes related to key excerpts from my readings; biases, values and expectations that I have brought to the project; ideas, questions and concerns about methodological and theoretical issues; notes emerging from conversations and meetings with various individuals who have influenced my thinking about this research, and personal reflections on the process of writing a doctoral dissertation and the meaning that I have attached to this life work.

Format of Conducting the Guided Autobiography Group

The following format outlines the steps that were followed in conducting the GA research group with women recovering from MI and has been adapted from Birren and Deutchman's (1991) comprehensive guide to leading GA groups with older adults.

Phase I

Initial contact with potential participants was made when women interested in the study called me directly or when I contacted them after receiving permission from one of the CRP nurses. During this Brief Telephone Interview, I discussed my background and research interests and provided information about the purpose of the study and participant requirements; asked screening questions to determine study eligibility; gathered demographic and health information; and scheduled (or not) a time to meet each woman for an initial interview if they were interested in participating in the study and met preliminary study requirements. It was also an opportunity to begin to develop

rapport with the women that later became research participants. Most of the women that I spoke to recounted, often in great detail, their illness story of MI as one of the first things we discussed. The urgency and detail with which women told these stories was striking.

Phase II

During the initial interviews, I met with each potential participant in a location that was convenient for them including coffee shops close to their home, school, and rehabilitation program, a place of employment and in one woman's home. During the initial interview, I provided women with a more comprehensive description of the study, continued to ask specific questions pertaining to study eligibility and group participation, and discussed and/or obtained informed consent (see Appendix E). I also inquired as to women's reasons for participating in the study and asked them to define the term "recovery." These latter questions were helpful in better understanding these women beyond their demographics and health information. The initial interview also provided an opportunity to further build rapport with participants, as women continued to recount their illness stories of MI, and to determine their time schedules and availability for participation.

Phase III

After recruiting six women for the research group, I scheduled our research meeting night (Mondays from 7 - 9:30 pm) based on the group member's availability; arranged weekly meeting space at the YWCA; arranged to borrow audiovisual equipment from the university to facilitate data collection; and began to meet with the primary group facilitator.

The facilitator was highly recommended by one of my dissertation committee members and after several discussions about the project she agreed to facilitate the research group for a nominal fee. Her background in both counselling and journalism, and her extensive experience conducting Guided Autobiography and Life Review groups made her an ideal candidate to facilitate the group. While she did not have expertise in the area of cardiac illness, she met all of Birren and Cochran's (2001) recommended qualifications for GA leaders and co-leaders including experience teaching or leading small groups, well developed empathy skills, organized and flexible, familiar with the GA format (a former GA group participant), a good sense of humor, humble and kind, and committed and interested in the nature of the group.

During the preliminary meetings with the facilitator, we pooled our collective knowledge and began to develop an adapted version of the GA format relevant to the

research question and to the research participants. Consequently, we corresponded several times in person and by telephone before beginning the group. As well, we met weekly after the research group started to debrief sessions and to plan for the next meeting. During these meetings, the GA format was frequently revised to adjust to the group's development and to stay aligned with the research question.

Phase IV

During the Introductory Session (Week 1), research participants, the facilitator and I met as a group for the first time. This first session focused on reiterating the purpose of the study, discussing administrative details including meeting times and group space, developing group guidelines and ground rules, describing the purpose and process of participating in a Guided Autobiography group, and participant and facilitator introductions. As well, guidelines for writing Autobiographical accounts and the first theme and sensitizing questions were distributed to the group for the following week.

Phase V

The next six weekly meetings (Sessions 2-7) comprised the Guided Autobiography group. The general format of these sessions included: a group check-in and announcements, participant's readings of their GA theme (approximately 10-15 minutes), group feedback after each reading (approximately 5-10 minutes), and a brief discussion with accompanying hand-outs of the next week's theme and sensitizing questions. A break was scheduled into each meeting and refreshments were provided. Most sessions ended with a brief check-out.

While the group was organized to run from mid November to late December, participants opted for taking 2 week break prior to Christmas to better manage the demands of the holiday season. Participants also felt that this break would give them time to better absorb the GA experience to date and to reflect on the remaining themes. Women agreed to resume the research group in early January for another two GA sessions.

Phase VI

A follow-up session (Session 8) was conducted almost 8 weeks following the completion of the GA group. All but one of the participants attended this session. One woman was absent due to concurrent academic responsibilities.

During this session, I shared preliminary observations and understandings of women's stories and emergent patterns, meanings and themes, and encouraged participants to clarify or add to these as necessary. As well, I asked the group to respond to specific questions that focused on assessing the trustworthiness of the data

(see Appendix G) and to provide recommendations for the current study and for conducting future GA groups for women recovering from MI.

Participants were encouraged to speak openly about their reactions to the findings and to give their honest feedback in response to the validation questions. While I suggested that women could submit anonymous written feedback, in addition to participating in the group discussion, none of the participants chose to do this. I have included participant feedback in the forthcoming discussion on establishing trustworthiness.

Data Analysis

Data analysis occurred concurrently with data collection and involved several stages including: a review of the data obtained through participant screening interviews; content analysis of participant's written autobiographies; thematic analysis of the video taped group sessions; a participant review of the researcher identified themes, and an in-dwelling of my field notes and research journal entries. These will be described in greater detail in the following discussion.

Review of Initial Interviews.

Data obtained from the brief telephone and initial interviews were reviewed several times following each participant contact and then partially compiled in a table format sorted by demographic and health information. This data provided the basis for developing brief participant profiles, thereby providing the reader with a contextual background to better understand women's recovery experiences (see Appendix H).

Content Analysis.

At the end of the six-week GA group, research participants collectively submitted approximately 30 autobiographies related to their MI recovery experiences. Birren and Hedlund (1987) suggest that content analysis is a useful means of analyzing autobiographical research data both in terms of individual analysis and comparisons across participants.

Consequently, a separate content analysis following the procedures outlined by Berg (1995) was conducted on participant's recovery stories for each autobiographical theme. More specifically, following each group meeting, I began the process of content immersion by reviewing each participant's autobiography several times. By reading these stories repeatedly, I was able to immerse myself in the data and become more familiar with women's described experiences.

I then identified and highlighted sections of the original text that appeared relevant to the research question. Highlighted sections of text were then reviewed and units of analysis were also identified as affect, patterns of behavior, experience and meaning, and significant

participant statements reflecting women's constructions of their recovery. These were then extracted from the text and organized into categories that appeared similar in meaning. For example, emerging from the significant relationships theme, women spoke to their painful experiences of terminated relationships, unresolved family conflict, and unfilled dreams. These meaning units led to emergent category of loss. Approximately five to seven categories of analysis emerged in each GA theme and provided the basis for my interpretations following each research session.

Following the completion of the GA group, the aggregate categories of analysis were subjected to thematic review across research sessions and organized into the formulation of six main themes which were mostly common to participants. To ensure that the categories of experience and meanings and the identified recovery themes were representative of the participant's experiences they were continually evaluated in light of the original autobiographical accounts and other data sources, as in a constant comparative format.

I presented my preliminary analysis of the GA stories and main themes to participants for feedback in the follow-up session. (Given that a completed analysis of the research data had not been completed at the time of the follow-up group, I mailed each participant copies of the completed analysis for review and clarification approximately 2 months later).

Videotape Analysis.

In this stage, videotapes from each of the GA sessions were reviewed following each research meeting. The benefit of utilizing a videotape format allowed for the reexamination of verbal and non-verbal communication amongst participants and to gain further understanding of how women construct their recovery experiences. Following the initial review of each videotape, each session was transcribed verbatim in order to have a hard copy of the research session to read and reference during subsequent viewings and from which to extract sections of individual and group dialogue for analysis.

Using the frequent 'viewing and listening' method, I reviewed each videotape twice while paying particular attention to women's individual stories, group feedback and dialogue, group stories, as well as group process. While viewing and listening to the videotapes, I recorded observations, hunches, questions and personal reflections in the form of research notes. As well, I documented issues and/or patterns or themes of experience and meaning and significant statements that emerged from each session. Following each video tape viewing and listening, I in-dwelled on the content of the video taped sessions and my observations before returning to my research notes to document or clarify additional impressions.

After completing the above process, relevant patterns, themes, meanings and participant statements were also organized into categories (often previously identified from the

analysis of women's autobiographies) that represented women's individual and collective constructions of recovery. These findings were integrated into the existing content analysis of women's GA stories.

Participant Review.

The participant review process took place during the follow-session approximately 8-weeks following the completion of the GA group. The purpose of the session was to ensure that the study findings accurately reflected and were relevant to the participant's experiences and understanding of their recovery experience. During this session, participants were asked to provide the researcher with feedback, clarification, and additional information if necessary in response to the preliminary findings (e.g. issues, meanings, and identified themes that emerged from the primary data sources). Participants were also asked to evaluate their experience of participating in the GA group by answering various specific questions (see Appendix G).

In addition, a summary of the researcher's analysis of the weekly themes were compiled and mailed to each participant for feedback following the analysis of the research data. Women were asked to mail their feedback back to the researcher using the self-addressed stamped envelope. Three of the five participants provided feedback and acknowledged that the weekly themes and interpretations resonated with their recovery experiences.

Field Notes and Research Journal.

Finally, an ongoing and iterative in-dwelling of my own journal entries and field notes were helpful in terms of further making sense of and contributing to the analysis of the research data. To facilitate this in-dwelling, I engaged in an ongoing process of reflexive inquiry. Schwant (1997) suggests that reflexivity is a process of critical self-reflection to explicate and articulate biases and assumptions and to understand how they impact on the research process.

While I wrote extensive journal and field notes throughout all stages of the study, I found it particularly helpful writing field notes following each research session and after my weekly debriefing sessions with the group facilitator and research advisor. In these notes I explored several critical questions in greater depth including: how do my roles and interests as a researcher, counsellor, and health-care professional (and feminist and white woman) weave into the research? What are my unfolding assumptions? What have I taken for granted? What do I expect to find? What resonates with me? What makes me feel uncomfortable? How does this phenomenon work? How might this phenomenon be different for another group of individuals? What are the explicit/implicit rules? How would I experience this phenomenon differently if I was another age, gender, and ethnicity? What language was used by participants to describe their experience and what does it mean? Who has the power in this research experience and in participants' personal experiences?

Other methods for promoting self-reflexivity in this study included a) dialoguing with members of my dissertation committee, other qualitative researchers, and colleagues within the area of counselling and health-care, and other female cardiac patients; and b) the reading of critical texts that explore qualitative methodology in terms of issues related to power and voice, representation of the research text, and of methodological concerns (see Hertz, 1997; Steier, 1991).

By engaging in the iterative process of reading, reflecting, and writing, I was better able to report how I have interacted with the research and how my position impacted the research process and findings. In doing so, I created greater accountability as a researcher and remain true to how I represented women's recovery experiences.

Establishing Trustworthiness

In qualitative research, issues of validity are typically addressed through establishing trustworthiness as a means of assessing the merit and quality of the research results. In this sense, qualitative researchers must persuade their audiences that their findings are worthy of attention (Lincoln and Guba, 1985). I will briefly outline the four criteria that were used for assessing trustworthiness in this study. (The reader may want to review the validity questions as outlined in Appendix G).

Catalytic validity measures whether the research experience acted as a catalyst for personal growth and/or change in participants. Lather (1991) suggests that research possessing catalytic validity impacts those it studies in terms of gaining greater self knowledge and a greater understanding of the world in order to be able to transform it. The strategy for addressing this criterion was through conducting a member-check (Lincoln & Guba, 1985) during the follow-up session. Lincoln and Guba suggest that member-checks provide participants with the opportunity to clarify their intentions, correct errors and challenge interpretations, volunteer additional information, and assess the overall accuracy of the data and researcher's interpretations. Participants were asked whether or not the research experience was beneficial in terms of facilitating greater self awareness and/or change within their lives. Other questions were aimed at providing women with the opportunity to critique and evaluate their experience as research participants (e.g. What was helpful about this experience?; What would have made this experience more beneficial?).

During the follow-up session, all members (participants) reported that their participation in the research project helped to facilitate the development of personal awareness and/or growth and change in their lives. As one woman noted:

I found it very beneficial. I also found it therapeutic because I think talking about it helps me heal. I think it was really important taking the time to actually go over what happened and see how we dealt with it and how our families dealt with it.

Another participant concurred,

I think it was therapeutic too. I liked the opportunity to think about my life in relationship to those questions and themes and doing an in depth check into what you want, where you're going, what seems to be really important and what doesn't really matter. I don't get as agitated in my job...I feel much more easy going about things that aren't happening as fast as I'd like them to.

A third participant commented on the benefit of "sharing and listening to other people's experiences and just reflecting on what really happened to me." Moreover, she suggested that participating in the group has helped her "learn how to pace myself better, and take time for me."

Pragmatic value measures the extent to which the research will be useful to others (including other female heart patients as well as health care providers). Although this cannot be predetermined, attention can be given to explicating researcher values and beliefs, delineating procedural steps and the interpretative process, and allowing others to assess the trustworthiness of the research. A member-check was conducted to assess this criterion.

All members agreed that the preliminary study findings and the process of conducting the GA group could be useful to other female heart patients and to health professionals depending on "how the information is going to be put out into the public." One woman suggested, "if it's read or taught or talked about, and I think it needs to be talked about more, then I definitely think it will be helpful. Send it to Oprah." Another participant described her efforts in trying to find cardiac self-recovery reading material that she could relate to as a female heart patient, "I read some stories but they didn't really resonate, they were mostly stories about men's heart attacks." She suggested that a book could be written for women based on the findings of the current research. A third participant alluded to the benefits of illness prevention by conducting similar groups with women, "emotional health, or lack of it, is probably one of the issues that women tend to deal with, which might be a preventative thing."

Krefting (1991) suggests that peer examination involves discussing the research process and findings with colleagues familiar with qualitative methods. At different times throughout the study, I discussed various aspects of the research process and study findings with other colleagues and qualitative researchers, several of whom were also familiar with conducting guided autobiography. I also consulted with three health professionals (including two cardiac care nurses and one physician) who served as peer reviewers in this validity check. All

three peer reviewers acknowledged the value of providing female cardiac patients with emotional support following recovery. One nurse stated "It was wonderful that these women had a private forum to talk about their feelings." As well, reviewers acknowledged that most medical resources deal with the "physical" and expressed their frustrations with the lack of time that they typically have to interact with patients despite knowing that they are often dealing with issues seemingly unrelated to their illness. Peer reviewers also felt that the data generated by the study was beneficial to other cardiac patients (both women and men).

Resonance evaluates whether "the text generated by the researcher is fitting and truthful to participant's experiences?" Ellis (1997) stated that "a story's validity can be judged by whether it evokes in readers a feeling that the experience described is authentic and lifelike, believable and possible" (p. 133). To assess this criterion, I conducted a member-check to determine whether participants were able to recognize the described experiences and findings as their own. Secondly, peer reviewers were consulted to comment on the categories and themes developed out of the data and how these fit into their understanding of women's recovery processes.

In general, member's preliminary reports suggested that they recognized in the data analysis the described experiences and findings as their own. One woman stated, "I was struck with how you were able to capture what we were trying to say." Members' suggestions reiterated information that was already evident in existing thematic categories. As well, members resonated with the underlying themes and reflected their stories of recovery.

Similarly, peer reviewers also resonated with the research session interpretations as well as the six emergent recovery themes. One cardiac nurse stated that "the analyses made sense and felt appropriate to what she knew of women's recovery stories." She suggested that while she was "working with the physical (the easy part) the emotions and stories of their lives, which I was privy to, would often keep me pondering on many levels throughout the day, weeks and they still do." Another reviewer suggested that "The sum of women's life parts seemed to influence, if not determine, their perception of their MI experience." Moreover, she suggested that in cardiac rehabilitation, "We do not have the luxury (time or place) to explore the personal meaning of these experiences." All reviewers spoke to the lack of time available in dealing with patient concerns that are not primarily about physical health.

Finally, participatory validity may be defined as the successful provision of necessary factors (e.g. safety, respect, and group cohesion) for encouraging participation and a sense of inclusion amongst group members. The principles of action research and Guided Autobiography are both complimentary in terms of encouraging individual and group participation. Simply

stated, participants were asked, "Did the research experience facilitate individual and group participation?" Member-checking was used to assess this criterion.

Through the member-check procedures, all participants reported that they had felt encouraged to participate both individually and as a member of the research group. One woman confirmed, "We definitely felt safe, we wouldn't be here if we didn't feel safe." Similarly, another participant stated, "You both encouraged our conversation and we encouraged the conversation from each other, and the questions were very good, directed questions for getting us to talk about what mattered." Lastly, a third woman stated:

There was active listening and there was time for reflection and I felt a great deal of empathy. While someone else's story wasn't our story, there was still that caring which was evident to me every time. So I thought that was very good.

As research, this group fulfilled the four criteria used for assessing trustworthiness as determined by member checks and peer reviewers. Women's feedback also demonstrated that that participating in the group was a highly supportive and therapeutic recovery experience.

CHAPTER FOUR

Results

Writing about one's life and sharing it with others is a high point of human experience...(Birren & Deutchman, 1991, p. ix)

The purpose of this study was to explore how younger women construct their experience of recovery following a myocardial infarction. Six women, between 48 and 53 years of age, voluntarily participated in an 8-week Guided Autobiography group, where they engaged in a weekly reflection and writing practice, and attended a follow-up session to review and validate categories and patterns of experience and meaning related to MI recovery.

This chapter contains women's constructions of recovery that emerged primarily through their written autobiographies and from the dialogue and process of each research session. The organization of this chapter parallels the unfolding of the research process as I begin by reviewing the introductory session including a depiction of women's tellings of their MI experience. Next, each weekly session was explored and the respective Guided Autobiographical theme was described and followed by transcriptions of participant's autobiographies, and group feedback and dialogue. Kearney (1999) suggests that "verbatim accounts from women have great power to convey the experience of illness and suggest avenues of support" (p. 11). I conclude each GA session by offering personal reflections as well as theme and group interpretations. More specifically, I outlined and described the themes that emerged from each GA session and then conducted an across theme analysis which demonstrated the emergence of six general themes. These will be described and discussed in Chapter Five.

I have created a multilayered text within this chapter to more fully represent the dialogue that emerged within the research group. The text format to indicate individual or group responses is a different font (e.g. dialogue). My hope is that the reader will experience a greater richness of understanding of women's stories of recovery. For clarification purposes, the term autobiography will be used interchangeably with the terms 'story' and 'narrative' in order to lessen the repetitiveness of the text.

With her permission, I have included in the text the voice of the participant (Margaret) who voluntarily withdrew from the study after the second session.

Introductory Session

Proposed Session Agenda

During the Introductory session, research participants met with the facilitator and myself as a group for the first time. The proposed agenda for this session included the following: 1)

introduce participants and facilitator, 2) review the purpose of the study, 3) describe and explore the format of Guided Autobiography and the connection to women's recovery from MI, 4) review administrative details (including meeting time, group space, data recording, and time constraints), 5) establish group guidelines and ground rules, 6) introduce the "life line" exercise and debrief, 7) distribute guidelines for writing Autobiographical accounts and distribute the first GA themes and sensitizing questions, and 8) facilitate a closing activity.

While the purpose of this first session was to review various aspects of the research method and format of participation, it was also an opportunity for participants to get to know each other and the facilitator, and begin to develop into a working research group. Rapport building and creating group safety was fundamental in this session's proceedings. As well, the proposed life line exercise could function as a warm-up for the 6-week GA format by familiarizing participants to the process of reflecting on previous life experiences and connecting these with internal processes and broader questions surrounding their recovery from MI.

The Unfolding of the Introductory Session

There was a natural unfolding of this initial session as the facilitators addressed most of the items on the proposed session agenda as well as accommodated the needs of the research participants who expressed an urgency to tell their stories of MI. In this sense, women quickly took an active role as participants, thereby contributing to the research curriculum and format of the session agenda. Due to time constraints, the life line exercise and closing group activity were postponed until the following week.

A significant component of the facilitator's introduction was a discussion that linked the purpose of participating in a Guided Autobiography with women's recovery from MI. More specifically, the facilitator explored the MI experience and recovery as an example of a life transition and emphasized the value of honoring and/or grieving the potential losses often associated with this experience. In addition to thinking about the more external aspects of their MI experience (e.g. symptoms, treatment, and hospitalization), women were encouraged to reflect on the internal impact of MI by contemplating questions such as a) How has MI impacted my life?, b) Looking back across time, who have I been up until now and am I still that person after MI?, and c) Is there something that I need to let go of and/or grieve in the process of recovery from MI?

During this discussion, the mood of the group became more somber almost as though participants had been given permission to give voice to the more vulnerable aspects of their illness experience which are not typically addressed by medical professionals within the realm of cardiac care. In this sense, the facilitator normalized the emotionality often surrounding MI, and validated the breadth of women's experiences.

Group Dialogue

During the session, women remained engaged and attentive to facilitators and each other. They initiated asking each other questions, expressed emotion, shared information and imparted personal theories about their experiences, potential causes of their illness, and their recovery needs. While most of these contributions served to enhance and expand the group discussion, some were obviously disruptive to the flow of the group dialogue. I have included examples of women's commentary to demonstrate the richness their dialogue.

Asking Questions.

Many of the questions women asked appeared to help them create a reference point from which to locate themselves and others within the trajectory of their illness and recovery experience. For example, a) When did you have your MI?, b) How did you know you were having the attack?, c) What did you think of the nurses that took care of you?, d) How long were you off work for?, e) Is everyone in the Healthy Heart program?, f) What medications are you on now?, and g) How often do you use Nitro?

Expressing Emotion.

A few participants talked about the feelings associated with having their MI. While Helen identified feelings of sadness, Sally talked about grief, "it's like a death." In contrast, Arlene adamantly expressed her anger:

I'm angry at my body for letting me down again and again. I'm really angry with it. You know...like shit or get off the pot. I'm angry I had this heart attack. It's the only thing that has really ever put me on my haunches. Everything else I've been able to deal with and go on. This one has made me weak and I don't like being weak. I can't do what I used to do. I get weak and I get tired much faster. I don't have the clean house that I used to have. I don't work the hours I used to work.

Someone said this to me and it makes so much sense. I'm a very busy person. Why am I a busy person? If I'm so busy then I don't have time to think about all the pain that I've been through. So I just deal with it and move on.

Arlene's candor gave the group permission to speak honestly in their expression of feelings and helped to define the parameters for participant involvement.

Sharing Information.

As all of the participants except one had participated in cardiac rehabilitation, they were eager to exchange details about their experiences. While Sally and Arlene described being very satisfied with their cardiac rehabilitation group, Sarah reported having switched out of an all-male group, where she felt extremely uncomfortable, into a co-ed group where she felt more at ease.

Bev, the youngest member in her rehabilitation group, felt “excluded” as the conversations of other participants, primarily in their eighties, often included topics that she could not relate to (e.g. transitioning into a senior facilities). Margaret also acknowledged feeling out of place in cardiac rehabilitation and withdrew from the program before completing it.

Hypothesizing.

A few participants offered personal theories explaining aspects of their illness experience. In talking about recovery, Arlene was adamant that “to get better, I know that I need more knowledge, exercise and I need to slow down. And slowing down will be the hardest part for me.” Helen expressed her belief that emotional factors may have played an important role in why she had her MI.

Group Guidelines

Participants and the facilitators collaboratively identified several group guidelines considered important to facilitating a comfortable, respectful and safe group experience. These included: a) confidentiality, b) respect for individual levels of sharing, c) the right to pass on GA readings, d) respectful feedback including refraining from judgment and advice giving, e) punctuality around beginning and ending sessions, g) mindfulness around over talking, and h) dealing with strong emotions and staying connected to the group (e.g. no rescuing). As well, the roles of the facilitator and researcher were clarified.

Interestingly, participants mostly expressed differing needs around the issue of confidentiality. For example, Arlene stated that “I’m not embarrassed about my MI. If someone can learn from my experience this is important.” In this sense, she felt open to having her MI experience discussed outside of the group. In contrast, Sarah suggested that “confidentiality is very important to me.” Her biggest concern was that she “did not want her family to know what had happened to her.”

Women’s Tellings of their MI Experience

Participant introductions were a key component of the introductory session both in terms of building rapport and safety between group members and as a means of locating each woman’s context. Consequently, participants were asked what they wanted to know about each other and collectively agreed on the following information: a) current age, b) age at onset of MI, c) MI symptoms, and d) significant details surrounding the MI experience. In essence, women wanted to tell and listen to each others MI stories.

During the telling of these MI stories, all of the participants were highly engaged as they offered comments or asked clarifying questions as needed. The following descriptions are a retelling of women’s stories and include verbatim excerpts.

Margaret.

Margaret volunteered to tell her MI story first and was a candid historian.

I had my heart attack in July, and I was forty-eight, and I knew I was having a heart attack. I woke up in the middle of the night and classic symptoms; what you see on TV I had. Crushing chest pain, nausea, dizziness, pain down my left arm...and somewhere in the back of my head I had heard that if you take an aspirin when you are having a heart attack its good. And I remember making it to the bathroom. I have no idea to this day whether I took that aspirin and then I collapsed on the floor and crawled to the phone. I live alone and my biggest fear in life has always been 'What happens if something happens to me in the middle of the night and there is nobody there'? I lived through it.

Sally: I hope that the laundry is done if I drop down (women laughed).

Yeah...well that was the thing too, because the house wasn't exactly the tidiest. And I vaguely remember having...many many men in my house and I've never had that many in there at one time before and they kept saying to me 'What do you want to take with you?' and I kept saying 'How am I going to get home?' I had no idea I was going to be in the hospital let alone for nine days.

[Several women nodded their heads in understanding her shock].

Margaret: So I knew right away.

Helen: You called 911.

Margaret: Oh yeah.

Researcher: You know what's interesting Margaret is that today I was listening to one of the nurses at the hospital and they say that 30% of men, and men have these classic symptoms more so than women, only 30% of men have what you just described. So the numbers of women that have those classic symptoms are significantly less.

Margaret: I've heard from many of the women that I've talked to that have had any kind of chest pains, whether its angina or an actual heart attack, that their symptoms differ a lot from mine. And I have noticed that everyone seems to feel something different. But yet I knew right away that that was what it was. Of course when I am going in I'm thinking 'triple bypass heart surgery.' But I have no risk factors other than being a smoker. I'm not overweight, no high blood pressure. No clogged arteries. I didn't have any arteries clogged. No family history. No genetics. And out of the blue, a 48 year old woman who is obviously not overweight is having a heart attack.

Facilitator: And I hear shock.

Margaret: Yeah...yeah...It was very odd...very odd. And to this day no one really believes me. And it took my own physician 2 months to accept the fact that I had actually had a heart attack. He would not believe it. He kept saying 'it's just angina.' And I kept saying 'Then why was I in the hospital for nine days?'

Helen: So what did they do for you then while you were there?

Margaret: Nothing. Well I had the angiogram done. I had an EP study done because I went into VTach. They have no explanation why.

Arlene: What's VTach?

Margaret: My heart went into a rhythm the wrong way and it was dangerous because those cardiologists ran.

Researcher: It's a very dangerous arrhythmia. And an EP study is where they actually zap a node that causes the arrhythmia.

Margaret: Well I don't know if they did that but they went in through the same area so I had all this massive bruising and heparin shots and it was real pretty.

Arlene: Did they put in a stent?

Margaret: No, there was nothing clogged. So I had really nothing done other than medication and observation for nine days in the hospital. And I have been told by a number of people that those women like me who have nothing done...like surgery wise...have a harder time dealing with it because there is no resolution. So my biggest thing still is if they don't know what caused it in the first place. So when is the next one going to happen?

Helen: But you're on medication now?

Margaret: Yeah, but not nearly what I was on then because it's now a year and a half post. So, basically I'm on one thing now and that's it.

Helen: What are you taking?

Margaret: Atenolol. It's an ace inhibitor. Is that Atenolol?

Arlene: That's Atenolol.

Margaret: That's what I'm on and nothing else. I mean I have Nitro.

Researcher: So you're really wondering if this is going to happen again?

Margaret: Yes...yes.

Helen: Do you need the Nitro very often?

Margaret: No, but I carry it with me.

Helen: Do you use it sometimes then?

Margaret: Oh I think the last time I used it was 4 or 5 or 6 months ago.

Helen.

In a brief manner, Helen recounted her experience of having the MI, ending with a question related to making sense of the event. Helen had her MI 3 years ago at the age 48. Compared to other women in the group, she had experienced significantly more recovery time (by almost two and a half years in some cases) than the other research participants.

At the time of her MI, Helen awoke in the middle of the night with extreme back pain that radiated down both hands and into her fingertips. Having "no idea it was a heart attack," she made several efforts to alleviate the pain. "I thought if I stretch it will go away; if I lie on the floor it will go away; if I take a hot bath it will go away."

Margaret: How long was the time frame?

Helen: For about half an hour and it just kept getting worse so my daughter called 911 and I was taken by ambulance to the hospital.

The following afternoon, Helen was diagnosed with MI; "I couldn't believe it...I was very shocked because I'm not overweight. I've never smoked. I run, I'm very fit and I'm vegetarian, so I have no risk factors except it runs in the family".

Facilitator: Did you know that?

Helen: Yes, but my mother who smoked and was overweight had all of the symptoms.

Helen underwent a heart catheterization 3 months after her MI as "it didn't appear that there was any urgency." While her angiogram did not reveal any blockages in her coronary arteries, she had some complications:

During the procedure, my artery spasmed which is what they determined the problem was initially although they don't know for sure. There was no particular information given about why an artery will spasm but when it spasms it may as well be clogged because nothing goes through. That's the thing, it has spasmed once...when will it spasm again?

Helen was off work for 4 months after her MI.

[Wow! Several women expressed big surprise].

Helen: I have a good benefit plan in my work so I thought well...I took advantage of everything...whatever there was available to me I was doing.

Unlike other participants, Helen did not attend cardiac rehabilitation given her already healthy lifestyle. Since her MI, she described vague and infrequent cardiac symptoms.

About every 6 months for some reason or another and it doesn't seem like there is any reason...like I'm not more stressed although sometimes I'm more tired...although you never know if that's because of the heart or because my life's so busy...which comes first...I'm trying to observe the conditions when I do need some Nitro.

While she has taken Nitro a few times since her MI, Helen has not required further hospitalization. Finally, in trying to make sense of her illness experience she described herself in the following way:

I am a major A type character and I push really hard and I started to do less after the MI for a while and that was pretty good but it is not my character so I am back to doing a lot of things that I love to do. I guess that's the hard part...trying to juggle doing less when you're really the kind of person that doesn't do less. I don't know if that's really what it's about anyways...I'm not really sure.

Sarah.

Sarah appeared nervous as she told her MI story, "you know it makes me very sad when I'm talking about this." She immigrated to Vancouver from Iran almost 5 years ago and is attending a local community college where she is upgrading her accounting skills. At 48 years-old her MI occurred last May while commuting to school on the local sea bus.

I felt chest pain...I was sweating and I had pain in my arm and shoulder. I knew it was a heart attack because my father had six heart attacks and I was always there to help him with my family. Because of the pain, I was lying down but nobody asked me anything ...like if I needed help. I was sick and everybody ignored me.

[The group gasps and shakes their heads in disbelief].

For more than a year, Sarah had commuted on the sea bus recognizing several people who acknowledged her daily. "They didn't even ask me, 'Why are you lying down, why are you crying...do you need any help?' Nobody, not even the woman sitting close to me [helped me]."

Arlene: And they ignored you?

Sarah: Everybody ignored me. As soon as the sea bus stopped they just left.

Helen: They left you there?

[The group responds in disbelief].

Sarah motioned for the attendant, "I was just pointing because I couldn't talk. He came and I said I'm having a heart attack. He called the other crew and they called 911." When the paramedics arrived they told me:

You cannot fool us you are not having a heart attack. [The group gasps]. It took 25 minutes before they decided to take me in the ambulance and they asked me to walk towards the bed because they didn't believe that I was having a heart attack. [The group gasps again and Sally says "Get the names of those guys."] In the ambulance they were discussing me...'I don't believe that she had a heart attack. She doesn't want to talk English...she can't talk English...that is why she is not talking.'

Sarah forced herself to talk to the attendants. "Why should I fool you? What is the benefit? I'm having a heart attack. I know the signs because I have family history...just take me to the hospital." She was finally taken to a local hospital where she was assessed and sent for a heart catheterization. They found blockages in four arteries and the interventionist performed an angioplasty with stents.

After her MI, Sarah took two and a half months to rest before returning to school part-time. She struggled with returning to the sea bus as a commuter and facing the passengers who had ignored her appeals for help during her MI:

They were surprised to see me. I could see they wanted to say 'Where have you been?'

But I couldn't...I was shaking...I was hoping that something [would] happen to

them...that they would pay for what they did to me. Every day I go to school in the

morning and I watch them and I just want to scream 'Why did you do that to me...why?'

Facilitator: When I think about recovery, I think that is a huge piece for you...that traumatic response because people did not respond.

For the past several months, Sarah has been seeing a psychologist through the cardiac rehabilitation program she attended at the hospital. "I couldn't talk about that experience until last week when I started to talk about it. My psychologist told me it is better to talk to women that are the same as me...that had the same experience." Since her MI, Sarah has been plagued with nightmares, difficulties sleeping and symptoms of depression. "I had nightmares almost every night. I'm alone and in a dark place and I am looking for help and nobody helps me."

While Sarah has no family or close friends in Vancouver, she currently lives with the son of an old family friend. She described the following:

I have a roommate. He helped me but you know in my culture, living with a man is not easy. Living with a man who is not your father, your brother, or your husband or your son is not easy because it is not common in my country. But I am scared of having another roommate. I have nobody else. My family is not here and they don't know. I didn't tell them about my heart attack.

Margaret: So you are keeping this to yourself?

Sarah acknowledged that the most devastating part of her MI experience was that people ignored her appeals for help while on the sea bus. "I cannot get over that. At that time I thought 'They don't accept me. They are Canadian and I am Middle-Eastern and they don't want me here.' Again, they are smiling at me and here in Canada!"

Facilitator: When something like this happens it is almost as if that becomes more traumatic than the heart attack. The way others responded and the way they didn't respond.

[The group showed great empathy and appreciation for Sarah sharing her story].

Sally: I'll take the sea bus with you.

[The rest of the group agreed and stated "We should all ride the sea bus with you and we'll stare them down"].

Sally.

Sally described her MI and her current experiences with a detached straightforwardness. Her MI occurred at the end of June 2003. Like several other women in the group she was also 48 years-old.

Margaret: You were 48 too? A very common thread here. Four of us at age 48 had heart attacks!

Sally: I think mine was quite mild. It happened at lunchtime while I was at home. I just had a new puppy.

Sally previously had pericarditis, an inflammation of the tissue that covers that outer surface of the heart, and wondered if her pain was a recurring episode.

I've been in hospital for that before and I thought maybe it's that. But this felt different just a wee bit. I waited for it to go away hoping it was the same. I moved around to see if it would hurt like the other thing but it was different. Then I started to feel it here (points to center of her chest).

After experiencing this chest pain, Sally called her neighbor who she wanted to take care of her dog. When her neighbor arrived, she called 911 and Sally's parents who live close by.

Sally described the paramedics as being "fabulous" as they promptly transported her to the emergency trauma room of the local hospital where she was quickly taken for a heart catheterization requiring angioplasty and stents. She offered few details of being hospitalized other than "I stayed a couple of days and went home." Sally described often feeling tired since her MI:

By the time you get washed and dressed in the morning it's time for a nap while at other times, you think 'today I feel great' so you then do what you did before and you are laid out for a couple of days. But you hate being like that and you don't want people to know that you're feeling that way.

Sally reported that she is currently not working.

I do get quite tired and I'm not working. I had stopped doing the hairdressing a while ago because of the arthritis. So I do some people at home. That was a major change, so I had to go into ladies retail. And you become a shopaholic so that wasn't a good thing.

Sally also discussed her father's response to her since having the MI and acknowledged feeling not believed in terms of the extent to which she had been impacted by the event.

Facilitator: It's interesting that your father did not really believe or understand you.

Sally: He had a bypass. He never had a heart attack. He had a wee bit of angina. And then he had angioplasties and feels normal. My dad doesn't understand why I am not right as rain. You know, after a couple of days 'oh, you should feel fine now...you shouldn't be tired.' 'No, I'm quite tired...give me time.' He thinks it was just a little angioplasty thing and you are back to normal. He doesn't know the impact of the heart attack even if it wasn't a huge knocking me out type.

Sally questioned whether her father had compared her MI to her experience of having angioplasties performed on both legs due to peripheral vascular disease. "I've tried to explain it to him. So mum just tells him to shut-up."

Margaret: What do you mean you had your legs done?

Sally provided the group with more details about the procedure and stated that, As soon as you're back to normal you feel terrific and you can walk again. So he's thinking it's like that. 'You should be alright now...hey come on. Well why are you tired? You shouldn't be tired.' He worries about me.

Facilitator: You don't feel the alright that he thinks you should be feeling.

Bev.

Bev articulately described the events surrounding her MI in vivid detail. Compared to other group members, she had most recently infarcted on the Labour Day weekend. She was 53 years of age and referred to her symptoms as being "classic" and remembered "feeling very tired that day."

Mid afternoon, while climbing the stairs in her home, Bev recounted:

This incredible crushing pain in my back and my arms and the back of my neck and in my chest and I thought 'I've done something...I've pulled a muscle' but there was a little voice saying 'maybe it was a heart attack' (laughs) but I didn't really listen to it.

Bev walked outside and called for her husband to come inside the house. "Tell me what's wrong' and I said 'I don't know...I just feel terrible' and I sat down in the living room." Bev's husband had an inkling that she was probably having a heart attack and called 911.

The paramedics arrived promptly and transported her to the local hospital.

They were fabulous with me. Unlike your experience (referring to Sarah) where they were so doubting and made you feel so terrible...the people who responded to me were terrific. I felt that I was really cared for and that what I was saying was really important and I was taken seriously. I really appreciated that.

In contrast however, Bev felt that the quality of care shifted dramatically once she arrived at the hospital. In emergency, she was given various medications that reduced her pain to a bearable level. Blood work eventually confirmed that Bev had had a MI. She was

transferred to the coronary care unit later that night and scheduled for a heart catheterization the following afternoon. The procedure included angioplasty and the insertion of two stents.

Bev recounted the typical procedures following angioplasty which included having her leg clamped for 4 hours to help stop the bleeding.

I bleed a lot and the bleeding did not subside so I lay on my back. They had poked around in my kidneys too because they suspected with the kind of problems I had with my artery that it may well be my kidneys as well and so for 16 hours I lay in one spot unable to move and not able to do anything.

[The group collectively moaned in astonishment at the imagined discomfort].

I hadn't eaten since the day before and I felt really terrible and I had a nurse that chastised me constantly all night because I wouldn't take pain medication and it was her mission in life to make sure I had some pain medication so I would go to sleep. I reassured her that I was not trying to make her life difficult and in fact, I had never slept on my back and if I were to be given anything at all to relax or to be put to sleep then I would immediately turn onto my left side and I would probably bleed to death throughout the night. And she was just miserable...totally miserable...and I have never dealt with anyone like that in my life and I hope I never do again. When you are the sickest and most vulnerable you need someone to be...[several women say the words "comforting" and "understanding"]. Well even if they don't understand at least something (laughing) ...["compassionate"]...yes compassionate.

That same morning the cardiologist that did the angiogram and placed the stents came in and said 'well, we fixed you. You can go home now.' And all the leads were pulled off my chest and I was sent home (incredulous). And there I was and I said 'but I'm still having chest pain' and they said 'we fixed you...go home'. So I did. That was the Thursday.

While Bev stated "I found that to be quite an experience," it was evident that she had understated her experience of being hospitalized which appeared from her descriptions to be highly distressing for both herself and her husband.

The day after she was discharged from hospital, Bev had moderate chest pain which continued into the next day. She tried to contact her family physician but found that she was away for the long weekend. Instead she managed to talk with her doctor's locum who was on a plane and who attempted to contact the on-call cardiologist for several hours. "This woman called back from the aircraft and said 'go to the emergency...they have spent tons of money on you...so go there.'"

Consequently, Bev and her husband returned to the hospital where she again felt her care was compromised.

They placed an oxygen mask on me and I said 'I don't feel any better...so my husband said 'The tank is empty what's going on here?' And they said 'This is a long weekend we are very busy'...and then they said 'Why don't you use your Nitro with the chest pain?' And I said 'I don't have any...no one has given me any.' And they were really surprised at that.

For the first week following hospital discharge, Bev described "hating" that she had stents in her heart.

I would see my arteries...this particular artery and I would see a steel gate. And a little voice in my head said I couldn't turn over onto my chest because this gate would close up and that would be curtains (laughs).

[Several group participants laughed with Bev despite the seriousness of her concern].

Researcher: What was that like for you?

Bev: At the time, it was pretty scary actually but I don't see that anymore.

Helen: Was there something else happening when you went back on Saturday?

Bev: Well they said 'It had only been 2 days since the stents were implanted and nothing will happen to them in that amount of time.' It was almost like...'There, there dear you go home now.' I was given the Nitro and I've use it twice since. I don't really worry if I'm going to have another heart attack. I probably will but I don't worry about it. I don't think about it.

Margaret: But do you carry your Nitro everywhere you go?

Bev: I do sometimes.

Margaret: I did for the longest time. I wasn't thinking about having another heart attack but I wasn't leaving the room without having the Nitro in my hand.

Bev: I don't really think about it anymore. I do what I can by myself. I've joined the Healthy Heart and I must get rid of this weight. I have some wonderful friends and a really supportive family and I have always looked at life with humour and I've been really lucky in my life. I don't really think about it too much.

Facilitator: Sounds like you have a coping strategy. Like a sense of really knowing even through the shock of it. A deep down knowing. Like you with the aspirin (points to Margaret).

Bev: I actually kind of knew before I had my heart attack. I had known for a year that I probably had a problem and I had mentioned it to my doctor because I used to notice my ankles swelling and just felt I was dragging an anvil around half of the time. And I have asthma and I am also incredibly anemic. So I fight with that all the time to make sure my hemoglobin is where it needs

to be and I kept rationalizing that away... 'ok it's my asthma.' I would walk even though I'm heavy, I would do a lot of walking and that little voice would say... 'It's probably that but I'm sure it isn't.' Even my own doctor was really shocked. She was just stunned.

Researcher: That little voice, I had heard that. And there is this phenomenon of women's body wisdom. We know when something is wrong and often try to convince others that this is something that is legitimate. It may not be a concrete thing but an intuitive sense.

Arlene.

Arlene's MI occurred while away on a business trip in the States. She began her story by describing inexplicable symptoms, including ankle swelling, several months prior to her MI. In October, Arlene had contacted her physician and was sent for tests which came back negative. Recurring symptoms the following January disappeared and she cancelled her follow-up doctor's appointment.

By March, Arlene was busy finalizing the completion of an employment position before taking a promotion to become an Administrative Assistant in her office. At that time, she was working 15 to 17 hours a day, 7 days a week and loved what she did. When her promotion came through later that month, she was sent to a training seminar in the States.

While at the seminar, Arlene developed symptoms that gradually became debilitating. At the end of the first day, "I had sharp pains in my feet. I thought what is wrong... what's wrong. I was anxious." Being a diabetic, Arlene knew she needed to eat but had little appetite. Not feeling well, she returned to her hotel to get a good night's sleep.

By morning, Arlene felt rested and returned to the seminar. A few hours later however, she felt that her blood sugars were rising.

I went to the back of the room and put my feet up and I felt really tired. 'What's wrong with me?' By 11 o'clock, I knew this was a wash and I needed to take insulin... I needed to do something.

Arlene returned to her hotel where she took her blood. "It was about twenty and I thought ...twenty... why am I feeling so rotten?"

[Several women asked for clarification around a sugar reading of twenty].

Arlene explained to the group the values associated with normal sugar levels. Despite taking several more doses of insulin and resting, Arlene's sugar levels continued to increase over the next several hours. She contacted her endocrinologist who also increased her insulin. By 8:30 pm, her sugar levels had finally come down. While she needed to eat, she had little appetite.

A few hours later, Arlene woke up at 1:30 am because of acid reflux.

I thought what is going on here (getting angry). I get up and I spit it out and I thought there now I can get some sleep. I take my sugars and I'm really high. I thought not this again and gave myself a whole bunch of insulin through the pump. And I am writing down what I am doing. And I'm going to the bathroom and every hour I'm taking insulin and going to the bathroom. So I know now that I have ketoacidosis (a state of insulin deficiency).

By 6 am, Arlene continued to feel increasingly ill. She called her endocrinologist again and he agreed that she should return home. Given she did not feel well enough to drive home, her boss offered to take her. "I'm starting to pack but I have no energy. I'm really tired so I lay down. When I get some energy I'm up again trying to pack my suitcase."

When Arlene began to vomit, she called the paramedics. "Thinking ketoacidosis...I've always been taught since I became a diabetic in 1988 that if this happens you go to the hospital." During the paramedic's assessment they repeatedly asked if she was having chest pain which she denied. "Well, maybe it's a little tight but that's it...nothing."

Arlene was transported to a local hospital's emergency department where she continued to vomit and have severe stomach pain. She was kept overnight and sent for additional tests which revealed she had had a heart attack. "I said 'You're talking about me...when was this supposed to have taken place (laughing)?" She was told that she needed a stent. "I couldn't believe how fast everything was going. Hold it here, I have some questions." The attending physician explained what was involved.

Well if you don't have it you'll die and if you do have it there may be complications. But you really have no choice...this is just the way it is. I've done this operation thousands of times before and you have nothing to worry about.

Arlene underwent the procedure which she described as "awful." Having experienced some complications, she was required to lie on her back for the whole day instead of a few hours. While hospitalized, Arlene was comforted by her sister who came to stay with her and did not leave her side for her entire hospitalization.

The next night, Arlene began to have difficulty breathing. Her condition worsened significantly and she developed congestive heart failure. The following day, she informed the nurses that she was leaving the hospital.

Let me out of this bed. The only way I'm going to get better is to get up. Friday they allowed me to get out of ICU for a half a day. The next day I said 'I'm leaving' and I left and went home to Vancouver.

Arlene first contacted her colleagues to ensure that they had completed their assignments so she would not have to worry about work.

[The group collectively expressed shock and was initially silent. A few participants said together, 'Given how sick you were I can't believe that you just got up and left!']

Once she returned to Vancouver, Arlene arranged to see a cardiologist and joined the cardiac rehabilitation program at the same hospital she attends her diabetes clinic. "I started in September and I think it's fantastic."

Margaret: I had to wait 3 months to be accepted in the program.

After a week of being home, Arlene returned to work to set up her boss's office as she had bought new furniture prior to getting sick and was concerned that he couldn't do anything without his office set up.

Margaret: I just can't fathom moving around that much a week after your MI. There was absolutely no way I could have if I wanted to.

Arlene: The reason I went back to work so soon was because it was very stressful for me not working. The doctor figured I would do myself more damage at home fretting and being upset than just going to work. I was in an office and I didn't do anything stressful. If I was tired I didn't have to work a full day.

While Arlene took her time, she admitted having to walk a lot to set up the office.

Helen: Given that you were in between jobs, were you covered by a medical plan?

Arlene had transferred to her own medical plan from a previous partner's plan less than 2 months before the MI. Consequently, her \$46,000 US hospital bill was fully covered by medical.

Facilitator: It's different for everyone. For you it's going back to work as being busy is less stressful than not working at all. So we learn from each other.

Arlene: When I had the heart attack they said that the right artery was where the attack was and they couldn't do anything with that. It was the left artery that was 75% blocked and that's where they put the stent. Because I'm a diabetic, the small arteries are plugged – they are gone and there is nothing they can do. My heart attack is a complication of diabetes. That's what it was.

Researcher's Process

In this session, I felt deeply moved by participant's stories and engrossed in the group process, yet somewhat overwhelmed. I attributed this to several factors including my own concerns about wanting the first research session to run smoothly, accomplishing the proposed tasks, containing a group of six female heart patients who were excited to dialogue with each other, negotiating the needs of participants while maintaining the research agenda, and taking in the richness of the individual and group dialogue and process. In this sense, perhaps a parallel process existed between both facilitators and the group participants as all of us were

concerned with wanting to take in the richness of the group experience albeit from different perspectives.

Debriefing the session with the facilitator immediately after the group and more formally the next day was extremely helpful in terms of better understanding the events that transpired during the session, developing strategies for addressing group process, and planning for the next session.

Interestingly, my impressions of the session following the videotape review were very different than my experience and impressions of being a participant in the group. More specifically, what I perceived as the group's vitality and at times disjointed group process was not captured on videotape. Instead, the session appeared to unfold in a fairly orderly manner.

This is a significant point with regards to the research process. Having to maintain multiple consciousnesses while conducting live research differed considerably from stepping out of the group interaction and into the singular role of interpreter while reviewing the session in video format. Being reminded that the purpose of the video recordings was to document the research process, enabled me to more fully relax into the role of researcher during subsequent sessions.

Researcher's Interpretations of the Introductory Session

The introductory session was a valuable first research meeting. While most of the items on the research agenda were accomplished, the session was characterized by a tension between maintaining the structure of the research agenda and women's needs for dialoguing with each other. Consequently, the urgency that was demonstrated by participants to tell their illness stories guided the session. The quality of women's urgency to tell their story was palpable; analogous to a lid bursting off an engorged container as women indulged themselves in asking questions, sharing stories, proposing hypotheses, and offering information.

The facilitator and I were successful at facilitating rapport building and the development of group safety as participants were engaged, interested and willing to contribute in the session. They were also supportive, respectful and appropriately empathic towards each other throughout the evening. A striking example of support was demonstrated when the group promptly responded to Sarah as she recounted her traumatic experience of being abandoned by others during her MI on the sea bus.

A highlight of the evening was clearly women's tellings of their MI experience. Embedded within each participant's story were distinctive experiences, personal meaning, and dominant themes. In pondering these stories, I wondered if the advent of a life threatening health event tends to amplify preexisting life issues and dis-ease. My impressions of each participant are as follows.

Margaret's greatest concern appeared to be anticipating her next MI. Despite this anxiety, she has continued to smoke believing she is powerless to influence this inevitable outcome. As well, her story suggested that she felt unsupported by health professionals while hospitalized and by friends following hospital discharge, and possibly in her life in general. Ironically, she eventually withdrew from the study because of feeling overwhelmed by her current state of anxiety and struggling with the demands of the research.

In contrast, Helen described having greater confidence in her body (and heart) at three years post MI. At this point in her recovery, her journey appeared to involve a deeper search for personal meaning and truth, which may serve as a passageway to better understanding why she had her MI.

Sarah's shocking story of MI is one of victimization and the sense of not being cared for or valued as a human being. Despite being a strong woman, she came from a culture that silences both women and men. While she felt silenced by her MI experience, participating in the group provided her with the opportunity to find her voice and challenge her stories of not being cared for and of being isolated in this country.

Sally spoke to the lack of understanding initially received from her father about the impact of her heart attack. As well, she expressed confusion as to the purpose of reflecting on the past and engaging in the GA process. This confusion may prevent her from fully accessing the potential benefits of participating in the research group including receiving support from other women who understand the MI experience.

Bev described a divergence between the exceptional care she received from the paramedics and an on-call physician, and the brusque treatment by various health providers while hospitalized. While her strength of character and spousal support helped her cope with the events that transpired during her hospital stay and the lack of information and resources following her hasty discharge, she was nonetheless distressed and disillusioned by her experiences. At times, Bev described difficult experiences with levity despite reporting to feel frightened or upset at the time. Participating in the group would allow her to explore her recovery in supportive and caring environment.

Arlene quickly stepped into the role as a brazen leader in the group. She clearly expressed anger towards her body for letting her down by having the MI and for now feeling weak and tired. From her descriptions, she has moved through her life as a strong and determined woman who has pushed past many difficult losses and health setbacks. Discharging herself from the hospital following her MI and returning to work in 6 days attests to her survivor nature. While Arlene insisted that she rarely reflects on adverse events, she was willing to

consider that her typical coping style (to just move on) may not best support her recovery from MI.

While each participant's MI experience was uniquely different, several significant elements emerged from women's autobiographies and the group dialogue. In general, participants described feeling overwhelmed at times by various aspects of their illness experience including physical symptoms, hospitalization and treatment regimes, frustrations in dealing with health professionals (e.g. communication difficulties and the lack of specific information), concerns about the future, and limitations (imagined or real) resulting from the MI.

As well, all of the participant's descriptions were suggestive of having tacit body knowledge that their symptoms were indicative of there being something wrong physically that required medical assistance. While four of the six women suspected that they were having some kind of cardiac event, all of the women sought medical assistance shortly after the onset of their symptoms.

At the same time, all of the participants expressed shock or surprise at being diagnosed with MI and did not consider themselves or each other to fit the stereotype of a "heart attack patient." In this sense, participants existed outside the cultural story that women, particularly younger women, do not experience heart attacks. Some participants suggested that this stereotype had been mirrored back to them in the reactions of others including friends, family members, and health professionals who were at times "dismissive" or "skeptical" about the seriousness of their illness event.

Also evident from participant's autobiographies and dialogue was their hunger for cardiac information specific to their individual circumstances. One participant noted that although she had read "everything out there" related to MI, "there was really nothing that spoke to me as a younger woman." Interestingly, I was struck by the level of sophistication in the medical knowledge and language spoken by participants.

Several women reported feeling dissatisfied by the information they had received from medical professionals regarding the cause of their MI, guidelines around resuming their daily routines including physical activity and sexual relations, the benefits of cardiac rehabilitation, and general measures to prevent another cardiac event. In this sense, it was clear to participants that medical professionals "do not know everything" about women's cardiac health. In the absence of physical findings and satisfactory medical information from her cardiologist, one participant constructed her own theory to explain the cause of her MI. Subsequently, women questioned where they could access credible and relevant health information. The group context represented a resource for these women as they obviously were interested in learning from each other as female MI patients.

Finally, participant's stories suggested that the experience of MI often called for women to become a different kind of person. In general, women talked about focusing more on self-care. More specifically, several women described needing to learn how to be more assertive in asking for information and/or help, in setting boundaries with others, negotiating and prioritizing responsibilities and obligations, pacing oneself physically, developing a greater body awareness and ability to interpret bodily symptoms, and decision making around lifestyle changes and redefining their health.

Guided Autobiography Theme One

Your Health and Experience of MI and Recovery

The format for this second session included a group check-in, discussion of participant's hopes for the group, completion of the life-line exercise, reading of the first Guided Autobiography theme narratives and group feedback, an introduction to the next GA theme, and a brief group check-out. All participants attended this session.

Group Check-In

Almost all of the participants reported feeling particularly tired this night as a result of overextending themselves over the past several days. Arlene acknowledged not feeling well as "her sugars were high like when she had her MI." Several women demonstrated concern and checked in with her over the course of the evening. In contrast, Helen described feeling "not tired" despite running a ten kilometer race, participating in a music performance, and marking papers over the weekend.

Both the researcher and facilitator shared their impressions of the previous session including various themes that emerged from women's stories of MI and the group dialogue (refer to the previous summary).

Participant's Hopes for the Group

Each participant identified her hopes for the group and the research study. Several women acknowledged wanting health professionals to have more female specific cardiac information. Arlene spoke to the importance of educating women about the health risks of MI.

I want to get the word out to other women so they can be more aware of what could happen to them and to be more accepting when it is happening. Not to go to bed like I did as it was the worst thing I could have done. So if women have the signs they will know what to do.

Two women expressed their belief that talking about their MI experience in a group format would help them (and others) better accept their illness. Sarah said,

I was ignoring my heart attack and I didn't want to face it or talk about it. My psychologist told me it would be better if I went to a group and talked about it and faced it. You have to face it.

Similarly, Bev reported feeling:

Glad to be able to share my story and I'm really glad to be able to listen to everyone else's story. I think through sharing our stories and listening to others we are able to feel better about ourselves and understand what's going on.

Facilitator: So Bev, you think that this group could be helpful by giving voice to your experience without being questioned and that in itself can be very healing?

Bev further elaborated on her experience of not being believed by friends that she did have an MI. "So because there isn't a cast or prosthesis or there isn't a something, they can't see the stents in your heart or the grafts and the bypasses and all that stuff."

[Women nodded their heads in agreement].

Facilitator: So again, you've had this experience but it doesn't get mirrored out there or validated, like that couldn't have happened to you.

In describing her hopes for the group, Helen postulated an eloquent theory explaining the potential cause of (her) MI which she continued to explore in greater depth in subsequent GA themes:

What I'm hoping for is a validation that emotional, psychological stories or experiences contribute or had something to do with the heart attack as well as or probably more so than physical attributes. I don't think in the health care system and I certainly know in the education system, that we pay attention to the emotional wellbeing of our people. I think it is bigger and more important than what we are paying attention to. It's just that we are imbalanced with rational, cognitive thinking and driving real hard on that road and we have a heart as well that needs nurturing, attention and guidance right from day one and its not happening the way I think it should. So I would like to see the validation of the emotional intelligence in health be brought forward. And women are more emotional than men, well maybe not but more willing to talk about emotions anyways and so maybe that is part of what happened here...I don't know.

Facilitator: I just had an image of you bringing heart into the room...the other kind of heart...the metaphoric heart.

Helen: Yes, exactly. I don't think it's a coincidence that the heart is associated with love and emotions and all of that and it drives our body and we all had heart attacks and it doesn't seem to have very much to do with physical factors...well maybe a little bit. But there is also another part of the story that the medical system doesn't pay much attention to.

Sally: Well they think that stress is a big factor. You mean we have to deal better with stress before it happens?

Helen: I don't know about that. Maybe. But stress is also good. Yeah I think stress is part of what I'm talking about but I'm not just talking about stress. I'm talking about your happiness level and how you process the big emotional events in your life like the birth of your children or the death of your parents or death of friends or divorce or any of those big deals. And how we process them and carry them with us because they can become part of our stories. In my reflecting on the heart attack experience, I kind of went through it but because it was all dealt with on a physical plane: the angiogram, the drugs, the actual experience, and cholesterol, whatever. It was all the physical rational side of the equation. I went to one counsellor about the emotional aspect of it. That was not a counsellor trained in health issues. That was a counsellor trained in social issues. So I kind of got nowhere. I still don't really feel that I have much of an understanding about what happened.

[All of the participants are highly engaged and some are nodding in agreement].

Researcher: It's like you recognize a gap between the physical and emotional aspects of the person that needs to be integrated in the care they receive.

Helen: In my experiences with doctors and the cardiologist it wasn't big on the priority list to look at the emotional wellbeing of my health and my recovery. I am a fairly high functioning adult, why would you want to look at my emotional makeup. I cope fairly well it appears. But looking at the physical side of things, yes, I had a heart attack and then you check out all the physical things and everything seems to be in place. So where are we... I still don't really know.

Facilitator: So if the experience of a heart attack is a physical one and an emotional one it would seem that the recovery process would involve both those things too.

Helen: The physical aspect looks at your family history, your health history, your exercise history, your diet history. The emotional side doesn't really look at your emotional history it just doesn't go there. It's all a big area that is just not addressed, not put anywhere, not resolved. It's just kind of there. Intuitively, I think it's a big part of the whole thing. I don't know that for sure but what else could be going on here because I have always been healthy. I function at a pretty high level of good health. I've never abused my body, never smoked, drank hardly at all, didn't party hard, slept well, and ate well. But I haven't always functioned well emotionally. When emotional things have happened to me I don't recover fast. They're big big deals and I take them and pull them in into my whole being and hang on to them very tight for a long long long time but that doesn't appear on the outside.

[Participants continued to ponder Helen's theory and some nodded in acknowledgement. I was flooded with the memory of a recent personal loss and my awareness of the term "suffering a broken heart." I too had wondered if the impact of my grief was harming my heart. Is the pain associated with our emotional and physical heart similar?]

Margaret felt that there was an absence of emotional care available while hospitalized: The emotional side is ignored and not dealt with in terms of having a heart attack. I know that was lacking for me while I was in the hospital for those nine days. Nobody came to talk to me about how I was doing. Not physically, but how I was dealing with (points to head). Not one person. Which I think was very wrong. They should have had somewhere along the line somebody come in and see me and anybody else that was there.

Not surprisingly, as participants clarified their hopes for the group, they also shared significant aspects of their MI and recovery experience that for some, continued to emerge in subsequent GA autobiographies.

Life Line Exercise

The life line exercise was introduced to the group with the intention of orienting participants to the life review process and to better understand which significant events in their past and present have shaped who they have become as individuals. In this sense, the exercise brought an immediacy of experience and awareness to each woman. This process of discovery could also help women tap into their coping skills and inner resources which may influence how they navigate their current recovery process and the choices and decisions that they make.

Women were provided with the following instructions: The life line can be one way of mapping significant life events and deciding if you think they are positive or negative. This is from the perspective of today. The first task is to put yourself on the life line at zero (when you were born) and then choose a point that will represent your death. Now choose up to five significant events (including the MI) and then spend a couple of minutes with a partner discussing one of the events that you have moved through and feel comfortable sharing. Say something about the actual event and consider the following two questions: a) How did you feel about the event at the time and from today's point of view, and b) What did you learn about yourself (e.g. How did you cope? Did you have certain skills or strengths?)

In general, participants responded to the exercise with strongly mixed feelings. While some participants expressed an interest in listening to and learning about other women's experiences, others did not enjoy the exercise. Arlene adamantly stated that "I didn't like the exercise. I didn't like it at all. I didn't like doing it. I liked listening but I didn't like participating. It's too much negative."

Sarah: I had the same feeling.

Building on her earlier theory, Helen suggested:

Using our reactions as an example, I would like to add that I think the emotional component of this is bigger than we think because I think the way we process the events emotionally in our lives causes us to feel positive or negative and the fact that people have difficulty doing this sort of reflection shows me that emotionally there's a lack of peacefulness or not healed stuff. So after fifty years, no wonder you have a heart attack. So if you didn't have a stomach attack or a lung attack or a bowel attack, there's a heart attack. And I think it has to do with the emotions.

Facilitator: And I think this kind of process allows us to look at those significant events and say "this is how I have coped with that situation." We all have our favorite coping strategies. I have heard that loud and clear about you Arlene. You said the last time "I just get to work and stay busy." [Arlene nods]. And then you can ask yourself "Is that helpful?" and "When is that helpful?" or "Is that something that you still do?" and "Is that something that you want to change or not?" So this becomes a process of self-awareness.

[The group became somber as women appeared to be processing the discussion and potentially reflecting on how they have dealt with past events including MI].

Your Health and Experience of MI and Recovery

In the first GA theme, women were asked to reflect on their experience and recovery from MI within the bigger context of their health and illness history. Sensitizing questions included considering health throughout the lifespan (including the health of family and friends), familial attitudes towards illness, coping strategies, the physical and emotional impact of MI, and changes in self and body image following MI. (For a complete description of the GA themes and sensitizing questions, refer to Appendix F).

Five of the participant's narrative accounts will be presented in this section. While Sally and Margaret did not bring their GA writing to the group, Sally submitted her narrative the following week. This has been included without group feedback following Sarah's account.

Arlene.

At the age of 18 I lay in a hospital bed. I was 6 months pregnant and weighed 89 pounds. I was feeling sorry for myself as I had contracted a syndrome called Gilliam-Barre. It [was a paralyzed] nervous system and I was unable to walk and my movement was restricted in other ways as well. The doctors predicted that I could spend the rest of my life in a wheelchair. There, lying in my hospital bed, I vowed that I would dance again. With the help of a blind physiotherapist, I was able to keep my muscle mass and

eventually the day came that I stood up, on my own two feet for the first time in 5 months, and they moved. I felt SO tall! I was ecstatic as I knew I would walk again.

I was released from the hospital to spend Christmas at home with my family, then early January my son was born. I was given lots of help and love from family, friends and the church, and my recovery started. Then came mother's day, and my poor little son never woke up (Arlene gets teary saying 'that hit me.' She continued to read choking back her tears). I was devastated and just wanted to go to sleep myself. My other daughter was neglected, I would not eat and the only thing that gave me back my will to live was the knowledge that a nervous breakdown would weaken my system so much that I would always be weak which was something I did not want to live with (choking back her tears 'funny this is doing this to me').

So, again I picked myself up and started, one day at a time, to live. It took two years before I was strong enough to hold down a full-time job. I did a lot of volunteer work and walking. The strain was too much on my young marriage and I left my husband. Determined to better myself I began a correspondence course to get my Real Estate license. It was the only way I could think to give my daughter a good life and support her with no father.

Then out of the blue, my car was rear ended and I suffered a compressive fracture at the 6th cervical. I was unable to work for 6 months. Suffering with migraine headache and tiring very easily, I pursued my career, eventually going to UBC to obtain my real estate agents degree.

Six years later, I met a very talented man who caught my eye and we eventually moved to Alberta and after several years together we got married. The relationship was very difficult as there were never any disagreements or arguments, just huge catastrophes. I started to get sick again. My left shoulder started to burn with pain. I was scared my illness was coming back. Then I developed a hyperactive thyroid. The next year was a bladder repair; the next my appendix was removed.

Then I developed insulin dependant diabetes. I joined a support group to try to understand more about this terrible chronic illness. I resented that I had to change my life, which meant I fought it every inch of the way. My marriage became more strained and I could not work the hours without stopping to eat. I could not do errands without turning around because I was having an insulin reaction. My endocrinologist suggested that I must change my life style or I would not live another 5 years. The stress was becoming too much. So, I decided to leave my husband, my home, my business, my life and start again.

I moved back to BC and settled with my brother. One day while riding my bike around the park my right foot started to ache terribly. I had a giant cell tumor in my right ankle. It had to be operated on and I ended up in a cast and on crutches; just another hurdle to overcome.

Then I decided to change my job. At 50 years-old, would someone really hire me? I ended up securing a great job. I really enjoyed what I was doing and worked long hours. After 2 years of proving my worth, I was promoted. The new job would consist of travel and office hours; a first for me in years, but I was all set for the challenge.

While away at a recent seminar for a new job, Arlene suffered a MI.

I had a heart attack (sobbing). Me. How was that possible? I could have died. What lessons am I not learning that I have to continually have these devastating health problems? What new weakness will I have to live with? What new restrictions? God, will it ever stop? (still crying) That's it. I guess I needed to do that.

Facilitator: What are you aware of right now? What was that like to read out?

Arlene: Well it started with the life line. I think I could of have handled it if it wasn't for that. I had so many major illnesses and I'm just so angry (sobbing). I don't want to be sick anymore.

Facilitator: Thanks for reading that I could tell it was tough for you.

Helen: I think you must be incredibly strong. I think I would have given up.

Facilitator: From everything that I know about you so far, you are someone that just gets back to business. "I just want to get back to business and this is going to be hard for me but I am going to sit here and do this." And that's what you did and I could tell it was painful and it took courage.

[The group is quiet and smiling at Arlene in support].

Arlene: I don't usually show tears so I guess it was a healthy exercise.

Facilitator: And the first thing was being 18 years-old in the hospital and you saying 'I will dance again.' I thought this is one determined woman. And your son died. And then you carried on with the real estate to provide for your daughter.

Helen: And she is so young, she's 19. That's like a child (shaking her head in empathy).

Researcher: One of the things that stood out for me was you talking about 'standing tall.' And I think about the number of times you have had the chutzpah to recreate your self and let go of things or to take steps forward and recreate yourself. I'm amazed at your resilience and strength (Arlene laughs) and determination and also how success has followed your losses. You also experienced a lot of success.

Arlene: Yes, too many. It's harder the older you get to bounce back. I'm finding it harder this time to bounce back.

Helen: It hasn't been very long.

Arlene: No, I'm impatient (laughs).

[The group laughs].

Bev.

Bev prefaced her GA narrative with another story of a recent accident where she had fallen head first down slippery porch stairs. I remember going head first down the stairs thinking all the way down that this is it for me. That my life would end on this day and I remember thinking, my husband who was recovering from some strokes, he's going to find me either dead or paralyzed and I won't get to see my daughter get married [the group moans]. And my son was graduating from university in a couple of months and I thought I won't get to see that either.

So in thinking about my heart attack and all the things that have happened in the last 5 years, and there have been some pretty devastating things, I'm thinking about my heart in a different way. So I just want to read this last part.

In the first few days after I had my heart attack, I found myself crying at times. At first, it was out of relief. I was relieved that I had survived. I was relieved that now there was a name that I could attach to those vague and troublesome signs and symptoms that I had been experiencing for months. My secret fears of a heart problem were now confirmed and had been treated. I cried because I am extremely close to my husband and children. I enjoy being around my children and I worried that I might not be around long enough (voice wavering) to see them realize their dreams, to attend their weddings, to hold my grandchildren (starts crying), to watch them enjoy their own families as much as I have enjoyed mine (sobbing).

My husband has had many health problems with two bouts of cancer and three strokes as a result of the radiation treatments that he received for his brain tumor. I had always been the healthy parent throughout my children's lives and now this has happened to me. My husband's father had suffered a massive MI when my husband was twenty-one and had died and now my youngest son is twenty-four. I wondered would he be losing his parents at a young age. I cried because I had never taken medication before (voice still wavering) and now I had this chronic condition for which I would forever take pills.

For the first while if managed to sleep, I would envision my stents. They seemed like steel culverts or steel gates and I hated that they were in my heart. Then despite that nasty hematoma I began to walk again. I went back to my daily routines. I decided that I would not let myself be defined by this experience. I talk freely with my husband

and somewhat less so with my grown children because I do not want to unduly burden them. I have not let the fact that I will probably need a knee replacement in the next 10 years define me nor the fact that I will probably lose the sight in my right eye.

I now look at life with fresh eyes or fresh eye and a half. I am doing all that I can within my power. I reckon that none of us know how long that we have to live and I have a deep and abiding faith that the length of time has been predetermined by God. I have helped myself by helping others as much as I can or as much as they want me to. I now look at my heart as a pump only. One that was defective for a time but one that has been patched. What is most important to me is that I love and I am loved and that's what I feel is the true function of my heart. When I think of my heart now, I don't think of the medical model now replete with stents but I think of the Valentine's model and that its function is to love. Without that love even with a healthy, undamaged heart I think that I would only be existing.

Facilitator: Bev what are you aware of? What was it like to read that?

Bev: I think of the impact that my death would have on my family (still crying). I wasn't crying for me, I was crying for them.

[The group sighs].

Researcher: It sounded like your experience of the fall actually had a stronger impact than your MI. That you might not have survived.

Bev: Yes it did. After I fell, for months I relived that every night. I saw the accident. I found myself going down and I heard the terrible crunching in my neck and thank goodness for that soggy grass...it saved my life. I think that fall was more devastating because I really did not think I would survive it. I was already prepared before I hit the bottom of the stairs that I would be dead. The fact that I survived it and didn't tear my favorite pants was really good (laughs). After I had my heart attack for a few days I was envisioning the stents in my heart and just hating them being there but I don't see that anymore. It was maybe a week or two and that was it but the other thing lingered for along time.

Margaret: Listening to you talk about love and being loved started to make me cry because I'm missing out on that. I don't have children. I don't have a significant other. That really bothered me when I was in the hospital (Margaret begins to cry). My roommate had kids and a husband and I had all the friends but no significant other taking care of me and worrying about me. So hearing you talk about knowing the purpose of being here was to love and to be loved. I agree with that but unfortunately for me it's not there.

Sarah: I would prefer to die.

Margaret: Well I don't know if I prefer to die but...

Helen: I think it's very wonderful that you enjoy your family so much and that they enjoy you. I think it's a real gift. And that you are so close to your husband and your children. It's very very beautiful.

Bev: It is. I really cherish that.

Researcher: The first time I met you, you talked a lot about your family and I thought this women's family is central in her life.

Sally: I noticed the same thing about family because I'm so close to mine. I lost a sister 19 years ago and they're scared they're going to lose my other sister to the drugs. I just don't want a heart attack that is going to kill me. I can't go before them because we are so close.

Sarah: I also had the same feelings around family. We are very close to each other. I am here but I don't want to tell them what happened because I don't want to make them worry. They cannot do anything. I love them very much. Two years ago, my brother passed away and they didn't tell me. They knew he got cancer and he had 6 months more and they didn't tell me. It was really bad.

Helen.

Helen introduced her narrative by showing the group her artistic and colorful writing journal that contained her narrative. "So I do mine a little differently, I made a book, 'Beckoning the Heart.' I'm thinking about the journey of recovery and discovery and I really wanting to draw forth on the emotional component of this story."

[Women express their amazement at Helen's colorful and creative journal].

My Health and My History and the Heart Attack.

The image of myself has always been of being physically healthy. I grew up in the country with lots of recreation and physical activity...hiking, biking, skiing, swimming, jogging, sports, etc. and I have maintained physical activity of some kind, that is being in good shape all throughout out my life. In fact, it is something I value in others and I'm proud of it. I'm looking forward to enjoying that part of myself as I grow older.

Consequently, I'm very conscientious about diet, bone care, joint care, weights and yoga. My frustration is truly a lack of hours in the day and prioritizing. Trouble is there is so much I love to do and want to learn. I want to do it all so to speak. My body has never let me down. It's a strong body and I haven't abused it very much over the years. Never smoked, didn't party hard, ate well, slept well, etc. I seem to recall a few childhood illnesses, whooping cough being the worst.

I think my health problem is one of more an emotional issue or psychological. I have always, for as long as I can remember, been someone who over extends. I'm

always and always have been busy doing things I love to do. Maybe this is healthy too in that it is usually my choice. I don't do much that is not my choice except when my husband left. That was definitely not my choice and that broke my heart and was without a doubt the sickest and weakest I have ever been. It took me years to recover and I can still feel the pain and sadness and sometimes anger and bitterness way down deep every once in a while. But I didn't tell that story now.

I was extremely outrageously busy when I had the heart attack and I had worked very hard for years prior to that. It goes something like this and I'm working backwards: On Thursday Oct 6 at two o'clock in the morning I had my heart attack. That Thursday evening I had been at parent teacher interviews for my class; the previous Tuesday evening I was teaching a class at UBC as well as being a full-time classroom teacher at the time with a struggling student teacher who wasn't coping well; prior to that on that Friday to the Sunday, I made a quick trip to the interior to put my mom in a care home and close down her apartment and brought all of her furniture to the coast; driving a one ton truck with everything in it which in itself, through all the mountain passes in October, was a little nerve racking. But I just kept doing it.

Professionally, I had been climbing the ladder of success with a new and different job opportunity almost every year for 6 years as well as I completed a Masters degree...achieving a 92 or 93% grade on a thesis while teaching full-time and being a single parent. So for a long time I was pushing pretty hard. And I still can feel tears close to my heart when I think of how hard I pushed myself. Why did I push so hard? Why did I do that to myself? I wouldn't ask my best friend to work that hard. But on the other hand the one thing I have to say is that my career has been somewhat charmed in that I have always had opportunities come my way over and over again. It's like my career unfolds and yields abundance for me in spite of myself. I do nothing and opportunities appear to happen. So I never said No! They are all neat and exciting opportunities.

The actual heart event happened during the night. I work up with an acute pain in my back. I woke my daughter up. I knew this was not normal. I couldn't get relaxed. She called 911 and the ambulance came. My whole hospital experience was wonderful. My friends and family all gave me love and care. My initial recovery was quite a quiet, gentle, and beautiful time. I did absolutely nothing and for me that was unbelievable. Until I finally felt motivated and then the only creative thing I could get going was to knit socks and I totally enjoyed knitting. My partner at the time took great care with me and of me as did my daughter. My mom had a stroke that Christmas...but survived.

I had to wait 4 months for an angiogram which of course was normal but during it my artery began to spasm and so the doctors assumed that this was my problem. I have had calcium channel blockers ever since. There really hasn't been any explanation why this happens or what to do to prevent it. Of course I don't really know either but I have some intuitive hunches about it all. My mom has heart issues and they run on that side of the family. So I am probably hard wired for it but I think there is more. I'm sure my emotional psychological spiritual self is also part of the equation but none of it is neat and tidy. Nor does it fit into a box. Rather it's bits and pieces of my story and it's all pieced together.

Helen showed the final page of her creative journal.

Today I ran the 10K in an hour and fifteen minutes. Not bad and it wasn't too hard. It was very enjoyable and I thought about trying to get my life into better balance. And I thought about how disciplined I am or am not. And I thought about all the people...that have defined my life. It really is about the relationships we create in our lives. The relationships, at least for me, are what I keep coming back to over and over. I want a new loving relationship but not yet.

[A few women stated they liked how Helen had done her journal].

Facilitator: How was that for you?

Helen: Pretty good. I love it when I get to work with color and get to express myself visually and writing wise (pauses) but I don't think I've addressed the emotional parts of my history. I keep touching on them but I never get to go through it and maybe transform it. And consequently it keeps coming back. Recently I'm beginning the menopause journey and from the reading I've done they suggest that if you have unresolved emotional issues, and you thought PMS was bad, they are going to really wallop you. It's true, some of this stuff, like my divorce is probably 15 or 20 years ago. A long time ago and yet sometimes it can feel like it was yesterday. And I go what about all the stuff I have done in the 15 years since. It's like none of it matters compared to that. So emotionally I think that's interesting just to not be afraid to go to the emotional places and try to heal those or patch them up a bit. It has been 3 years for me since the heart attack so I probably am not as maybe wounded - it might not be the right word. I do remember the first year after just building my confidence and taking things really slow. All I did was teach. I only did one job. I enjoyed that actually I remember thinking I had not enjoyed my teaching in that way for a long time since I was a new teacher. And I really kept my life in good balance. I was going for massage. I was walking. I just didn't ask that much of myself. But I also got a little bored. This is very nice but I'm bored. So now, 3 years later I'm not back to where but I am pretty close to where I was in terms of busyness. Its not things that I don't choose to do. I

choose to do it all. And it's all wonderful and exciting and interesting and my job is great and I've got all kinds of great things happening but I'm noticing that I will schedule...most people will schedule one thing to do in a day. I will have five and will go from one to the other to the other to the other and the fact that I was able to do this, this and this. It is kind of a weird way to be. But that is how I know myself and I don't dislike that part of me but I think that it's not a great way to be. It's not a bad way to be, I just think I need to achieve a bit more balance and I don't know quite how to do that. I don't know what to let go of.

Facilitator: It's hard for you. That really came through just how much you want to do everything and how well you do it.

Margaret: What stood out for me was that I am the complete opposite. I was doing a lot of jobs prior to the heart attack but once I had it, I didn't want to do anything. The hardest aspect of everything was the financial issues so I had to get back even though I didn't feel up to it. I had nobody to help me do anything. So you were talking about having lots of friends and family helping you with everything and being there for you. I didn't have that. And talking about your heart going into vasospasm and why did that happen and is it going to happen again. I go through those same issues because that was the same as me. They don't know why I had a heart attack. My heart went into vasospasm and then into VTach. And they can't say it won't happen again and that is what I struggle with.

Helen: I think it's about managing the variables that you can. I have a hard time managing this variable of being passionate about my career, my art and my music and somehow marrying them.

Researcher: But it's not as straight forward as minding your cholesterol or doing exercise three times a week.

Helen: I do all that. That's the stuff that fits into a box. I can do the physical stuff real well. The emotional stuff is really difficult for me.

Facilitator: It really came out clear that the loss of your husband is still a question for you.

Helen: Yeah well it comes and goes.

Facilitator: I also hear, 'How can I embrace my life fully after MI?' 'Can I still do it?' I want to.

Helen: My life is really full but it's not in balance. I'm trying really hard to get it in balance. I mean what do I let go of because I don't have anymore time? I know I should spend time relaxing.

Sally: Do you make time for family and friends?

Helen: Yes I do. My daughter lives with me and so I make time for her. I make time for my mother who is ninety-four and my friends...not tons of time but I am available for them.

Margaret: Doesn't sound like you are. Sounds like you have no time left.

Helen: Well, I guess it depends what you do with friends. I don't go out and party.

Sally: Lunch...window shopping. No little social thing.

Helen: No I don't do that. My social thing will be I run with people, I jog with people, I play music with people and I do art with people. But I don't sort of just come and visit I guess. I probably should. I should probably be much more available for my friends to just call up and say 'Hey what are you doing?' They probably know not to do that because I am usually not available and some have even said 'you're never available to be spontaneous because you are busy'. And I say 'Ok I'll be spontaneous what would you like to do?'

Margaret: I'll be spontaneous next week at 2 o'clock.

[The group laughs].

Helen: (Laughs.) What would you like to do...and the option? I don't go to bars very much. I don't know. It's like the options presented aren't as appealing and the things that I really enjoy doing. So I end up not doing them.

Sally: Yeah but just going out. Stop and smell the roses. Like let's pick an area. You live in Kits or something. Let's go down to the West End and we'll browse in all the shops and stop and have a coffee. It's amazing because I feel like I'm on holiday when I go to another neighborhood. It's interesting to see all the shops.

Facilitator: So Sally is that something that you've done before the heart attack?

Helen: Yeah that's a good idea.

Arlene: I'm terribly spontaneous. I love doing things on the spur of the moment. Like going to a dinner theatre. I like the arts too. Just kidnap someone and let's go.

Facilitator: So Helen what I hear in your story is that I want to do it all and I like to be busy. And I want more relationship or I want something closer.

Helen: Yeah but I've been in a relationship for about 8 years. A very challenging relationship and I'm not totally out of that relationship but it's not the relationship I want to be in...at least not in that capacity. That's a whole other story.

Sarah.

Sarah prefaced her illness narrative by telling the group why she had come to Canada. She speculated that her heart attack occurred as a result of the "bad things that happened" to her and then described a series of tragic events that occurred while still living in Iran. I have summarized this dialogue and included her illness story.

When Sarah was 28 years-old, her fiancé was shot and killed by the government. For several years, she remained housebound and could not go out. Sarah spent 6 months escaping

[from the government]. Eventually she began to work and attended university to become a child psychologist but the onset of the revolution forced her to leave school.

During this time, she became involved with a divorced man who had two young children. She agreed to work for him and managed his office for 7 years. She also worked with his daughters, who she described as being "very bad before" but became "very good children."

After 7 years with her boyfriend, Sarah was blackmailed by a co-worker regarding a recent abortion. She explained that sex without marriage and abortion was illegal in her country and if discovered could result in being "stoned." Over the next 6 months, Sarah paid her co-worker, whose husband was with the secret police, large sums of money. She explained the following:

Some people work with the government and they can do anything they want. In my country, somebody who has a connection can say you did a job...which you did. That's fine. That is enough to kill you. It's that dangerous. So I couldn't do anything. My boyfriend said you have to go away. She started asking me for more money. I had a lot of money invested in the office and she knew that because she was the assistant accountant. So I escaped.

Sarah traveled to several different countries before arriving in Canada 2 years later with a forged French passport. Shortly thereafter, she discovered that a brother back home had died of cancer. Her family had not told her he was sick for fear she would return and be apprehended by officials. Sarah acknowledged not knowing whether she could safely return to her country now or at the time of her brother's illness.

[The group was attentive and expressed shock at the intensity of Sarah's experiences. Several participants asked why she did not marry her boyfriend. Sarah continued to discuss her relationship with the group].

I didn't have any major illness until the age of twenty-two when I developed rheumatism. At thirty-eight, I had an inner ear infection which affected the labyrinth in my left ear and was not quickly diagnosed. It almost left me paralyzed. I was in my country and my family took good care of me.

I witnessed my father's heart attacks six times with my mother and my brother. We have a family of heart problems and high cholesterol, but I was told that it will pass only to the men of the family.

My heart attack happened on the sea bus. I was going to school. Prior to my heart attack I was stressed out. For almost one year, I was highly stressed and worried. I could not sleep or be relaxed. I was frustrated and very tired of not sleeping. I had an unforgivable experience when I had my heart attack on the sea bus with paramedics.

During my hospitalization, everything was good. The nurses were very friendly and kind and they took a good care of me. At school, nobody helped me deal with my financial problems although they knew I should not be nervous.

After 3 months, I joined the Health Heart program at the hospital. After I was discharged from hospital, I had a hard time coping with my worry about the future. I was always thinking that I will not be able to work like I did before and employers will not hire me.

Two years before I had my heart attack, I lost my older brother. I was here alone and did not have support of family or close friends. I experienced severe depression and my doctor recommended that I take Prozac. A year before my heart attack, I experienced pain in my shoulder and left arm, but my doctor said it was because of my depression.

I had psoriasis when I came to Canada, but after 2 months my skin was cured. I did not have any skin problems until I started studying at the college. The course was full-time and I needed to work very hard. I felt stressed by some of my teachers and one of my class mates. The result was my early heart attack. Now, my psoriasis has come back. Whenever I get worried, my skin starts itching and getting irritated. It is getting worse every day.

I always had a good nutrition plan. Before I came to Canada, everything I ate was organic. No additives or preservatives are used in my country. Also we do not have such different kinds of cheese. Here I have eaten lots cheese daily without exercising. Before I was very active, but here I am not. Now, I have been trying to walk every day, exercise at least three times a week, and only use low fat foods and more vegetables and fruit.

Sometimes I have a little chest pain, especially if something bad happens or even when I am watching a movie which is like my life. I use Nitro spray and it works.

My heart attack has had a very strong impact on my life. Although I have tried not to be worried, I do worry. Whenever I go on the sea bus, I remember that no body helped me when I was dying. It does not [allow] me to trust people. I have the feeling that I am alone and that nobody cares about me.

I have nightmares. I see myself alone and naked in darkness. I am scared to go in the dark or I see myself lying down on an operating table and I can see my chest is open. People are operating on my heart. Then they forget to close my heart and I can see my heart moving. Sometimes, I see my brother with me. He had open heart surgery and wants to take me to see a good doctor. I can see his heart and my own heart. In my culture, they say that if someone is dead and you see them in your dream and they ask

you to go with him then you are there. My roommate comes and knocks on the door to wake me up from the nightmares.

I am scared to move when I am sleeping. I am worried about my stents and I think they will break. I get tired very fast and it makes me mad. Every morning, I feel badly because I must take my medication. I think that the heart attack has ruined my whole life and I hate it. Why me? I feel I have to live alone because no man wants a woman who is sick.

Facilitator: You said you thought there was a link between your heart attack and your story.

Sarah: Yes, because I think I was abused for taking care of his children, taking care of the business...everything. How come a man takes everything but doesn't give anything except money. He paid all the expenses. I had a lot of money in my country and I wanted to come here. But he couldn't marry me (raises voice).

Helen: So he paid you to come here and go to Malaysia. Does he help you to live here?

Sarah: Yes, but I wouldn't accept his money to live here.

Helen: He won't give emotionally to you. He won't marry you and he won't come to see you.

Sarah: No he has another girlfriend now, after I left my country. He has the right to have another one. I left him.

Facilitator: When I heard your story I was struck by the level of stress in terms of dangers. What was it like to tell your story?

[Several group members nod their heads in agreement].

Sarah: At first I didn't want to tell this but after I heard the stories I thought we are here to share everything and I should trust my group.

Facilitator: That seems amazing given what your story was about with the level of secrecy and danger that you experienced.

Sarah: That is why I asked for confidentiality.

Margaret: I just admire the strength of the women so far telling their stories. Everything that each one of you has gone through it amazes me that you are here today. Especially you (looks at Sarah).

Sally.

As a child I had a very happy childhood. The only illness I had was tonsillitis. I had them removed when I was 8 years-old. When I was sick, my mum pulled the settee out and I lay there with a cup of tea and a magazine of my mums which was special. When I went into hospital, it was a four bedroom, not a ward, and I got to pick the bed beside the

aquarium. It was beautiful in the dark all lit up. As a teen, in winter I had a few ear infections. We had a great family doctor.

My mum never seemed nervous when she needed an operation, neither did my dad. I think that's why I have been okay before operations or being sick. Mind you, this time is different only because I haven't bounced back as quickly as before.

I'm really enjoying the Healthy Heart exercise program. I'm learning a lot, but I still tend to push myself. I have to learn to say no and take time for me. That includes eating on time and right.

Although Sally did not read her narrative in the group, I have included my comments in response to her story. In general, I was struck by her guardedness of expression. She said little about her lived experience of illness (including MI) or how she was impacted by surviving a life threatening event. In this sense, her story felt vacant of her adult self.

Margaret also stated she had forgotten to bring her narrative to the session. She described having difficulty remembering details of illness events and struggled with the process of writing, perhaps questioning whether she was 'doing it right.' Despite being active in the group discussion, Margaret often compared herself to those she was giving feedback to with an underlying tone of self-judgment. For example, she believed she had less of an interesting life than others, less support, less care while hospitalized, and perhaps less of an ability to write. I sensed that Margaret felt uncomfortably exposed in the group and perhaps believed she was not worthy to be a participant at this time.

Group Check-Out

Following the reading of women's GA accounts and group feedback, the facilitator conducted a brief group check-out as participants were encouraged to comment on their experience of the session. While two women acknowledged that "it was amazing to hear [other women's] stories," Sally expressed her concern that the group felt like therapy and that she didn't understand the facilitator's practice of exploring participant's feelings following the reading of their narratives.

Sally: Yeah the stories were nice. I didn't know it was going to be a therapy group where you said 'how did that feel to read it?'

[The group became silent and looked at Sally].

Margaret: It does feel like a therapy group more than anything to me. Not that there's anything wrong with that but that's the feeling I get.

Sally: I don't get it because most of the people have been emotional so that's what it felt like - quite emotional. So why did you ask? It's like going to the psychologist or whoever with a problem

and then they say 'well how do you feel about it?' Well I came because I need help. So I guess I feel frustrated.

Facilitator: That feels like an intrusive question?

Sally: Yeah maybe or just to me doesn't fit after you heard someone just open up.

Facilitator: That's good feedback. I will tell you the purpose of the question. When people write it is like a private experience. When you read it out loud it becomes a public story. We did notice that some people got emotional...something else happened. It changed just in the experience of reading it. And so that question, 'what are you aware of,' is just to give you a chance to process that or not.

While there were only a few minutes remaining in the session to address Sally's frustrations, the brief exchange provided the researcher and facilitator with an opportunity to further clarify the purpose of debriefing the GA narratives, thereby highlighting the differences inherent to private reflection and group witnessing. The facilitator also outlined the differences between 'doing therapy and being therapeutic.' Sally's feedback also demonstrated to the group that it was acceptable to openly address individual concerns or issues with the facilitators.

Alternatively, Sally's feedback could also have been construed as a challenge to the facilitator and more of a reflection of her resistance to engaging in the GA process, especially given she did not bring her writing to the session.

Researcher's Process

During this session, I felt more relaxed than the previous week. Mostly, I attributed this to more fully easing into my role as researcher and feeling confident that the facilitator was primarily responsible for facilitating the group. In this sense, I was able to focus most of my attention on understanding women's constructions of recovery. As well, it was heartening that all the participants returned for the second week.

Given my lack of experience conducting GA groups, I was intrigued with how easily the process unfolded as women read their stories and provided feedback to each other. I was struck with the magnitude of emotional loss and intensity of living that was evident in women's stories as well as their resilience. Moreover, I felt that I witnessed the potential power of the GA process as participants shared their experiences and accompanying emotions (some for the first time) within the safety of the group context.

I felt particularly moved by Bev's story about understanding the 'true function' of her heart and Helen's theory on the emotional and psychological origins of her (and possibly other women's) illness. Their messages resonated closely with my own evolving beliefs around emotional health and healing.

Despite the significance of the session, I left the group having a few concerns. Given Sally's feedback that the group 'felt like therapy' coupled with the emotionality of the evening, I

wondered if other participants found the group and what they were being asked to do too emotionally intense. More specifically, I wondered if we were encouraging women to take the lid off their emotional selves without providing adequate support to process their experiences. In my reflections, I likened the experience to working as an individual counsellor to women that participated in a sexual abuse support group. In this capacity, women had the opportunity for further support to process what emerged in the group setting. I also revisited the question, 'when does research become therapy'?

Ultimately, my biggest concern was whether women would be harmed emotionally as a result of the GA process. My counsellor self felt triggered in terms of my sense of responsibility given that I did not know how capable these women were in terms of their ability to contain big emotions given how quickly the first theme accessed painful memories. I also wondered if unveiling emotional pain in these cardiac patients would manifest itself as physical pain. Ironically, I ran into Sarah at the hospital the next day on her way to see her psychologist. She acknowledged needing Nitroglycerin following the group and believed that expressing her emotions while telling her autobiography had triggered her angina.

After debriefing with both the facilitator and my research advisor, I was better able to explore my concerns about the GA process and research responsibilities. We discussed the importance of reiterating to participants to intentionally choose how much they want to share about themselves in terms of respecting their own sense of safety. This related to an important discussion about the parallel experience of women learning to pace themselves and focus on self-care as an important factor in their recovery.

Researcher's Interpretations of Theme One

This was another powerful session as women demonstrated a high degree of emotional intensity in the reading of their autobiographies, feedback and comments offered over the course of the evening. While the previous week focused on the exchange of detailed MI information, this week's session continued to feel analogous to a lid bursting off a container as women expressed strong emotions associated with their experiences including the MI event.

In general, all of the items on the research session agenda were attended to as women participated in the Life Line exercise and the reading of their autobiographies. It was also evident that women exhibited interest and care for each other. For example, when Arlene arrived at the group not feeling well and with 'high sugars' other participants inquired in detail about her symptoms over the course of the evening.

It was evident from the group discussion that women had different experiences of constructing and sharing their GA accounts. While Bev, Helen, Arlene and Sarah more readily constructed their first theme, Sally and Margaret acknowledged having difficulty reflecting on

and articulating their experiences. Women who did present their narratives also reported varying experiences as some had a significantly harder time reading their stories than they had anticipated. Whether this was attributable to the depth and meaningfulness of the material discussed, variable proximity to the MI event or predisposing psychological factors remains unclear.

Half of the women became teary in response to reading their GA accounts and providing feedback to other women. While Arlene's expression of uninhibited emotion may have been sobering for the group as she volunteered to read her narrative first, it provided permission for other participants to express a depth of emotion. This was evident as Sarah acknowledged that it was after hearing Arlene's story that she could talk about her own. While women may have felt vulnerable as a result of sharing themselves emotionally, the experience appeared to create a sense of intimacy within the group. As well, the group continued to define for themselves the parameters representing acceptable behavior and practice as research participants.

Also emerging from this session was a developing sense of participant's personality style particularly related to emotional and cognitive processing. Simply stated, some participants appeared to be more comfortable and capable of providing insight and reflection into their illness and recovery experiences than others.

Reflecting on women's rich and detailed narratives and dialogue, several significant issues emerged. For most participants, the MI event appeared to be a sobering event that forced them to stop and reassess their lives. In this sense, most women had the sense of feeling changed the experience as they reported more physical fatigue, weakness, and a reduced stamina following their MI. Several women described feeling more vulnerable while a few others acknowledged struggling with depression. These symptoms were more evident in the women who had their MI within the year. Other women acknowledged having anxiety about the potential recurrence of cardiac symptoms or another MI, uncertainty about the future, or feeling more connected to their mortality as they realized that they could have died.

All but one woman reported being highly stressed prior to their MI event. Women attributed their stress to various factors including situations that they had little control over such as recent significant health crises or the death of a family member; ongoing financial challenges and/or dealing with the pressure of school; or being overloaded in terms of working twelve hour days and/or juggling multiple work responsibilities. Each woman had experienced either a definable period of ongoing stress characterized by multiple stressors or endured a hectic schedule at the time of their MI.

I was also struck with the degree of emotional loss that was evident across women's descriptions. To illustrate, four women acknowledged being impacted by deaths of family

members, while other's described painful separations from significant others (partners), difficult life transitions, loneliness, personal health crises, as well as anticipated future losses. In this sense, much of what women spoke to was about changed, lost, or absent relationships with others.

In response to dealing with adversity, a few women reported adopting the attitude, often passed down by family, of 'don't look back...just move on'. Consequently, these women often immersed themselves in their work as a means to cope. While this non reflective coping style had theoretically worked, current illness restrictions or the seriousness of the MI event forced these women to reevaluate this strategy. I was particularly struck by one participant's story whose determination and strength or character allowed her to survive multiple losses and setbacks. Despite her historical unwillingness to reflect on the emotional pain associated with her losses, Arlene intuitively knew that stopping to reflect was a central piece of her MI recovery and that the GA process was an important vehicle of support.

The issue of support emerged in all of the participant's narratives and dialogue. More specifically, four participants acknowledged having strong support from family and friends during their MI event and recovery. The remaining two women identified lack of support as a central feature in their recovery narratives which also reflected a significant sense of loss. One of these women commented that "no one would want to be with a sick woman," as though her worthiness as a potential partner was compromised since her MI. Evident in her history was the death or loss of several significant male figures. Again, I wondered if women's preexisting emotional issues or concerns are heightened by the vulnerability associated with experiencing a potentially life threatening event.

Interestingly, only two women were partnered at the time of their MI; one woman in a heterosexual marriage and the other in a same-sex partnership. Again, the issue of significant relationships emerged in most of the participant's dialogue.

Women also spoke to initiating self-care measures directed at improving their physical health as part of the early stages of their recovery. For several women, this meant self-referring to a cardiac rehabilitation program and exercising, while for others this included eating healthier and losing weight. Several women also spoke to the importance of trying to manage their emotional stress and suggested various strategies they felt would be supportive of their recovery including living a more balanced and present life, becoming more assertive, taking more time for self, slowing down from previously hectic schedules, and potentially further developing relationships with others. A few participants accessed their spiritual beliefs to help make sense of their illness experience and to guide them in recovery.

Guided Autobiography Theme Two
Your Major Life Work and Recovery from MI

The format for the second session (and the remaining GA sessions) included a group check-in, reading of the theme autobiographies and group feedback, an introduction to the next theme, and a brief group check-out. While Margaret notified the researcher that she would not be attending the session due to illness, Sally did not indicate she would be absent but also missed the group.

Group Check-In

Participants were invited to comment on current functioning and any discoveries from the previous week. Considerable group discussion focused on sharing information and posing questions related to cardiac treatment and individual symptomology. For example, Helen asked participants many detailed questions including "Does it feel different lying on your left side than your right side in bed?" and "Can you feel where the stent is?" Arlene wondered "Does anybody know the statistics on whether bypass surgery always follows having a stent put in?" These kinds of questions were reminiscent of those presented during the introductory session.

A few women described feeling very tired. Sarah reported ongoing sleep difficulties, potentially related to her medications, which have made attending school and completing homework very difficult. She stated that before the heart attack, "I enjoyed being with people, but now I do not. I love to be alone in peace, quiet and the dark." As well, she acknowledged becoming easily angered this week by others and aware of not trusting people, "I think people are just pretending to be nice and kind but they are not and sometimes I feel that everybody is wearing a mask." In part, she attributed her outlook to her traumatic sea bus experience.

Helen also acknowledged feel very tired, irritable and short-tempered, and believed she was fighting off a cold. Having gone to work, despite feeling unwell, Helen acknowledged feeling a sense of 'responsibility' to her students given that their other teacher was also away.

In contrast, Arlene described feeling happy this week and was excited about having just decorated her Christmas tree. She exuded a radiance that was evident throughout the evening. Arlene talked about starting an alternative remedy that is believed to reduce the aches and pain associated with diabetes and fibromyalgia.

While Bev acknowledged feeling sad that a dear friend had died from cancer, she also discussed her recently improved health.

I have felt so well I am just amazed (laughs) and I am really happy about it. I have energy that I haven't had in a long time. It's like I've been dragging an anvil for a long time and I've gotten rid of that and I'm really happy about that.

Having just seen her cardiologist, Bev spoke to the importance of receiving honest and forthright information about her heart health. She had also managed to ask her doctor specific questions that she was unable to think of while hospitalized.

Both the researcher and facilitator shared their impressions of the previous session with group members.

Your Major Life Work and Recovery from MI

In this theme, participants were asked to reflect on their experience of recovery from MI within the context of their life work which could include career or other significant life roles. Sensitizing questions included considering factors influencing their chosen life work, the impact of MI and recovery on fulfilling life work responsibilities, support needs related to life work since MI, coping with obstacles that have impacted life work, and future plans.

Five participant autobiographies will be presented in this section. While Sarah did not submit a written narrative, she opted to dialogue within the group. Consequently, I have transcribed her exchange and included the group feedback. I have also included Sally's brief narrative (without group feedback) which she submitted the following week. Margaret did not submit a written narrative.

Bev.

My career and life work have been altered many times and influenced by many factors. When I was really young, I always believed that I would someday be a nurse. I always believed that I had a nurturing nature but somewhere along the line I decided that I did not want to go into nursing.

Instead I studied business administration and began working for a major company in Alberta in their public relations department. I was in a junior management position and part of my job required me to oversee the bus and truck card ads, to get stickers and posters out to various companies in the province, and to manage a school liaison program.

I met my husband of 32 years. His work was in British Columbia so I left my home, family, friends, and work to move here. I did work for several other well-known large corporations in a similar capacity; however, I never enjoyed my work in the same way as my first major job.

My husband and I decided that once we had a family, that I would be a stay at home mom. That's what we both wanted. In 1976, our daughter was born. Three years later, we had a son. Many of our friends and acquaintances at the time chose to do the same thing. Many of the women were nurses and teachers who put their careers on hold to raise their children.

As a stay-at-home mom, I still managed to be involved in the community in many ways. I volunteered for many organizations, co-taught prepared childbirth classes and continue to take evening classes. When our youngest child was about ten I went to work for the school board. This was the best of both worlds. I could work outside the home but I could also be with my children during the summer and statutory holidays and professional development days. I worked there until several years ago.

In 1998, my father was dying of cancer so I traveled to Alberta in May to spend the last 3 months of his life with him. In August of that same year, after my dad died, my mom was critically injured in a ranch accident. I had returned to my own family only three days earlier so I returned to Alberta to attend to my mom. I wouldn't be able to return home until November.

My job at the school was held for me in my absence and I felt both flattered and guilty. My mom had been injured so soon after my dad's death that I hadn't been able to even mourn his loss. Upon my return home, I found it difficult to return to work, although I have always believed that once I stepped through the door at my place of work, no matter what was going on at home that I gave my job my complete professional attention.

In April 2001, my husband suffered two strokes, one at work and one in the hospital. September 11th took place and my daughter's fiancé fell apart and refused to seek treatment. After much soul searching, my daughter called off her engagement and marriage so we were trying to comfort her too. I took early retirement from the school board because I felt disconnected from what I was doing. I needed some time and space. I needed to take care of myself and my husband.

Two months later, I had a devastating fall, head first fall from the landing of our back stairs and had some of my own physical and mental images to confront. I had been working with a teacher friend of mine who had started a small catering business some eleven or so years earlier. My physical recovery put a halt to my work for several months. I have always been very strong mentally and have always worked hard to confront my fears and concerns. I have a wonderful support network of family and friends and I have never been afraid to ask for what I need.

It's been 3 months since my MI. I help my friend for a couple of hours twice per week with the baking and catering. Baking and creating delicious and nutritious food is something that I'm good at and that I enjoy doing.

What the future holds is unclear at present. Perhaps I will become a full partner in my friend's business and we'll expand, perhaps not. My husband plans to retire in about

a year and a half or so. We may travel and do some of the things which we were unable to do before. My mother-in-law and my mom have some health problems, particularly my mother-in-law who turns 90 years-old in January.

I have not made nor am I going to make any firm plans as many twists and turns in my so-called career path have changed my circumstances and greatly influenced what I have done. I would never have altered my decision to stay home and parent my children, together with my husband. Nor do I regret spending time with dying or ailing parents.

I can never point directly to something that I've published, nor to a building that I've erected, a statue that I have carved, but overall, I have been satisfied with my life. I have raised two wonderful, compassionate, capable, responsible young people who have gone on in search of their life's work. No monument or building could ever compare. I will continue my quest to be the best that I can be, help out where I'm needed, be a loving wife, mother, daughter, friend and neighbor. The need in the community is great, my strength is returning so I plan to do as much volunteering as I am able.

I don't know what the future holds but certainly my husband's health will dictate some of that and his father passed away of a massive heart attack when he was fifty-six. His father had a very successful business and he was a very busy man. He and my husband's mother had always planned to retire and do all these wonderful things. Well they never got to do it and my husband is very mindful of that and given his health situation we both want something different in our life. So where that takes us I don't know but that's where I am right now.

Facilitator: What stood out for you in your own story when you were writing about this theme?

Bev: I don't know really. As I say, I'm quite satisfied with how things have gone. I guess I have a very nurturing nature and so at one time I thought I would be a nurse or a social worker and then somehow I went a different way. But at every turn, even though I haven't actually done those jobs, I'm involved in helping in that capacity.

Facilitator: Yeah it is a really strong life role.

Bev: Yes. That is where it's at for me.

Facilitator: You talked about twists and turns and the job that you loved and made a choice to leave. This sounds so much like a woman's story. For example, loving your job and making another major decision that had to do with nurturing and caregiving and those of kinds of choices based on that value. And the dilemma in that of trying to do both of those things or when you do make the choice sometimes asking 'what didn't I choose' or 'what was the path not taken.' And I think when you get

to a certain age, there is always that question 'what is the path that I didn't take' and is there something still to do about that?'

Bev: My life experiences are so rich. I am very grateful for all of that because I have done so many things. Overall, I am very satisfied with my life and if it ended tomorrow I don't think I would have any regrets. I don't think, 'oh gosh if I had only done...'. I mean there are a few things that I wished I looked at more when I was there but overall I still feel that I have a lot of life left but I don't look at it with regret.

Arlene: That's a pretty powerful statement. Not very many people could say that. It's not just the commitment to that but not feeling that you have been cheated because a lot of people think 'I could have done this and I could have done that' but because of whatever...I didn't. It's nice that you feel filled.

Bev: Yeah. Well it was a choice that was really made. I think sometimes people feel they should do something and so they do that but there is always that part that resents having been forced to make that. My commitment to change what I had originally thought I would do was done freely.

Arlene: Your husband turned out to be a great guy.

Bev: Yeah he is a great guy. He's not the stoical nice guy that people talk about. No, he really is a nice man.

Helen: I would have liked to have your life.

Bev: I feel really blessed actually. I think part of this is that I grew up in a family where I had my grandparents and my great grandparents all either under one roof at one point or in close proximity. When you have that many arms telling you how special you are from morning to night (laughs) it's pretty special.

Helen: A nice thing to experience.

Bev: I wish it for all people but unfortunately it doesn't always happen. As I say, I feel really blessed. My husband also grew up in a really loving and nurturing family and so he's gone on to be a good husband. And that was my goal is that my kids grow up to be good partners and that they be responsible people and whole people and not always feeling that there is some part missing.

Facilitator: That's a life work role that is obviously very strong for you; the nurturing role and the parent role.

Helen.

I am a teacher. I am a learner. This is my life's work and my passions. I did not always want to be a teacher, in fact, I didn't really know what I wanted to be other than loved

and love in return. My daughter led me to the world of children and I transformed into an elementary teacher at the age of thirty-nine.

However, there's more to it. Actually, my mother taught me the value and importance of creating everyday. She showed me how to make the everyday ordinary into extraordinary and I became an arts teacher. Not just visual art but more an approach to the whole philosophy of learning through engaging one's hands and creating; a process that motivates learning in all the subject areas.

As my career developed, my passion for the arts in education grew and for a few years, politically the system seemed rich. And then came the cutbacks and of course with that went art and music programs as if none of it mattered. Luckily for me, my career is charmed and I'm always able to find a niche myself and I flourish. I'm continually growing and developing as an arts educator and arts in education advocate. Still it takes its toll, the continual justification for the arts in a system of incredible bean counting for accountability about that more valued and important subjects in our curriculum. Meanwhile, children are killing each other, are overweight and don't listen or don't know how.

So I'm a very hard worker and very passionate about what I do as a teacher. I teach kids, adults and teachers about thinking creatively and in the process maybe do some healing. When we create we're happy. I don't think any of this had anything to do with my heart attack...well maybe the passion had something to do with it.

I've pretty well achieved my career goals to date and I'm in the process of creating new ones for my retirement years. At present, I'm becoming a musician. I'm very goal oriented and I keep on learning and achieving. Luckily for me, I had never been sick in my career so I was able to take 4 months off. I slowed down for about a year and a half after the MI but now I'm pretty focused again on achievement. So, I think my challenge is to learn to live more fully in the present moment...more balanced and yet, at the same time, continue to grow and develop and maintain my passion. I often wonder if I keep myself so busy because I'm alone. Probably...but it's not so bad. I really enjoy all the things I endeavor to do.

My career does present some challenges. Teaching itself is exhausting work. It takes a lot of energy. And I feel sometimes locked into it. I'd like to live in a smaller town but I'd have to start over with seniority so I'm planning to leave teaching by the age of sixty. I started late and so I'm a bit behind pension wise and financially, but I guess it's all relative.

There have been lots of changes in my career. I've had many different teaching experiences and I've never found any of them to be too much. They've just been another opportunity to grow and usually interesting. In fact, I've liked all the changes that I had very much but I must also learn to discover who else I am or what else defines me besides teaching.

Arlene: I think you make an excellent teacher.

Helen: Not today. Go away and leave me alone.

[Several women laugh].

Bev: They need to see that too...that you are a real person and that you have days where you are not as energetic or you're not feeling well or whatever. Because sometimes I think kids think you come with the room.

[Several women laugh].

Helen: But it is hard to function as a creative person in a system that isn't a very creative system. It purports to celebrate or support creative thinking but it doesn't do very much in it as a system to spit out really creative people. I mean it just perpetuates itself.

Researcher: Are you saying that being a creative person in the system is hard work?

Helen: It is draining. The advocacy role that you have to continuously play is draining. Will we never understand this? This boy was just killed on the weekend. How can this possibly be happening in our world or in our schools at this time? I find it amazing. At the same time, politically we are ordered to count more beans. Some of it is very valid but lots of it is totally ridiculous in order to fulfill these goals that are also imposed.

Facilitator: I heard that your story was about passion.

Helen: Oh yeah, I'm passionate about it (laughs).

Researcher: And now the frustration because you care that much. But also there was something you said recently; the frustration of feeling that you are alone in this and the frustration because the system isn't balanced. I had this picture of the system as the body. So how do you manage that stress?

Helen: I'm very fortunate because in my career although this is happening, I still am singled out to do wonderful things. I get to do all kinds of creative things personally.

Facilitator: I think it is also important when you are doing heroic work or pushing the system that you need to find other kindred spirits. When you do it alone you are part of the weight of that trying to change things.

Arlene.

In my early twenties as a single mother, I knew that the only way I could give my children a home was to do a job that a man could do. So after researching the work field, I decided to go into real estate.

For 25 years, I pursued the next sale. I was always hustling the next deal. I worked long hours and tried to put some of my earnings back into myself through education. I bought a home for my children and myself, owned my car and was able to have my own schedule which was good with the kids. I also ended up spinning my wheels a lot. Twenty-five years ago when you sold real estate you didn't have the cell phone or pagers and when the phone rang you had to run. All I lived on was commission. Because of this sometimes I didn't spend as much time with my children as I wanted to. I was always on the go.

When I went to Alberta with my future (second) husband, we opened up a music store which became the biggest of its kind in central Alberta. Mind you at this time, I still had a real estate company in Vancouver which I came to six times a year to handle things.

I loved dealing with figures and loved the idea that I didn't have to hustle all the time. Customers came to us because we gave them excellent service. Our prices were reasonable and soon we had customers traveling for miles to shop at our store. I loved the job but it wasn't my dream, so when the marriage broke down I left.

I went back into real estate when I returned to British Columbia but my heart was not into it. I slowly moved more into property management but soon created my own company doing mini vacations while working with merchants at a local resort. I really enjoyed what I was doing.

My diabetes went out of control, mainly over the stress of the relationship I was in at the time. So because of my health I was unable to work and then moved down to Vancouver to be closer to my family. I lived on my savings for about a year but I could not work. I was so close to being hospitalized so many times. It was really hard.

But once I started feeling better, I was wondering if anyone would hire me. Here I am 50 years-old and I decided I don't want to go back into real estate. I wanted to do something different. So I did up my resume and went out and hit the road and within three days I had a job [the group cheers] Hurray, someone had faith in me.

After 6 months, I had another job offer that I decided to take and did that job for two years. I loved it and felt like I was getting paid to be on a vacation. I decided to create a discount/loyalty program that became very successful and spent hours designing a booklet and had it printed to be put in every unit of the resort. The program

was expanded to several other resorts. All my hard work paid off and I was given a promotion. I was asked what I wanted out my career with my employers and I said I wanted to manage one of our resorts. He then asked me to become his administrative assistant going in to that route by the back door. Another goal would be met for me.

Then all hell broke loose when I had my MI. Because the job was just given to me, I felt I could not take any time off. Everything was at a stand still waiting for my return to work. I returned to work and found I tired very easily. I knew that I had to keep going and with patience I would get better. I also knew that once I was stronger I had to start exercising as it is very important to help to heal my heart and make it strong again.

My heart attack has left my fellow associates with the feeling that I am not physically strong and that I probably should stay in the position I am in now. That really pisses me off (voice lowers). It's true at this point in time but it really bothers me. But I also feel that I probably would not be as good as a resort manager at this time because it is a very hard job.

I'm impatient with my health and angry that it has made me step back to reevaluate goals. I also feel that I won't be able to retire as I need the good health insurance to cover my prescriptions. Not only did I have a heart attack but I'm a diabetic and I'm on the pump and all of this cost thousands of dollars. So I'm very expensive. I'm not an easy keeper any more (laughs). I am going through a bit of a transition to become more logical on what I would like to see in my future.

Of all the illnesses that I have had to deal with, this heart attack has really hit me the hardest. One of the reasons is probably my age as it is not as easy to bounce back as you do when you are younger. The other is that it came so unexpectedly. No warning. It is truly scary to think that you could die that easily, and there is nothing you can do about it. Nothing you can do to make it not happen again. Because of my diabetes, my heart was damaged. The very small arteries were plugged and could not be fixed. They are still plugged. It has made me feel weak and vulnerable.

To sum up, I feel very fortunate that I was given this job prior to the attack, because I probably would not have been offered it after. It is a better job than my previous job, only because it does not put pressure on me and allows me not to over do it. But can you imagine what I could have done with good health?

Helen: Yeah (nodding). Wow!

Facilitator: How was that to read for you?

Arlene: It was hard to get around this because it really bothers me. I have been on my own as you have for a lot of years (looks at Helen) and we don't have somebody we can get help from

physically, emotionally or financially. So if I'm unable to work I'm sure I can go on disability but I have bills to pay and I am very committed to pay my bills.

Helen: But it's also interesting your projection for your future in terms of the medications you will need for the rest of your life and if you have a good plan that will cover that because that's huge.

Arlene: It's really really important.

Facilitator: So a shift in priorities in a way and the way you are thinking. You were very loud and clear "I'm pissed off this is happening and I don't want to slow down" but I also heard you actually planning how to do that.

Researcher: I kind of hear one foot in one foot out. Sort of you saying "I have gratitude for having this job because I need to be different."

Arlene: I need a pay cheque. I'm really glad I have it.

Researcher: But I mean in terms of your health. You said before if you were doing that other job there is no way you could have kept up.

Arlene: I wouldn't have been able to give it the attention and I wouldn't have been as good at it as I am now. You know the person that replaced me is doing not even a fifth of what I was doing.

Researcher: Right, so I suspect that you would do any of your jobs in a passionate and creative manner because that is who you are. Again, that passion in whatever you choose to take on.

Helen: So is there a chance you will get to run one of these resorts maybe next year or as your confidence grows? It hasn't been that long since you had the heart attack but maybe in a year it may look like you are pretty stable and reliable and your health is reliable and that you might be able to do what you wanted with the one of the resorts.

Arlene: Well I've got to do something because I don't get paid enough (laughs) and I need more money because I've only got so many more years to live and work before I have to retire. And I won't be able to successfully retire. Why am I even worried about retirement I don't have enough money saved anyways? So I'll end up going on welfare and I don't want to do that. So why am I worried about it? (laughs). Why am I worried, I can't do everything? You work all your life for retirement and then you need to get a divorce and you lose everything and you have to start all over again. And then you get sick which makes it hard to start over again.

Researcher: All these obstacles.

Arlene: Yeah and then not only that. Now it's the medications. It costs me so much money for medications in order for me to survive. It would take my whole pay check once I retire with what they give you because I was self employed for so many years I don't have a big pension plan because all the money I had invested is gone because the stock market took most of it.

Helen: So do you have a plan now where you are reimbursed for your medications?

Arlene: They pay for it.

Bev: You certainly are really powerful. You've had so much to contend with but you've always managed to find a way to achieve whatever goal you set out for yourself. I have no doubt that you will do okay in the future too. I really think you have a lot of strength and I think even though your body has let you down you will still do whatever you need to do to get along.

Sarah: I think you shouldn't be worried. You have a home and you have a good job. I think we lose the moment because we focus on the future. You cannot do anything about the future.

Arlene: You can have goals for your future.

Sarah: Yes but having goals is different than worry (group nods). Sometimes I'm really worried because I can't see my future. When I was young I didn't have any worry about my future. Now I have heart disease. And I have nothing here. My money is blocked. In my country they say if she wants her money she has to come back here. I'm worried about my sister. They are really suffering there. You have your freedom. You can talk. You can make decisions for yourself.

Arlene: You know something, with all the illnesses I've had in my life I learned a long time ago, when I wake up in the morning it's the best day of my life. I live it to the fullest and I live my life to the fullest everyday...everyday.

Sarah.

Sarah stated that she had difficulty writing about her life work given that she currently does not have a job. She briefly spoke about her experience of living and working in her former country and the differences of being in Canada.

I wanted to take a course that would allow me to help children. I didn't want to stay here; I wanted to go to a country where they need people to help. I already had experience [working with children]. In any event, they told me that I should take accounting because I have lots of experience. And sometimes I would like to have my job which I had before. And sometimes I just want a small house in a small village beside the forest and the beach and do nothing but cooking, baking and cleaning home (laughs). I told you the first time I had to clean my home I was crying and complaining to God 'what happened to me that I have to clean' (group laughs). I really used to have a life of luxury. Now I understand it is not a big deal.

Facilitator: It is all part of the process related to how you cope with big change in your life. How do you do this?

Sarah: I am always telling myself 'you are not scared here.' When I first came here I saw the police and I was scared. But now I feel safe. I like them. In my country, people are worried to

have a connection or talk to or get close to them. They [would] escape there but not in this country.

Helen: Is your country Iran?

Sarah: Yes. It wasn't like that before the revolution, my country was better than here. It was really good. I loved that country. But after the revolution it changed.

Helen: When was the revolution?

Sarah: Twenty-three years ago. But if you go to my country you'd think it happened last week. The government doesn't let people get over the revolution. They keep it alive.

Researcher: So in terms of you being here, it sounds like you are reorienting yourself to life as it is Canada and realizing that for instance the police are safe rather than dangerous.

Sarah: Yes. Many things I wasn't familiar with here but I felt unsafe with when I was in my country. For example, I was fighting with government. We always had to do something to fight back.

Facilitator: So I'm also hearing it's like realizing different goals that are possible. Like for you it could be about feeling safe and what that's worth to you because that is what I'm hearing in everybody's story.

Sarah: Yes absolutely. And though I'm not making money now...in my country when I was there, I was one of the successful women. It's not easy getting such a job but I had the best job. I worked for four bosses. And now all of them are my best friends. They send me a birthday gift every year. They have stayed in touch with me. They have said whenever you come back here your job is safe with the highest salary.

Helen: Why don't you go back there?

Sarah: Because I can't. I don't know. If they catch me...if they know...

Arlene: There has to be another change in her country before she is safe to go back.

Sarah: I can go back if I marry here and then they cannot prove anything. But if they caught me or my doctor they would kill me...because abortion especially for women who are not married is adultery.

Helen: They would kill you if you went back?

Sarah: And my boyfriend and nobody could socialize with my family. They would be isolated by society. It wouldn't only be myself. And I know if they caught me I cannot stay quiet. For sure I would talk because it's not easy. They beat you. They torture you. They don't believe you because it's not like here.

Helen: They would kill you because you had the abortions?

Sarah: Because I've had sex without marriage and I've had abortions.

Helen: Oh because of that.

Sally.

My life's work was altered before my MI due to arthritis. Now it's something I do on the side. My life was more impacted by the arthritis which became so severe everything was difficult. My family helped and so did my roommate. By the way, I was a hairdresser for 30 years. That is what I wanted to do since I was about 5 years-old. I loved going to work. I still enjoy doing hair.

The arthritis seems to be under control. I don't have as many flare ups as before. The first time my heart hurt it was the arthritis or pericarditis. The doctors say that's why after the MI I still feel sore. But one day at a time. Sometimes, I'm fit as a fiddle and sometimes I cannot move, but I try to stay positive. I have great support from my family.

Given that Sally did not read her narrative in the group, I have included the following observations. In reading Sally's narrative, I was aware of the continued brevity of her writing and the absence of emotional expression. I was left wondering about the potential impact of having lost her livelihood as a result of deteriorating health and whether she had any thoughts or feelings about future plans related to her life work.

I initially viewed Sally's narratives as being resistant in terms of completing the task of reflection and writing introspectively about her life experiences. I now wonder whether these fragmented stories reflect her coping style as she compartmentalizes and concretizes aspects of her world as a method of containment.

Group Check-out

Following the reading of participant's narratives, women were encouraged to comment on their experience of the session. Two women spoke of the value derived from participating in the sessions, while others acknowledged the strength of character evident in all of the participants.

Arlene: I find it very healthy to go through these themes and really think about what we are writing down or what we are doing or what we are talking about. I know it is (healthy) for me because I don't sit back and reflect on anything. I go forward and I don't look back. It's something that is lacking in my life.

Facilitator: Thank-you for keep coming because you have said that all along and you keep coming. Good for you (Arlene laughs).

Facilitator: Anything you are going away with tonight Sarah.

Sarah: A good time and good conversation and I'm talking...especially with my English.

Earlier, Sarah acknowledged that it was "getting easier" for her to talk since the first research session. "After [Sally] heard me talk about the sea bus, she told me 'we should go together on the sea bus.' I felt that I had somebody. That was nice and I will never forget that." Unfortunately, in her absence, Sally did not hear the impact that her support had on Sarah which she perceived as being restorative.

Helen: There are strong people here.

Bev: That's what I've noticed. Very powerful women and we've all shared the experience of a heart attack and although there are variances in that we all have that common experience. It's interesting to see how we're dealing with that.

Helen: It seems that each one of us has our own passion about our lives. Yours is your family (looks at Bev); yours has been your work and your health (looks at Arlene); mine has been my work; and yours has been your whole life (looks at Sarah)

[The group laughs].

Facilitator: What I'm really hearing tonight is 'I want to live my life to the fullest and in that how do I work with this.' Like having to reorient or rethink in the face of that.

Helen: None of us are weak characters; like there isn't one of us that is wishy washy or a weak character. Each one is very strong and forthright in what their beliefs and values are.

Before closing, the facilitators also suggested rescheduling the research meetings to accommodate for the holidays. While the participants appeared to favor this plan we encouraged the group to revisit this decision the following week when all of the group members were present.

Researcher's Process

In general, I felt encouraged that the group was becoming more cohesive and comfortable with the research process. As well, it was clear from women's feedback that they were valuing the experience of participating in the group and finding it helpful in terms of better understanding or clarifying different aspects of their experiences including their illness and recovery from MI.

At the same time, I felt concerned about the two participants who had not attended this session. While Margaret had notified me that she would not be attending the session due to illness, I had the sense that she was not being fully candid regarding her continued participation in the group. I also felt uneasy that Sally had missed the session without contacting the facilitator or myself. When a cardiac patient fails to show up for an appointment there is always some concern that that person is not well. In Sally's case, I also recalled her expressed discontent with the group process the previous week. My counsellor intuition wondered if her

absence and lack of contact was an act of noncompliance; synonymous to an angry client that arrives late or misses her session. As a researcher, I felt concerned that the absence of two participants would impact the quality of my data collection. In this case, my concerns surrounding the commitment and compatibility of participants with the research method speaks to the importance of potentially creating a more sophisticated participant screening procedure for future GA groups.

Debriefing sessions with both the facilitator and research advisor were enormously helpful in terms of addressing these current issues. Given that I had screened women for the group and conducted the initial interviews, participants tended to defer to me around issues of organization and authority. In order to balance this power differential (and encourage participants to be accountable to the facilitator as well as myself), the facilitator and I decided that she would contact the absent participants to discuss their participation status in the project. I agreed to deliver the next GA theme to Sally and retrieve her missed narrative. During this visit, she reiterated her concerns about discussing personal material and her tendency for shyness but still agreed to continue attending the research sessions. I reiterated the GA writing and group guidelines around setting boundaries around disclosure based on personal limits.

As well, I explored the power dynamics that appeared to have transpired with Sally and Margaret over the past couple of weeks. I was able to tease apart my concerns around not wanting to offend or ultimately lose participants if I were to directly name their reluctant behavior and how this was interfering with addressing these concerns in a straightforward manner. This dynamic is analogous to a common counselling scenario where clients describe their fear that if they name the truth then the other will leave or abandon them. Upon reflection, I more clearly understood the importance of directly voicing my concerns within the group and in doing so modeling for women the importance of finding their own voices within the research group and in other areas of their lives. Moreover, this experience gave me a greater appreciation and understanding of when women (and men) often choose not to question or challenge health care providers for fear of jeopardizing the quality of care received.

Researcher's Interpretations of Theme Two

For this session and the remainder of the project, the group was moved to a more spacious meeting room that all participants reported as being more comfortable. In general, there appeared to be an ease and cohesiveness amongst the participants that was not as evident as in previous meetings. My sense was that the four attending participants were particularly engaged in and committed to the GA process and represented a good working combination of group members. Alternate explanations could include that these women were feeling more comfortable and safe in their roles as participants or perhaps the group had

developmentally reached its working phase. Interestingly, the two absent group members had also not brought their narratives to the last research session. Nonetheless, there seemed to be a greater depth of discussion as women were engaged and interested in each others stories and dialogue surrounding the life work theme. As well, there were many moments of levity and humour within the group that was mostly absent from the previous week.

Women also clearly expressed an appreciation for and understanding of the value of the group as well as for each other's individual resources and strengths. In this sense, although women's stories and contexts were diverse, they were able to connect to each other's shared strengths and resilience. Embracing and reinforcing these resources and strengths and their will to thrive was an important aspect of providing feedback tonight. The group ended on a highly positive note as participants were clearly committed to attending the remaining sessions.

Several important observations emerged from participant's narratives and dialogue. In general, I was struck by the clarity and passion in which women defined their life work. All participants' narratives demonstrated strong commitments to both career and care giving responsibilities. Three women, two of whom were single mothers, described balancing their evolving and successful careers with parenting their children, while the other two participants worked at careers as well as being heavily involved with care giving family and/or significant relationships. They used positively framed words such as "driven," "dedicated," "goal-oriented," "determined," "independent" and "successful" to describe themselves in relation to their life work.

Most participants' life work was also strongly connected to their life values and beliefs. One woman's creative passion translated into her work as a creative arts teacher and advocate. In this sense, her emotional and psychological growth was intertwined with her evolving creativity and work career. For another woman, her drive to survive as a single mother took her into the male world of business where her tenacity and survival skills enabled her to become successful at most entrepreneurial ventures.

I was also struck with women's descriptions of how much of themselves they gave in terms of time, emotional energy, focus, and commitment to their careers, families, and other relationships. Their ability to put 'other first' appeared to be both a personal strength and a liability as women often reported ignoring their own needs, or feeling "stressed," "overwhelmed," and/or "worn-out" at times. As previously mentioned, most of these women described being excessively busy, stressed or overwhelmed for a period of time prior to their MI.

The impact of MI and recovery on women's life work appeared to differ amongst individuals. Two women reported having pre existing health concerns that had, at times, affected their ability to work. More specifically, one participant considered her arthritis to have

been more debilitating than her MI and responsible for preventing her from working at her chosen career. Another women's career history was characterized by several cycles of high achievement and stress followed by significant health setbacks including her MI. Two participants described taking a significant amount of time off school and work to rest following their MI, while others gave themselves little time before returning to their responsibilities. Despite feeling tired and weak, one woman felt obliged to fulfill the responsibilities of a new job a week after hospital discharge, while another woman also returned to her role as homemaker and part-time employee approximately one week following her MI. Although she described feeling physically able, she had been given virtually no guidelines for post-MI care from health providers. For these women, immersing themselves in their familiar work roles may have served as a means of coping with the disruption and distress of MI despite potentially putting themselves at risk for further cardiac injury. Moreover, both of these women alluded to feeling responsible or guilty if they did not fulfill their respective employment and familial responsibilities.

While some participant's narratives were suggestive that the impact of MI would likely not deter them from engaging in their life work but may result in needing to modify how they conducted their lives including attitudes towards work. This typically involved a trial and error process of learning what they could manage physically and emotionally as fatigue, weakness, occasional angina, and often a shattered sense of confidence (fear) in their bodies or health were thought to be primary obstacles in comfortably resuming their daily activities. As well, for most women it also meant enacting a dramatic shift in self-care by becoming more mindful to diet, exercise, and a focus on stress management including letting go of unrealistic expectations and/or perfectionist tendencies (e.g. always having a clean house or never saying no). Given participants' busy lives, the notion of slowing down was unfamiliar and did not occur without effort. Interestingly, only one woman had returned to a similar pre-MI state of busyness which she attributed to having greater confidence in her body (and heart) after 3 years of MI recovery.

One participant however, described feeling "very angry" that her MI had left her feeling "weak" and "vulnerable" and believed that her work colleagues now perceived her as being less capable of doing her job. Evident in this woman's narrative was a strong sense of unfulfilled dreams related to her career but also a deep injury to her core identity construction by which she had previously defined herself as being a capable and successful (career) woman. This was akin to her body (her heart) betraying her "capable" self. Considering earlier discussions with this participant, the association of being weak and vulnerable may be tantamount to her feeling like a failure or victim; a role likely to elicit a sense of shame and anger.

Moreover, several participants discussed their future life work with an air of tentativeness or understanding that they may have to reevaluate current goals to fit with potential health limitations. For example, one woman suggested that not reaching her ultimate career goal was forcing her to reevaluate her life and life work in a more realistic way. Another woman described her concern of not having the financial support of a partner and the sacrifices she may have to accept in order to ensure a steady income.

While various questions emerged from participants' narratives in relation to their future including "What in my life has contributed to having a MI?", "Do I keep busy because I'm alone?", "What do I need to do differently?", and "How do I make the changes I need to make?", they also seemed to connect women to a greater awareness of personal meaning and an understanding of 'How does the experience of MI fit into my life and my understanding of who I am in the world?' As one woman suggested 'How do I live a more balanced life when I have been driven for so many years? Another woman asked "How do I now want to live my life given what I know?"

Guided Autobiography Theme Three

Significant Relationships and Recovery from MI

The format for this session included a group check-in, a brief discussion of the location of women in their healing process, readings of the theme autobiographies and group feedback, and an introduction to the next theme. A group check-out was not conducted.

Sarah notified the researcher that she would not be attending the session due to angina. Moreover, Margaret eventually contacted the facilitator to officially acknowledge her withdrawal from the study after several attempts to reach her. She reported having difficulty with increasing anxiety and found the demands of the group emotionally overwhelming.

Group Check-In

Participants were informed of Margaret's decision to withdraw from the study and were encouraged to share their reactions. This brief discussion was framed in terms of Margaret practicing self-care and served to segue into exploring how women were generally experiencing the group.

In general, Bev, Arlene and Helen each indicated that their experience of participating in the group and the GA process was both interesting and rewarding as they collectively offered the following comments, "I am really comfortable doing the writing;" "the group is making me reflect and deal with issues I wouldn't normally deal with," and "journaling is a really good process and I'm finding it very helpful." In contrast, Sally expressed her ongoing struggle with understanding the value of the reflection and reminiscence process. The facilitator very briefly

reiterated the purpose of the GA process in the context of better understanding women's recovery experiences.

Both the facilitator and researcher also took the opportunity to review with participants strategies for providing constructive feedback to each other following the reading of the theme narratives including "I" statements and framing comments from the other person's perspective.

As well, the group renegotiated the research session schedule as all participants agreed to take a break beginning mid December and then reconvene after the holidays in early January for two more sessions and a follow-up group.

Women's Location in the Healing Process

To further contextualize their experience and discussion of the themes, participants were asked to identify where they saw themselves in the recovery process. Sally easily identified herself to be at the beginning of her recovery and related this closely to her work and progress at the Healthy Heart program. While concerned that her arthritis would hold her back she has seen great improvement and progress in terms of gaining physical strength and mobility. She suggested that moving through recovery will involve continuing with her current routine.

Interestingly, Arlene did not locate herself in her recovery from her MI given that she has been more worried about her diabetes becoming unstable rather than her heart. She did however suggest that the MI has been a significant wake-up call for taking her diabetes treatment much more seriously. While she acknowledged feeling limited by and having ongoing difficulty coping with the fatigue associated with the heart attack, she felt that with perseverance and hard work in the cardiac rehabilitation program, she will get physically stronger.

Bev estimated that she was half way through her recovery process and feeling "quite strong." She acknowledged resuming her daily activities about a week after hospital discharge in part because she felt good but also "because I didn't know any better." In addition to attention to diet, exercise and mental well-being, not feeling afraid of her heart or by the information received from her cardiologist represented a sign that she had made progress. Not thinking about her heart anymore would indicate a more complete recovery.

In contrast, Helen acknowledged feeling closer towards the end of her recovery process but questioned if there was an end point. "Once there is a MI, there never is a life like there was before the MI because you know that it is always possible." Feeling physically stable and confident and aware that the MI doesn't only define her identity has been an important marker in her recovery process. Although she has regained her bodily confidence over the past 3 years, Helen suggested that the healthy image of herself will always be connected to the experience of having the MI.

Significant Relationships and Recovery from MI

In this theme, participants were asked to reflect on their MI recovery in the context of support and significant relationships. Sensitizing questions to help participants reflect on this theme and generate self awareness included examining the relationships that have shaped MI and recovery, the impact of family rules around support, family coping styles, support needs facilitating recovery, asking for and receiving help, and the quality of relationships with health providers.

Five participant autobiographies are presented. While Sarah was absent for this session, her completed narrative has been included without group feedback.

Helen.

Sometimes I feel as if I've always been alone and other times I feel I've always been loved. My parents were wonderful and I always knew from the "get-go" that I was loved and cherished. I loved them and still cherish my 94 year-old mother but they have always been old. This may not seem like much but it had a huge impact on my life. I made every decision alone as they were too old to really understand and as they got older, they grew harder of hearing. This became one of my senses of being alone but there was never a lack of love. I could talk to them but they couldn't hear or understand the workings of a modern young person's life when they were retired.

My siblings are older by 10 years or more and we're not particularly close and yet there are no bad feelings for the most part. We all just have different lives and not much in common. Even though we shared the same parents we didn't share the same home. They had all left home by the time I came along. We don't force it and we share responsibility for our mom.

Growing up was more like growing up with grandparents. It's hard to tell who had the power. My dad earned the money but my mom ran the house. They didn't fight, and worked together well for over 60 years. I would get comfort from both of them. They were often tired and quite relaxed and happy to stay at home. I had lots of energy and I had to go, go, go. Like I've said, I'm a busy type of character. So their age was both a struggle and a weakness. It was stable and quiet and peaceful but boring.

We weren't rich as money was quite tight but I didn't want for much either. We had a strong work ethic engrained in us. I usually looked at younger parents with a lot of envy and fuller families seemed more exciting.

I was popular at school and soon had my first love and my first broken heart. Puppy love they called it not true love. It was about 4 or 5 years before my heart felt ready to love again. (Interestingly, this person has come back into my life lately which is something quite special).

And then I met my husband-to-be at the tender young age of twenty-two. He was so sure of who he was, what he wanted, how to get it and I was lost about most everything. He loved my creative spirit and I was inspired by his. All went well for a while. I gradually gave away my power, never really taking responsibility for my own future or my own self development. He was enough to keep me involved and we built his career until I finally got pregnant and our daughter was born. And for the first time in my life, at age twenty-nine, I knew that I was supposed to be a mom and a homemaker and I loved it except when I didn't because it was challenging at times with no stable income. My husband was a musician, which is a difficult yet wonderfully exciting world, but to make money he had to travel for months. Anyway, I poured all of myself into my husband and daughter and after 13 years he lost interest.

When he left I was devastated. I was very broken and very sick and very suicidal and depressed for about 3 years. I was also incredibly scared of life. I was a 35 year-old single mom with a 5 year-old daughter and I was a cocktail waitress. It took me a good 7 years to mend that broken heart and still today I can remember.

I then met a beautiful gentle man who would touch my heart like a poet but I was curious about women and met an incredible person called Letty. Life went into overdrive with difficulties and challenges but I loved her with all my heart. This relationship took an enormous toll on my heart in many ways that I would never have anticipated. That's where I was when I had the MI.

Sally: That's great going back to school at thirty-five. How long did it take to get your teaching degree?

Helen: I went back to school and became a teacher when I needed a real job to keep my daughter. My husband left when I was thirty-five and I was a teacher by the time I was thirty-nine. I failed my first practicum because I was under so much stress because I had a 5 year-old, Japanese students living with me to pay the rent, and I was working in a bar and going to school. That was hard but not that hard.

[Group participants shake their heads in amazement at Helen's story].

Researcher: Not heart hard.

Helen: No. I have a strong work ethic so I can do that. I can work day and night. That wasn't the hard part. The hard part with Letty was that she came from a very dysfunctional and angry family. She had a lot of anger. In my life up to that point I didn't experience what angry meant even though I had been angry with my husband. I didn't know really what anger could do to a person and how it affected her and in turn affected me. My mom and dad never fought. My family was stable, quiet, and peaceful. Her anger was right underneath her skin and volatile

which made it challenging. She also got sick very often and I'm sure she got sick because she was so angry. The first time, two, three or four times you have compassion and you jump in to do what you have to do. A couple of years down the road it just got harder and harder to deal with her being sick. She had big sicknesses like thyroid problems or another time she stepped on a nail in a barn and almost lost her foot. This caused me a lot of stress. I couldn't fix the stuff that went wrong. I couldn't walk away. I could I guess but, I didn't because I loved her and I still love her. That's not even to mention the whole gender stuff and sexuality business and same sex partnership stuff which is very complicated.

Facilitator: Were you aware of anything in your experience of reading your story

Helen: I'm aware that in relationships, I tend to be a rescuer or I just jump in. The relationship obliterates my life like my husband whose family and everything was way bigger and important than mine. I have a great relationship with my daughter and her life doesn't overshadow mine. It's not equal because I'm her mother but it is healthy because she's her and I'm me and I don't lose myself in her. But I think I lose myself in all the other relationships. And it's odd for me because I think I'm a strong independent character except in relationships when I'm not.

[Participants are intent but quiet].

Facilitator: I had an appreciation for this big heart you have. Almost like this naïve kid too. You called yourself a rescuer and I was struck with how you just jumped in and you wanted to be loved.

Helen: A rescuer who likes to fix things and try and make things calm and boring (laughs) which comes back to my family. I don't like conflict. I don't deal with conflict well in a relationship. I will do all kinds of contortions to get out of conflict. And with Letty it was conflict all the time.

Whether it was anger or illness there was always conflict.

Arlene: Did your relationship with Letty end when you had the heart attack?

Helen: No. She came back from her farm back east to take care of me and she was wonderful. She took wonderful care of me and I healed really well. She was just wonderful. It was interesting because of the heart attack she learned how to manage her anger better as a result. She didn't cure herself but she managed to control her anger in a much more positive way. Our relationship didn't really end until maybe 2 years after the heart attack.

Arlene: Do you believe that your heart attack was the cause of your relationship ending?

Helen: Partly. Partly I'm not willing to live in a relationship that is that difficult no matter how much I love that person. Every inch of the way was a difficult struggle. After our relationship ended she went back to the farm and then stepped on the nail. Because her medical wouldn't cover her back East she came back here and lived with me for 6 months. It was my turn to help her because she had helped me. During that time, our relationship healed, not to the point of us coming back together but, at least we were not angry at each other. We learned to love each

other again through that experience of her almost losing her foot. We are no longer together but she is my best friend. We have been very close because of things we've shared.

Arlene.

I have a strong sense of family. I hate to see my family need anything and always want to help them with whatever they need. I am the one in the family who is approached to help make any major decisions.

The family was at a water slide park when we got word that mom was in the hospital. The doctor was concerned and asked all of us to gather around. They ended up sending her by helicopter to Vancouver where she had stones removed from her liver. It was very painful and the doctors were not sure if she would survive. After she was released from the hospital, she came to my home where I nursed her back to health.

Another time, I was driving down the highway when I received word that my brother had driven off the road while driving back to his home and had broken his neck. I turned around and went back and stayed with him until they wheeled him into surgery. Once I knew he was okay, I left. When he was told how I had stayed with him he was so grateful. He had a rod bolted to his neck and is doing fine.

Last summer, my sister was diagnosed with ovarian cancer. It was devastating when the surgeon told me that they found cancer and on her liver. We started educating ourselves and found that she had a real battle to fight. I was with her every step of the way, but found it so emotionally draining to be faced with the thought that my sister may not live. I prayed for her everyday, as did a lot of other people. Then out of the blue her doctor told her she would not need chemotherapy or radiation. The cancer was diagnosed as a un-cancer which is very rare. We felt this was a genuine miracle and were very thankful.

Then came the day when my blood sugars went right out of whack and I developed ketoacidosis. When I was transported to the hospital, I was able to let my mom know what was happening. My sister was very concerned and drove down to States to stay with me while I was in hospital. We were all very surprised when told that I had had a heart attack. She slept in the same room and I was so grateful. I was so scared and do not know what I would have done if left alone. She helped me to digest what was happening to me and to help make any decisions that I had to make. My sister was able to keep everyone informed, taking that pressure off me. My family all gathered around to be with me.

I feel so lucky to have my family. I may have been unsuccessful in personal

relationships but I have a strong family. We find any information we can so we can share with each other to help understand our health concerns. We talk about it until we do not need to talk anymore.

This wasn't the way it was when we were growing up. Our mother was so busy that she did not have too much time for us. There was a lot of competition with each other and fights often broke out. I used to beat the living daylights out of my sisters. We were given chores and responsibilities and were expected to do them. I don't think we felt much love growing up. Our father was there but didn't really do much for us. I remember as a young wife my mother giving me a blanket for Christmas while she gave my two younger sisters a lovely pantsuit. I was 18 years-old and felt left out (shakes head).

It's funny how you re-live your parent's lives. I hated the fact that my mother was always so busy but ended up being the same kind of mom. I wished I had learned at a young age that if I wanted happiness I had to give it. Nobody wants to hear angry words. Instead people like hugs and told they are loved. I do this more now the older I get. I wished that I had told that to my children every day of their lives. I think I could have been a better mom if I did. I was too busy chasing the almighty buck. I was a single mom and too proud to take a hand out. Why weren't my children more important than my pride?

I lost my son when he was a baby, but I lost my daughter as an adult. I don't understand why but she's gone and the pain hurts me every day of my life. This is her choice and I must respect it. When I was in the hospital she phoned everyday to see how I was but would not talk to me. I believe she loves me but doesn't like me. Should I hate her? Should I forgive her? It would be so much easier to forgive her if I only knew why. This is the heavy weight that I always have in my heart. Along with losing her, unfortunately I am unable to see my grandson. So, I have lost him too. This is the kind of life changing pain that you go through and are never really the same when you come back out the other side. You tend to put barriers up, so you aren't hurt again.

I cherish the time I can spend with my other daughter and my granddaughter. They like to come over and hang out with grandma. It makes me feel good. My daughter often phones just to see how I am doing. I feel so blessed to have her. I tell them every time I see them how much I love them and give them a big hug and a kiss. My daughter doesn't expect as much from me as she did before my MI. She took it very hard and doesn't want to anything to upset me. My granddaughter cried all day when she was told about my MI. Now it is her that comes to me to give me a hug, rather than me going to her.

My family has always thought that I work too hard and blame that for my heart attack. They do not believe I look after myself sufficiently. They want me to put me first always in order to look after myself because they tell me that they are not ready to loose me. If I don't look after myself, who will?

One thing we have all learned from the experiences we have been through is never miss the chance to tell each other you love them, always hug when you say goodbye, and make more time for each other. Good things do come out of catastrophes.

[Group members nod their head in acknowledgement].

Helen: How old is your granddaughter?

Arlene: Eleven. My grandson is six. My daughter walking out of my life is one of the biggest things that has affected me.

Helen: Just like that? And you never really understood why?

Arlene: No. When she was pregnant with her son she wanted me to be with her because her life revolved around me and she was always with me. She became ill and we almost lost her and the baby. But the day he was born she was a different person coming out of that operating room. She's not the same daughter I raised. I didn't even feel comfortable around her. She's not really a nice person anymore.

Helen: Is she still married?

Arlene: Yes and her whole life revolves around her husband. At first, I blamed him because he is very possessive of her and he didn't like the closeness that we had. She developed bipolar after she had the baby and I didn't understand that at all. She broke up with her husband but I guess with counselling he now understands her. Apparently the counsellor said that "she won't be sick if she is not around me." So I guess she is blaming me for her problems but if she feels good why not see me? But who am I to force the issue?

Helen: That's really painful. Wow.

Arlene: At first I blamed myself but I know now it's not my fault.

Facilitator: It is a very big loss and I am sorry to hear that.

Arlene: It's very painful.

Facilitator: I really understood that you have learned from the things that you regret. You also said several times about the importance of telling people you love them.

Sally.

My mum and dad both made decisions together. I could call either one for advice or if I wasn't well although sometimes you just want your mum. They taught us "always to come to your family and they will always be there for you" and they have. At first, my dad thought I would bounce back from the MI but now he says "don't worry about anything

just take it easy.”

We have always been close. My sister and I were more like twins. We did everything together but her husband was very jealous of our family's closeness.

When my younger sister died, my third niece was almost 3 months old. My other sister wasn't allowed to come out to Vancouver for the funeral so she went to church in Toronto. She has never gotten over that. Her husband was emotionally abusive but as soon as he turned his anger towards his kids she left him and started a new life in Vancouver. She ended up being a drug addict and had cleaned up but this year has been particularly bad.

This year my dog Mitou died. My sister was going to stay with me that night but she got tipsy and went on a rampage.

Dad had colon cancer and had it removed but ended up with pneumonia. Mum was diagnosed with lymph cancer and had that removed. My sister was always like mum's best friend and driver because I wouldn't drive but she wasn't there for my parents when we needed her.

I left my job to spend more time at the arthritis clinic and to help everyone. I cleaned my sister's place again hoping she would stay home and learn to enjoy her home again.

Then I got sick in July of this year. I called a friend across the road to see if she could look after my new puppy. She came right over and called my sister and 911. My sister then called the family and came to hospital. I told my mum “not to worry I'm okay.” They were wonderful in the hospital including the doctors. I had very good care and lots of friends came to visit. They were all shocked.

I'm not good at asking for help because that's always been what I do for everyone but I'm learning a bit. My best friend who lives in Calgary often calls now and if I feel too stressed I call him and we always have a good laugh or we cry. We did after my dog died. Some friends are quite surprised at how close the family is and how we are always there for my sister. We not only love each other but we like each other.

I'm grateful for the Healthy Heart Clinic. I never realized I would enjoy exercising. I just wish I could afford to go to a gym. Maybe at some point I will. I just wish my sister could be fixed as easily.

Sally: I didn't elaborate too much. It was a hard year with people getting sick.

Facilitator: Your mum and dad getting sick and your other sister using drugs. And then you talked about your sister that died when you were younger.

Sally: Nineteen years ago. That was hard on the family. My other sister has never really

accepted that. We now call to say "I love you" and hug and kiss but you stop doing that. You know that you still love each other so when you do say it you know it's really special.

Helen: What did your sister die from?

Sally: (pauses) Suicide. She fell off the balcony.

[The group expresses their surprise and condolences].

Researcher: I am sorry to hear that. So 19 years ago you would have been around 30 years-old. And she was your younger sister?

Sally: (whispers) Yes, she had just turned twenty-four. Suicide usually happens between the ages of seventeen and twenty-four. I thought if she had just stuck out through that year maybe she would be here. My mum never believed it was suicide. She went to psychics and this one clairvoyant spoke through the dead. My sister apologized and said "mum please forgive me...you have to believe me it was an accident." So mum is fine. That was closure for her. But my other sister has never had closure. A couple of years ago we even had a native ritual where everybody says something. I was quite upset going with her. She always wanted something special on the day she died. (Sally yells and raises hands) "She died get over it...it was a long time ago." It really hurt me so I said "this will be the last time." Nineteen years that's enough.

Researcher: So you were frustrated with her still grieving.

Sally: Yeah.

Bev: Did she get to go to the funeral?

Sally: No she didn't. And that was probably a big thing.

Facilitator: Is she still talked about by your sister and your mum?

Sally: Yes often.

Facilitator: It strikes me that people grieve differently and in a family that can really trigger different people. Sounds like there is frustration between you and your sister around how you have dealt with it differently.

Sally: Yeah but do something during the year. It doesn't have to come up over and over (raises hands in dramatic gesture). My sister never had support from her husband. But it's like she dwells on the whole thing like an excuse. People that have seen her in the last month were shocked at how she looks because of the drugs. But she says she's got an excuse, "Oh my dad's got cancer and my mom's had cancer and my sister had a heart attack and it's been so stressful." But she's not been there for it. She ran away and did drugs. It's been stressful on us and hard reaching out to try and get her back.

Facilitator: The thing that really struck me too was that you have your difficulties in asking for help. What helped you to do that?

Sally: I don't really say "I feel awful today could you go get this" or "I'm just too weak can you change the bed could you come and help."

Researcher: How would we know that you might need help?

Sally: Ask my best friend. I don't know (laughs). I'm tired from the heart attack but I needed a lot more help from the arthritis when it was really bad. My best friend did everything. He stripped and made the bed.

Facilitator: And how did your best friend know to help?

Sally: (pauses) I said I couldn't do it. He knew I couldn't do it.

Facilitator: Right, you actually said it.

Sally: I had hands like baseball mitts they wouldn't do anything. And we lived together at the time. He cut my meat for me. I felt stupid. I had it so long I started getting depressed. I tried to hide in front of him but he saw it because I wasn't who I used to be and he made me go to the doctors to get some help.

Researcher: It is hard to hide depression.

Sally: I tried but that took a lot of energy. I was just drained. I think taking a lot of happy pills has helped it. Because maybe it helps the stress and the depression because mine is stress induced. It's not coming on as much now.

Facilitator: I want to encourage you to ask for help or say what is happening to you because I know it sounded like your best friend was willing. I think people want to help and usually do when they know what needs to be done and especially in your family it sounds like there is a lot of love and a lot of care.

Bev.

The members of my family are emotionally and physically strong people. They have always seen what needs to be done and have rolled up their shirtsleeves and just got it done. As I grew up on a working ranch, there was little time to sit and brood about something, nor to procrastinate, nor to take sick time if it could be avoided. We would just "suck-it-up" and get the job done. While I am glad that I learned a strong work ethic from this early modeling and that I'm dedicated to whatever I'm committed to do, I feel guilty if I am unable to fulfill my obligations. I guess it was always understood in my family that if you made a commitment to something that "come hell or high water" you "should" see it through and you "ought" not to allow illness, emotional upset or major life changes discharge you from your commitments or obligations. These "rules" have impacted my recovery from MI in that soon after coming home I basically started up where I'd left off. I was doing my household chores and my social obligations about a week after and I even resumed working with my friend for a couple hours a day three or

four times a week. And I took charge of my physical recovery by joining the Healthy Heart Program about one month after my MI.

I have always had a close bond with my family when I was growing up. I also have had a close bond with my husband and children. There is very little about myself that I have not shared with my husband. He has seen every side of me; my hopes, fears, desires, frustrating situations, things that make me laugh, things that make me sad, etc. I have several really close women friends with whom I can confide and also share my hopes and fears and my stories, without fear of ever being judged. They're just terrific and such a life line for me.

I used to have great difficulty asking others for help. I was always glad to help others but for some reason I couldn't ask for help for myself. About the time that I had children, my attitude changed. I don't know why but I still try to do as much as I am capable of doing by myself but now I'm not as reticent to ask for help when I need it.

My relationship with my family is most important to me. I feel loved and secure and valued for who I am when I am with them or when I am not with them. I feel that love and that connection. They have offered much needed support, care and encouragement during my recovery.

I also have two really close friends who have serious life-threatening chronic health conditions. I have confided in them about my MI, the treatment I received and the plans that I have and the steps that I have taken to ensure my best possible recovery. Their continued support has just meant so much to me.

The one area where I was somewhat surprised and disappointed that I didn't get the support I needed was from my husband's family and their reaction to my MI. No one from his family called to ask how I was or if I needed anything. I told my husband about my feelings. My mother-in-law would talk to him but she never talked to me. So I just told him I felt really disappointed that no one had asked me directly about how I was feeling. He immediately took up my cause and spoke to his mother about our discussion (laughing). I didn't expect him to do that and actually I don't really know if I wanted him to. I was just expressing what I felt. But I guess I'm kind of glad that he heard what I was saying and I'm glad that he values me for the person that I am and that he wanted his family to express concern even if that meant reminding them that I wasn't on top of my game.

I was very satisfied with the treatment provided by the paramedics who attended to me and provided early treatment. I was treated respectfully, as credible and I was treated promptly. I didn't feel that some of the doctors and nurses treated me as well. I

was not provided with all the information that I felt I needed regarding my angiogram/angioplasty. My post-op care wasn't very stellar either and I felt that I was discharged far too soon. (Laughing and gesturing) I just felt this foot on my behind and "see ya...here's your binder and go now." They gave me this binder from the Heart and Stroke Foundation and they said "go home we fixed you" and those were the words they used. And I thought well isn't this just dandy.

[Group shaking their heads in disbelief].

Overall, I am glad that I was near a primary care hospital because I have had other experiences with my mother of being transported in a critically injured state over really rough roads for miles and the fear of not reaching her destination and I'm glad I didn't have to make a long journey. I am also happy that I was attended to promptly and that I didn't have the mental anguish that some patients experience when they are waitlisted for months at a time before receiving treatment. I am also grateful that the money was available to pay for the very expensive procedures, blood tests, medical supplies, etc which I received. I am most grateful for the Healthy Heart Program. I have gained a great deal of knowledge about my MI, the drugs that I take and what diet, exercise and emotional support that I received there.

Bev: As I said I was frustrated because I felt that I didn't really address these things fully but I got some of it off my chest. I guess especially about my husband's family. His mom is a good person but she's a strange one sometimes and I guess I wasn't surprised by her reaction in a way. She pulls me in by one hand and pushes me away with both but I thought it would be different after the heart attack. She always compares anything I have to her other family members and they have always had it worse.

Facilitator: It is so unhelpful when people do that.

Bev: The reverse is also true in that they have always done something better.

Arlene: I would have loved to have been raised in a family like yours.

Bev: I hope that I have done that with my kids. I was very lucky and I know that. I didn't know that at the time because I just thought that all families were like mine. Even when I met my husband I still thought all families are like mine (laughs) until I actually met his family and then I knew. So that was quite a rude awakening.

Bev: I hope that we have done those kinds of things with our own children. If they're sitting around like this one day that they can feel the things that I have experienced. It would be interesting to be a fly on the wall and see what their perceptions are.

Researcher: Again, I am struck with how central family has been for you and the value that you have put in providing for your kids the same kind of solidity that you have experienced.

Facilitator: I was struck that you were able to voice your feelings with your husband and I just get the sense from you that you are slowly asking more for what you want. Right off from the beginning you were talking about the kind of family you came from is loving but it is also a "roll up the sleeves, suck it up and get the job done" and how you just went back into that right after your heart attack. I was left puzzling with that for you like where does that leave you? How is that for you?

Bev: I guess that is what I have always known so I guess that doesn't seem foreign to me. Friends said "you shouldn't be doing that...you're making beds?" Yes (laughs) and I think "oh maybe I shouldn't be doing that." But that's what I have always done so I guess the guilt would be all consuming if I didn't do that because it's so much a part of what I do. I mean if I really couldn't manage it physically I wouldn't do it, I guess, but obviously I could so I did (laughs).

Arlene: What really struck me with what you read and I think it is so unique and so nice is that you spoke to your husband about the fact that his family didn't phone you. Instead of making excuses for them, like most people would do, he just went and spoke to them because they were wrong and that is so special.

Bev: Yeah it is.

Facilitator: It's interesting about support. Sometimes when you just ask for it you get it.

Arlene: Well often in a relationship you talk but they don't hear what you are saying and sometimes it is so hard to try and get what you say across because they are so busy making excuses rather than just listening to whatever you say. I just think it is so nice that you have that kind of relationship. It is very special. I have been through a few relationships in my life and I have always been looking for the one that you have. I won't be in a relationship if it is going to be stressful and I have had some terrible relationships. And I find that it is not stressful being on my own and I'd rather do that than have the relationships that I've had unless I find one like you've got because you have a very special relationship. And I know you know that too (laughs). You don't see it very often.

Bev: I do.

Sarah.

My father always made decisions but after we grew up my brothers mostly made the decisions. Then they married and moved out. I was twenty so my father gave me the responsibility to make decisions.

My next sister and I were very close and we had to decide what was best for the family. When making big changes we always gathered the family and decided what was best for everyone. My father always told my mother "let the children make decisions so

that if something happens to us they could manage their lives and they could support each other" although she disagreed. I never liked to talk to anyone about my problems and I always found a way to handle my problems without asking for help.

The strengths of my family are still in loving, caring and helping each other, and keeping the family close together even when we are far from each other. The weaknesses were that my parents always cared about their sons more than their girls. I had a feeling that my father wasn't happy to have five daughters and I never believed that he loved his daughters as much as his sons. In my culture, this is very common, but my father was not like the other fathers. He was very open-minded.

We were a happy, noisy family and our friends and relatives always called our family the best family. My brothers were always there for us. They took good care of my parents and my sisters. At least three times a week, we had dinner together even after my parents passed away.

Everything was good until my older brother passed away 2 years ago. I was not there but I can feel the gap between the families. After my sister and I moved away everything changed. They are still close to me but the relationship between my sister and my sister-in-laws changed.

My father's heart attack and financial problems were major problems in my family. After my brothers finished university and had good jobs we always had financial help from them. When I started to work we didn't have any more financial problems. In fact, after I got a promotion, I had good earnings and the chance to invest some money until I came to Canada.

I learned not to ask for help from anybody because whenever I needed something there was a major need in the family so I learned to accept whatever was possible to have.

My last relationship with my boyfriend was the most important to me because it had the worse impact on my life. I realized I have should never trust any man. He cheated on me and after that I am not able to trust any man. I lost my confidence and I am afraid of being in a relationship.

Since I came to Canada the only close friend I have is my roommate. He is my best friend's son and he is always there for me. He has been taking care of me whenever I need him but he is a man. All of my life, I have always avoided talking about my life and needs with men even my brothers. How can I feel comfortable talking to him? But I know he is my brother now and he always says "I am your brother."

The greatest difficulty I had after my heart attack was financial problems.

I had to slow down so I stopped full-time school and have taken part-time [studies]. The student loan people asked me to pay back my loan and the grant because I [was no longer a] full-time student. My graduation was postponed; I have no job and I had no more money left; I have to pay for my medication, rent, expensive food diet, transportation, and my tuition. I should not be nervous, worried or angry but I am angry and sad that nobody is helping me. For the first time in my life, I asked for help but no one helped me. Now I really believe that I must not ask for help.

My family does not know that I had the heart attack. I have needed financial and emotional support. I felt supported from the Healthy Heart program and my teachers, but I never got financial support from an organization or a person. I think women need a specific organization to help them. A woman like me has nobody here for support and she really needs support from the government.

Given that Sarah did not receive feedback in the group, I have included my response to her narrative. I was particularly struck with the tension between Sarah's needs for support (especially while living in Canada) and her reticence in asking for support. It appears that her two recent experiences of asking for help and not receiving what she needed (during her MI and with the student loans office) has further perpetuated her belief that she should "not ask for help from anyone" and that "people won't help her."

I was also struck by the loss of support including the death of her parents and older brother, changes and divisions amongst the family, feelings of betrayal by her former boyfriend and a lack of current social support outside her roommate. Embedded within this narrative may be a subtext suggesting that the significant men in her life end up leaving her. Given that she doesn't talk about her experiences with men in her life, I was curious that she didn't mention any close relationships with women.

Researcher's Process

In general, I felt energized by tonight's group. There was a striking depth of authenticity and honesty expressed in participant's narratives and group dialogue as women talked about some of the 'messy' relationships in their lives within the context of MI recovery. I was particularly aware of the trust necessary for women to tell these stories which was a testament to the safety and care that had developed in the group over the past month.

I felt particularly moved by Helen's willingness to share with the group her experience of being in a same-sex relationship at the time of her MI. I was also struck by the quality of care she had received from her female partner during the initial phases of her recovery despite the conflict that was evident in their relationship at the time. While the literature focusing specifically on women and cardiac illness suggests that women's best support following a significant

cardiac event does not necessarily come from partners or spouses (see Arthur et al. 2001; LaCharity, 1997) there appears to be an assumption that all participants are heterosexual with male partners. To date, I have not read any literature documenting the quality of support received from female partners of female heart patients. One can only assume that given women's roles as caregivers that their support following a MI may be more sensitive to the specific physical and emotional needs of their female partners. Interestingly, two other women who demonstrated an interest in participating in this study also identified themselves as being in same sex partnerships and acknowledged the superior care received from their female partners during and after MI. This is clearly an area of research that has yet to be explored.

In addition, I was relieved that Sally had returned to the group given her absence last week and in view of Margaret's decision to withdraw from the study. I was also moved and encouraged by Sally's willingness to engage in the group by sharing her experience of family relationships including the events surrounding her sister's suicide and her role as caregiver in the family. I felt grateful that she allowed herself to have the experience of group support around such a tender issue.

My initial response to Margaret's withdrawal was disappointment given her valuable contributions in the initial research sessions, and regret knowing that there was an unused space for a younger voice to articulate her recovery experiences. More importantly, I felt concerned about Margaret given the obvious lack of support and resources in her life. Despite the fact that I may have thought this group would have benefited her, I respected her ability to say no despite feeling overwhelmed and to define her own boundaries around self-care. While I was aware that she was not able to talk to me directly, I understood from the facilitator's discussion with her that she was concerned about letting me down as well as the group. I left a voicemail after the session to acknowledge her decision and the following email several weeks later.

Hi Margaret,

I have been thinking about you a lot lately given that I am up to my ears in data analysis for my research. The group is meeting on Monday for our last follow-up session. Having reviewed the first two sessions which you attended, I am sorry that you felt you could not continue and felt uncomfortable talking to me about it. You made such great contributions and comments and so well represented one younger woman's experience of having a MI. Anyway, I hope you are well and I that you have access to support around heart/health. Although free services seem to be harder to come across these days there are some out there which I am aware of. If you are interested in this information about these please feel free to contact me. Take Care.

Following the group, I arranged for a collaborative debriefing session with both the facilitator and my research advisor. It was a rich and integrative experience as multiple layers of voice and perspective emerged from the dialogue between the three of us. We discussed our individual experiences of participating in the group and in working with each other, group dynamics, and further clarified the GA themes and sensitizing questions for the remaining research sessions. Consequently, I felt that I gained a better understanding of my facilitator's experience in the project and identified areas of improvement for conducting future GA groups.

Researcher's Interpretations of Theme Three

Tonight's session ran smoothly as the group was rich in terms of participant's narratives and personal processing. Again, I was aware of the increasing depth in which women were sharing within the group. Having two participants absent also increased the time available for individual and group dialogue. In addition, this was the first week that Sally read her completed narrative to the group and openly engaged in a dialogue about her recovery experiences. In general, the group appeared to be negligibly impacted by Margaret's decision to withdraw from the study.

As a result of tonight's group process, I became particularly cognizant of the extent to which the participant's experience of and understanding of their narratives (and personal process) was influenced by the facilitator and researcher. More specifically, in one exchange Sally was encouraged to take responsibility for having difficulty asking for help but was also supported in realizing that she had been assertive enough to ask for help from a friend while debilitated with arthritis. Similar opportunities for facilitating women's awareness occurred across the research sessions and were a valuable and therapeutic component of the group process.

In general, various characteristics were evident across women's narratives and dialogue. Most participants described having a strong connection to their families who represented a major source of support in their lives and at the time of their MI's. Three women articulated specific qualities which constituted family support including "feeling loved," "safe," "valued," and "respected," as well as "a sense of togetherness." For some women, family support also meant actions such as sending prayers, advocacy, and education (e.g. about one's illness). One participant, whose sister stayed with her while she was hospitalized, identified the following components of her support as helpful including her physical presence throughout her hospital stay, reassurance, assistance in decision making, liaising with family members, and obtaining information from care providers.

Another woman described having strong family messages about "turning to family" during difficult times, but offered several examples where family members did not appear to be

emotionally present during family crises. Interestingly, at the time of her MI, she chose to contact a neighbor friend who then contacted her sister.

Evident in all participants' narratives was the clearly identified role of caretaker as women demonstrated numerous examples of exceptional (almost heroic at times) devotion to the care of others. Embedded within some of these narratives are often examples of women putting the needs of significant others before themselves to their own detriment. For one participant, her role of caretaker was evident in her intimate relationships as the needs of her partner(s) tended to "obliterate" her own. While she otherwise experienced herself as a strong, independent and highly successful career woman, she puzzled at her tendency to "lose" a sense of herself in her relationships. This narrative reflects a larger cultural story about women in relation.

Another participant described having a very stressful past 5 years as a primary caregiver dealing with serious family health crises, including the death of a parent. Despite being aware of intermittent physical symptoms and significant weight gain, she attributed these to the stress that she had weathered over the past several years. Having the MI forced her to attend to her own failing health and to improving how she cares for herself.

Similarly, other participants described having difficulty asking for help from others given that they have always been in the role of caregiver. One participant described feeling angry and frustrated as a result of struggling with setting boundaries with friends and family around caretaking and emotional support. For this woman, I suspect that this struggle was impacting her recovery process given how "stressed" she reported feeling and that there may have been a connection between her symptoms of depression and perhaps a chronic sense of feeling powerless. Interestingly, her "struggle" appeared to be evident throughout the research project as she demonstrated growing irritation with the reflection process, missed (two) research sessions, and submitted several fragmented and incomplete autobiographies. Despite her frustrations she did not withdraw from the group and linked her involvement in the study to her commitment to the research and the researcher, as opposed to her own process of recovery and as a participating member of the group.

Two other women who claimed to be more comfortable receiving support from others described feeling "guilty" when they were unable to fulfill their homemaker and employment responsibilities respectively. One woman reported being able to let go of expectations around household but not career responsibilities and resumed work a week following hospital discharge. In contrast, the other participant understood that family rules of always fulfilling responsibilities impacted her recovery as she returned to the pace of her daily routine about a week after her MI. Another participant chose not to tell her family that she had had an MI to

prevent them from worrying despite her own lack of social support.

All participants wrote about significant losses associated with relationships to partners and/or family members. More specifically, these losses included unresolved conflict with family members, terminated love relationships, the death of significant others, or leaving family due to immigration. In general, I was struck by the depth of loss and emotional pain that still exists for several women. Interestingly, some women described their relational losses in terms of the pain suffered in their heart. One woman measured her broken heartedness by the time taken to heal from intimate relationships, "it was 4 or 5 years before my heart felt ready to love again," and "it took me a good 7 years to mend that broken heart." Moreover, she described the relationship she was in at the time of her MI as "taking an enormous toll on my heart in ways that I would never have anticipated." Another participant referred to the "heavy weight that I always have in my heart" as a result of the "life changing pain" endured as a result of her daughter's decision to sever contact with her.

Surprisingly, only a few participants mentioned the care they received from medical professionals in the discussion of this theme. While one woman briefly mentioned receiving "very good" care from hospital staff, another participant reiterated the dramatic division in care received by paramedics and hospital staff. She used words such as "very satisfied," being treated as "credible" and with "respect" to describe the care offered by paramedics and which fit closely with her family support values. In contrast, her descriptions suggested that she did not receive adequate information from hospital staff nor did she have the experience of compassionate care which appears to have solidified in her illness narrative as a harmful component of her recovery experience. Another participant spoke to the powerful experience of receiving "honest" information about her heart from her cardiologist. In this sense, information can be construed as a means of including the patient in the treatment process, facilitating coping and regaining a sense of control, and as a means of lessening the power that is inherent in exclusive (medical) knowledge thus offering the opportunity for human interaction and dialogue.

Guided Autobiography Theme Four

Self-Care: Dealing with Stress and Personal Needs and Recovery from MI

Tonight was the last scheduled research session before taking a 3-week break in lieu of the holidays. The group has agreed to reconvene in early January. The session included a group check-in, readings of participant narratives and feedback, a brief check-out, and an introduction to the next GA theme. Tonight's group comprised of Bev and Sarah. While Arlene had previously indicated she could not attend the session, Helen and Sally were absent without notice.

Check-In

While waiting for other participants to arrive, Sarah described to Bev the impact of depression on her daily living as well as the changes to her life roles since leaving her country of origin. In contrast, Bev described having a recent incident of chest and back pain after pushing herself too hard and questioned if she was having another MI. This led to an important dialogue about setting reasonable limits for herself and her struggle with perfectionism. Both women's dialogue was very relevant to the issue of self-care.

Sarah: I'm not busy. I don't have any responsibility here like you do.

Bev: Yes you do.

Sarah: I have nobody here.

Bev: But you are working. You are putting so much pressure on yourself doing this program and trying to look after yourself and trying to recover. You've got a lot of stuff on your plate.

Sarah: I think I am doing nothing and I don't have responsibility but I am tired while I am like this. Before my home was clean, shiny, everything was organized but now...no. I can't do it anymore. I could clean my home in two hours. Now I am working and I have to take a rest.

Bev: A friend of mine became quite depressed after she had her baby. One thing that was helpful for her was to really take care of herself. She just took things in small bites and with all of us supporting her and encouraging her and taking care of the baby she started to feel more like she was in control. Maybe you are just trying so hard to do everything you think you should be doing.

Sarah: I'm not doing anything. Before I cooked now I don't cook. Even if there is nothing to eat and I'm dying from hunger I don't like to cook. I don't like to clean. I don't like to do anything.

Facilitator: I'm curious if you heard what Bev said to you?

Sarah: She told me I have to move step by step and then rest which is what I always do.

Facilitator: What was it like to hear her say that to you?

Sarah: (long pause) I think she doesn't understand. She believes I am doing something but I am not doing anything.

Facilitator: So you can't bring it in. It is hard for you to hear it. I can hear it but it is hard for you to take it in. It's hard to believe I guess for you.

Sarah: Hard to believe I'm doing something?

Facilitator: Yes

Sarah: Maybe. Yeah because I think when I don't produce anything...when I don't make money or I am not in a relationship with anybody...I don't have love...I don't feel I am useful anymore.

Facilitator: The usual things that you are used to measuring yourself by are not going on right now.

Sarah: When I was in my country, I always helped people. I had really big responsibility taking care of my mom...not doing something physically but emotionally. I was satisfied being there with my family and friends. But here, whatever I do, I am not doing anything like that.

Researcher: So you don't recognize your life here. You don't recognize you in your life here.

Sarah: Exactly! I think that I don't belong anywhere. I am not in relationship with anybody. I have no life because I used to love people around me. Everyday and every night people came to me. My nieces and nephew came to me if they had a problem. Here...I really do nothing.

Facilitator: I guess what I noticed and what I heard was you being very critical of yourself; like being mean to yourself; like ganging up on yourself.

Sarah: Yes (nodding her head) because I feel like I am two persons. One of them is always telling me bad things like "You are nothing...what have you done in the past 5 years?"

Researcher: That critical voice and giving yourself a hard time and telling yourself that you are not very good is very characteristic of depression. After awhile, people sometimes start to believe that voice as the truth rather than just messages that you tell yourself.

Facilitator: It's interesting what Sarah experiences and other people who are seeing you. When I hear your stories and the importance of love and family and relationships it may not be the way you experience yourself right now because you have been through a lot of big changes. We see that you have done a lot since you have come to this country. Basically starting over and it didn't sound like it was your choice entirely to come here in some ways and there's a lot that you miss about home. Since you value relationships of course it would very hard to be here and away from people you love.

Bev reported having a very busy week including participating in a charity event that she had committed to and "needed to honour."

Bev: I probably overdid it on Friday night and then Saturday night as I thought "oh, I'm having another heart attack." I had pain in my back and in my chest and that went on for a while and I used my Nitro that I haven't been using. My husband was really concerned and I am leaving tomorrow on my trip. He said "Should I contact my doctor...what should be happening here?" but we talked about it and really there is probably not much that can be done. Sometimes these things happen. I know that I was trying to organize many things and just really busy and probably really overdid it (laughs). Without being put through a whole battery of tests again there probably isn't definitive answers. Sunday I gave myself permission to rein it in a little bit.

Facilitator: How was that?

Bev: It was better but even tonight I am not A-one. But other than that I am looking forward to going tomorrow.

Facilitator: I hear that you were reading signs and how you made sense of them.

Bev: I am usually aware of what I am able to do and I usually work to that limit but I know that I really did more than what I really should have (laughs) so I'm sure that has caused some of this.

Researcher: So Bev when you say you did more than you should have do you mean going, going, going where you don't get a rest?

Bev: Yes. Doing just one more thing...like "oh let me take that." Anyway...not a good idea.

Facilitator: Last week when we were talking about significant relationships and the messages in your family were to just soldier on and just do it. That makes me wonder how hard it is not to do?

Bev: Sometimes quite hard because I used to set such high standards for myself and I imposed so much on myself that nobody else had to and I think that was difficult at times. I started to let some of that go when I had kids because even the best laid plans would just fall apart and I started to realize that what I was doing was not healthy. I expected so much of myself and in doing that I also expected a great deal of others and I was sometimes disappointed when certain things didn't happen. So I knew in order to model healthy behaviour for my children and in not placing those expectations on them I had to let something go. I had to start in small ways. It was really difficult but I think in the long run I'm much healthier for it mentally and physically or I probably would have had a heart attack many years ago. But there are still times when those old voices come back and "you must" and "you have to" and if I don't really rein that in then I am right back to that place (laughs).

Researcher: So it takes a conscious effort.

Bev: Yes it does. It's so much better than years ago. I was just so hard on myself and expected so much and now I can actually think "well it didn't work....this is what I planned but it didn't work okay I know the next time." (looks at Sarah) When I hear that you are not doing much I hear that you are. When I was expecting so much of myself sometimes I didn't value what I did or who I was and that's where it is really important to remember that you are loved and someone loves you and you are valuable for what you are doing.

Facilitator: It's so interesting that concept of valuing yourself and it comes up so many times as women too that we are taught to look after other people and especially when you have had something life threatening like a heart attack. It really calls on you to put yourself first as a matter of survival and that could be a completely foreign idea like "I don't know how to do that."

Dealing with Stress and Personal Needs and Recovery from MI

In this theme, participants were asked to reflect on how they experience stress and tend to personal needs and self-care within the context of their recovery from MI. Sensitizing questions to help women reflect included exploring family messages and gender rules related to self-care, signs and symptoms of stress, past and present coping styles, stressful aspects of MI

and recovery, ways of coping with MI and recovery, current stressors since MI, current needs for self-care, and the experience of asking for support.

Five participant narratives have been presented although group feedback is missing for those women who were absent from the session.

Bev.

I have typically always been a patient person. I am usually able to cope with most situations; however, I have found that during the last several years I react more negatively when there is a great deal of noise and activity in my immediate vicinity. I find myself becoming somewhat agitated. I can't deal with excess noise and commotion like I was able to in the past. I usually try to remove myself if possible to a quieter area. I find walking particularly helpful, or I really enjoy bathing. There is nothing as soothing as a warm tub full of water, infused with some lovely fragrance to calm me and help me to feel in control again. I also like to read and more recently, I've taken up Tai Chi.

Since my MI, what has been most stressful is anxiety over the deteriorating health conditions of my mother-in-law and even my own mother. My mother-in-law will be 90 years-old in January. She is very frail. She still lives on her own even though she really isn't able to do so without help from our family, especially my husband, other family members and support from the community care workers. Often she does things, which could be dangerous for her or could even potentially end her life, so it's a constant worry for us. Is she safe? Do we need to drive out there to check on her? Often we will get a call later at night that she has gotten in over her head about something. My husband, who is still struggling with the aftermath of three strokes, will have to get in his car and drive to her home to help with whatever the problem. His mother refuses to even consider putting her name on a waiting list for a care facility. She is partially deaf but won't consider using a hearing aide. She has severe arthritis and has great difficulty walking but insists on using a walker, instead of her wheelchair. She is unable to shop for herself and gather her own mail but insists that she is living independently. We don't want to see anything happen to her so this causes a great deal of stress for us. There isn't much that we can do about it at present. Unless she has a major fall and fractures a hip or her mental state deteriorates she will probably continue to stay where she is.

As well, holiday times and special occasions have become somewhat nightmarish for us because we want to insure that she is included; however, she is terrified of falling and doesn't really want to leave her apartment. It is a major undertaking to get her into her wheelchair and to transport her to her destination. She places so many restrictions on where she is willing to go and what she willing to do that some of the joy of special times has been replaced with anxiety and tension.

I just try to be extra kind to myself before any such times and try to cope as much as possible. What I can't change, I try not to worry about too much but sometimes I come home with the worst tension headaches. My husband knows this, but he is caught between a rock and hard place. He is a loyal and devoted son. He loves his mother and he wants to see her happy and as healthy as possible but he also wants to please our family too. I know that this is at times overwhelming for him and then I worry about his health as well. We talk at great length about our feelings but there is no easy solution. We also talk with friends who are experiencing similar problems. They also have sick aging parents and are having to juggle their needs with that of their families and their own needs as well. What is to be done?

There is no clear or definitive answer. We just have to keep talking to each other. We find time to go out for dinner or go for a walk together. We hug a lot and sometimes we cry together out of our frustration.

I have a strong faith in God. I am very thankful for the richness and the fullness of my life. I am thankful that such a good, kind, generous and loving man is my husband. I am thankful for two wonderful children. I love to spend time with them. I like them as people and enjoy taking with them. I love that they are dedicated to their jobs, and loyal to their friends and to our family.

I am trying to take care of myself by taking my medications as prescribed. I try to eat sensibly and plan to start a supervised, sensible weight management program after the New Year. I joined the Healthy Heart program at a local hospital and I feel energized to exercise again. I have learned to relax more and give myself permission to let go of things, which are beyond my control. I don't feel the need to be such a perfectionist anymore. I used to feel really guilty if I sensed that anyone that I loved and cared about was unhappy so I would try my best to rectify the situation, sometimes at great personal cost. I have come to realize over the years that each of us is responsible for our own happiness. I contribute what I can and I just leave the rest up to the individual in question.

What do I need right now? I don't really know. I am able to ask for support from my husband. He listens with understanding just as I listen to him. Sometimes he is too protective and worries too much about me – I tell him about that too. I just keep following the road to recovery. I'm not sure where it will lead. It's just one foot in front of the other, one step at a time.

Facilitator: What was it like to read?

Bev: It was okay. This has been an ongoing process for me not just since my MI but before as I said earlier I was such a perfectionist. I was a control freak (laughs) and everything had to be perfect and so it's been an ongoing learning process for me. Sometimes I succeed and I am really happy and able to follow my plan and other times it fails miserably and I go back to those horrible old ways (laughs). But I keep working on it.

Facilitator: I have been struck by what strength you have in your positive attitude. Perfectionism is something that can drive you and it is just endless and I appreciated the way you reframed things and talked about what you appreciate and what you are thankful for.

Sarah: I think she is doing really well and she looks happy. I always see that. I see how you love your husband and your family. I think whoever has such a family and husband...I think probably must be happy. No one is without problems but having a good family, loving them, giving them comfort or supporting them it must make you happy.

Bev: I think it certainly helps but I also think that for a time, I didn't like myself very much and no matter how much my husband loved me, the fact that I didn't like myself that much...he couldn't love me enough. I think that is what I'm saying here; that I had to let go of some of those old habits of expecting more than what was reasonable of anyone. I placed so many expectations on myself and when I couldn't meet those self imposed demands I didn't like myself very much and I thought I should be doing more. Having children and also recognizing that I couldn't keep that up or the person that I love the most was going to be driven away. I try to put myself in his shoes now and it must have been very hard to try so hard to love me and then to have me think "I'm not enough, I need to be more." I think by having that attitude I could have pushed him away. So it was a good thing that I recognized that (laughs).

Facilitator: That's very powerful. It's almost like a choice you made at some point.

Researcher: Hearing your story, I was also struck by the intensity of your ongoing worry and concern about your mother-in-law.

Bev: It's overwhelming at times. She thinks she is living independently, but she isn't. She is almost agoraphobic and won't leave her home and she is not happy with what's done. There are so many things. For my husband, I worry about him because he is not well. He is living on borrowed time himself. His sister lives 10 minutes away and she has just declared that she is having a life and so then it falls to us. The pressure is overwhelming at times and the responsibility; even planning this time away, even though it's 5 days is frustrating.

Facilitator: I hear the frustration in your voice of resentment and anger?

Bev: I don't resent it, but I worry about her. She does really strange things. The worry just consumes so much of our life now and I just think, well, there is no solution because if we say to her, "Could you consider putting your name on a list?" Because you can't just parachute into a place and she insists on living there and it would be so much more convenient for us if she lived nearer to us but she won't consider moving back to Vancouver. So we are caught, we are powerless sometimes to change the situation.

Facilitator: Talking about stress. I can see all the stress reactions even talking about this.

Bev: With my husband's health too, that is really more of a concern than mine and what is he going to do with that. And that's always there. Because of his cancer and the treatments, the blood vessels were so damaged in his head, because he had brain tumour, and the vessels don't function the way they should so he has to be so careful all the time. We live with that time bomb because another stroke will probably kill him. So it is probably going to happen. It's always a question of when. We do see the stress in his life because you know, as I say, I was always the healthy partner and now I have this and that was not expected. So there is all this stuff to think about.

Facilitator: When you see complex relationships as you are describing its like again, 'What can I do?', 'What's in my power?' It goes back to the question of how do you do manage your stress? It sounds like you've got some strategies that work. But I was curious that you said that you didn't know what you needed.

Bev: Well I guess I have been doing some of these things for a long time. Do they always work? Sometimes. Is there more that I need to do? Maybe. I don't know. I think worrying less would probably help but it's in my nature to do that so I don't know how I would stop that. I try to unhook myself from it. I'll try the counting backwards strategy (laughs). I'll see how it works.

Facilitator: It's a process; you said taking a tub, withdrawing sometimes, walking, and spirituality.

Bev: Yes my faith has seen me through so many difficult times and I am so grateful for that. It really has given me strength and courage to go on. And my husband shares that as well. Our faith has really enriched our lives and helped define who we are as people.

Sarah.

I know the signs, which warn me that I am stressed; for example, skin irritation, headache, and dizziness. Emotional signs are feeling easily irritated, disappointed, depressed, and the need to be left alone. I feel overwhelmed and totally hopeless. I cannot concentrate or do anything, I cannot sleep or rest.

The thing that helped me the most before I came to Canada was meditation, but since I came here I cannot do meditation. After my brother passed away, the only thing that helped me is going out, walking in mall and pretending that I am shopping for my family. After a few minutes of watching the store windows, I get better and feel less stress.

The most stressful time I have is during exams or when I have an important meeting. Since I started studying at [the college], I have had a stressful time. I have felt stressed out about trying to be organized and the time pressures.

After my MI, financial problems were overwhelming for me. I have decided to ignore all the letters that I have had about my loan and not think about them. But

sometimes, I am not able to ignore the bad things which come through my mind. Sometimes the thoughts scare me and make me restless. I always pray for something that will destroy my memory and let me forget everything including my name.

I think financial help and having someone to love would help the most. I am not used to this condition which I am in now. I always had a good income, and was emotionally supported by family and friends. I never learned how to cope with stress without any help. Having a good partner could be very helpful to recovery and coping with stress, but one of my worries is that nobody wants a woman who has heart problems.

I did not learn anything from my family about how to cope with stress; they were always very calm and smooth. It seemed there was nothing to make them worry.

I always knew what I wanted and how to get it but [in this country] I am confused and sometimes don't know what I really want. I have joined the Healthy Heart program, I am seeing a psychologist, and I have been trying to imagine good things that I desire to happen in the future.

Right now the thing that makes me most depressed is my student loan and the letter which BC student loans sent to me to pay back my loan and grant. It does not matter to them that I did not quit studying; I am a good student. I had a heart attack. I feel they do not care about me and nobody understands my problems. I have no job and my medication is expensive. Since the MI, I have borrowed some money. I worry about what will happen if I cannot pay it back. So far I have not gotten any help and I do not have any hope that I will get help later.

Facilitator: What was it like for you to read out?

Sarah: I could hear my voice (smiles). I usually don't talk out loud by myself. It was like somebody else was telling me my life story...about my problems. But I don't like it (laughs). I can't hear myself.

Researcher: What did you hear?

Sarah: Everything bad. I didn't hear anything good. I don't like that.

Facilitator: When you talked about being depressed, the lack of sleep and nightmares and some of the symptoms of trauma from the sea bus incident are very stressful and these may change. That is what happens when you are depressed. You often feel confused like you may not feel like the real you. There is the real you and you are wondering where she is. It's like something has happened to her. Everything that I have heard from you so far is like a lot has happened to Sarah: moving

countries, leaving family, having a heart attack, and financial pressures. That's one of the big stressors when you think about basic survival: food, shelter, and money.

Sarah: You know I am not used to getting money from anybody, so it is really difficult for me. When I go shopping, I have to be very careful what I buy. And with my roommate, we don't separate our expense, he buys what he can and so do I. Now it is really difficult. Before it wasn't like this. Every time he asks me to go to a restaurant for dinner with his cousin, I say "no, I am not coming." And he'll say, "no I want to pay for you." It really bothers me.

Researcher: Because you are used to being independent.

Sarah: Exactly. Last Monday I was really bad at school. My teacher called 911 for me. They called but I told them, "no I am not going." I made an excuse because every time I go to the hospital I have to pay fifty-four dollars for the ambulance and I can't. I have to save my money for my medication. I think that is really important. I was really, really mad. I didn't want to tell them. And my friends, they kept asking me "Why do you say no?" I don't want to tell everybody that I don't have money. I don't have enough money. I don't want to say that.

Researcher: So you are mad at the situation.

Sarah: Yes. I hear my sister and they're not enjoying their life in my country. I cannot do anything. They have hope now I am here but I can't help them. To sponsor them means I need a \$30,000 yearly income. I don't have it. But this is not like me. I was always very helpful. Now, I am tired of being sick. Did I tell you that my doctor told me I have lupus? One day I have a headache, earache, and chest pain. And the next day I have lupus.

Facilitator: So what keeps you going Sarah?

Sarah: Really? I don't like to say what I'm about to tell you. My boyfriend always said to me "You cannot be successful there." And I want to tell him, "I survived. I can do everything I want. I don't need you. I don't need anybody's help." Even my family and even my brother offered me help.

Facilitator: So you are making a choice not to ask or get help.

Sarah: Yes. Because my brother, my family, they didn't know really why I came here. They think that I don't like it there; that I want to be here or that I am looking for freedom. My problem is that they didn't know why so they disagreed with my decision. And they said "You can't succeed if you go there. You cannot live independently there."

Facilitator: I think what I'm hearing is that you have your own rules about how you are going to live here and you are not going to ask for help. Is that working for you?

Sarah: It's really difficult. But I decided to do that. I don't want to ask for anybody's help.

Facilitator: I'm confused. It sounds like your boyfriend might say that. But I think I'm hearing that your family would like to help you.

Sarah: My family would like to help me, but if they want to help me then they have to put themselves under pressure. If I want to get help from them, they have to sell something, they have to do something. And I don't want that. That's my choice.

Facilitator: I'm starting to feel that I understand more about your choice and the financial pressure that you are putting yourself under too; and the importance for you to feel independent.

Sarah: My father wasn't poor, he could manage. It wasn't easy, but it was enough for an average life. But I started making money when I was 13 years-old. He always said "Why are you are not getting money from me?" Why? I can make money. You don't know how much I enjoy making money.

Researcher: So, how much you enjoy being independent? It's like a life-line.

Sarah: Now I am not satisfied. I am really not happy because I am dependent on at least my roommate. I know he helps me. I can see that.

Facilitator: So it's who you have been in the world as independent financially and to not be that person sounds incredibly stressful. You said something in your story about imagining a future. I'm curious about that. What would a hopeful future be for you? What would you imagine?

Sarah: When I close my eyes I see myself in my small house, close to a forest, having a fireplace, a German shepherd dog, a good partner, and we are sitting and having wine. I bake, I cook; we are going for walk in forest.

Researcher: Sounds pretty calm and simple.

Sarah: Yeah, I always imagine myself like that.

Facilitator: So the qualities that I hear are that you really care a lot for family relationships and animals. And I also really got that you are incredibly determined because you are at school taking accounting and you are determined to stick with it, especially when you talked about being age thirteen and almost defiantly telling your Dad, 'I can take care of myself.' That's determination.

Sarah: Yes exactly. Because I always said that if I want to do something nothing can make me not do it if I really want it no matter how risky or how dangerous it is. But now, I don't want to do anything. But still I am studying because I don't want to let my boyfriend say "You are spoiled."

Facilitator: So, you are doing it more for him, rather than yourself.

Sarah: Yes. I want to prove that "No I am not how you think. I can do everything."

Bev: I guess if it were me, I wouldn't worry so much about what he thought.

Sarah: I want to forget him. I really want to do that.

The following narratives (without feedback) were submitted by the women that were absent this evening.

Helen.

Stress for me has been a big part of my experience. Single parenting is very stressful, especially while building a career. I think I just got used to it, which I think created problems. Long term or chronic stress is what was happening to me at the time of my heart attack. But frankly, the only stress that I really feel overwhelmed by is relationship stress. I am a hard worker and I like to work, so job related things don't seem to create much problem for me but relationship dysfunction really causes me to feel uncomfortable and I stew and fret about things when it comes to the people in my life.

I know that I am stressed by relationship issues when I can't sleep at night or I keep going over and over things in my head. I think I need to exercise more assertiveness over my feelings. By that I mean I think I need to hear my feeling, listen to it, own it, articulate it to those that it concerns and move on. Often times, I will just ignore feelings and soon things are lost in the business of life. This is a goal for me now but things have changed personally and I am not in the relationship that I was in or at least it is not the same and I am living on my own. But I still need to learn to articulate and express my feelings more adequately when issues come up. I haven't had the relationship stress that I had at the time of my MI and I hope never to have that kind of difficulty in a relationship again.

The most stressful part of the whole experience has been not knowing what caused it exactly and if it happened once, it could happen again. I seem to notice my heart feeling tired or "stressed" when I am extremely tired so maybe this is one of the things I will just have to learn to be content with the fact that I can't push myself quite so hard. Easier said than done because my way of thinking doesn't really know what "normal" amounts of achievement are. Sometimes I ask myself what I am trying to prove and I answer that not really anything. I just want to be good at things...well, actually excel at things would be more like it.

In the past I have coped with my life by just working hard and I still do that, but I am trying to get a balance in my life, as I have mentioned before. This is not easy for me because there is so much that I like to do and I am a learner. But I think I am working on trying to prioritize; I am going to get into some yoga in order to try to cope with the stress that comes up in my life. I have done some before just after my MI but since then I have gotten too busy again! At the time I was building confidence again with my body and so I couldn't do much in the way of the poses, but I did like the breathing. I feel pretty confident with my body now and I think it would really help to keep myself centered and calm.

During the 3 years since my MI, I have found it very important to begin to take my spiritual journey more seriously. I have enjoyed every single minute of turning inward to find peace and joy within myself. I have purposefully been seeking spiritual guidance relatively regularly and plan to continue this journey. It has really helped me to feel happy within myself. This has been the most profound change in caring for myself to date. I am pretty good at having a healthy diet, getting exercise, sleep, etc. And I am learning to get better with expressing my feelings in positive ways. In fact, I think I may go for some more counselling upon this issue. I also am struggling with definite sexual ambiguity. I just don't know what I want or maybe I do but am afraid to ask for it?

Menopause is an interesting time. I read a great book, *The Wisdom of Menopause*, and it helped me to realize that this is a great time in a woman's life to gather up personal strength and go forth. "The future belongs to those who believe in the beauty of their dreams" I think Eleanor Roosevelt said that wonderful quote. I am just in the process of really identifying my dreams for the future. Let's say they are in the gestation phase. I'm thinking, visualizing, problem solving and I think I am getting confident enough to articulate them. Prior to this time in my life I have been too busy just surviving or taking care of others needs to really take my own dreams seriously.

So what I need right now is to prioritize all the things I want to keep doing and learning. I need to get to some Yoga and to get back to some weekly running and I need to articulate my dream!

Arlene.

Stress is something that I never really dealt with until I developed diabetes mellitus. It was the first time I was ever told that I could not handle stress. My marriage was full of catastrophes instead of discussions. Though I did not understand exactly what stress was, I did mention it to my husband, only to be told that 'he' couldn't handle stress...so we were at a stand still. So I left. I felt that it was me that kept getting sick, and if he insisted on not realizing the importance of what I said, then I would not stay. I felt that my life was more important.

You would think that challenging or threatening things would be the meter that you relate to stress, but I find that what bothers me the most is disagreements. Just simple little arguments really stress me. I find that I did not have a meter to judge this prior to my heart attack, but now I definitely do. I get those tight little feelings in my chest, that difficulty breathing, like I have eaten way too much and feel so full that I can't get my breath. Ironically, it doesn't take much, someone driving and getting upset with the traffic, another person on their computer and getting frustrated, someone assuming something that is wrong and will not listen to reason, someone acting differently toward me and not explaining why. That really upsets me. I used to try to fix

everything; now I just try to ignore it. Sometimes that is stressful...can't win!! The biggest thing I try to do when confronted with a situation that upsets me is "let it go", or "not buy into it." I am not nearly as aggressive as I used to be.

I remember feeling so upset when I developed diabetes. I hated the fact that I had to change my daily routine and try to make a stable one to follow to help control my blood sugars. I always failed. My blood sugars were never under my control and I always had a hard time eating at the same time, exercising regularly and taking my blood sugar reading daily. Life kept getting in the way.

Well, that is not the way it is now. Since my heart attack, I feel I have no life of my own. I eat the same foods at the same time, exercise daily, I have a Jacuzzi tub with bubbles every morning and read my book, drink very little and have little social life. I guess deep down I just want to put my life in order and maybe, just maybe, this diabetes won't attack me again. My heart has been damaged. I tire easily. I ache all over all the time. Whenever I over exert myself, it takes me days to get over it. I have a hard time getting excited about anything anymore. I feel I'm always under more stress now because I have even less control over my body. Diabetes was bad enough, but now my heart has been damaged and I feel so vulnerable.

I've been broken again, how many times can I pick up the pieces, glue them back together and keep going. The cracks keep getting more noticeable. I feel like I'm turning into an old lady before my time.

There are lessons that we are to learn in life. Will I live long enough to learn all my lessons?

Sally.

Sometimes I feel agitated or my chest feels tight maybe both. I've always taken a deep breath and reached for a cigarette. Now I take a deep breath and dream. You see I was always a dreamer as a child. I didn't know what stress was until I met John but that is too long to go into. I don't like asking for help. Thank God I have such a wonderful family.

Similar to her first two narratives, I was struck by the abruptness of Sally's descriptions and the absence of emotional expression. As well, I am left wondering about her experience of stress and self-care in the context of her MI recovery although earlier discussions provided more details of her life experience than is evident in her written accounts. Like other participants, Sally did however allude to having experienced significant relational stress.

Group Check-out

Both participants were encouraged to respond to the following question, "Has there been a change that you have made that has resulted in a positive change since your MI?" Bev spoke to her experience of a significant weight gain over the past 5 years.

Sometimes I look in the mirror and I don't recognize this person who is looking back. I have always exercised and had a healthy diet and I used to run. I put a lot of time into taking good care of myself. When my father got sick and then my mum and doing a lot of those things, I didn't have time to go to the gym anymore. Then I was injured myself and had a long recovery. So to me it was positive to start the Healthy Heart program because I came back into a familiar setting. It feels good to be exercising again.

Sarah acknowledged having difficulties "talking about her past" until she made the commitment of seeing a psychologist through the Healthy Heart program. "I am talking now; I feel there is a connection and I am trusting someone, I think it is a good sign."

Researcher's Process

Despite the attendance of only two participants, tonight's session was exceptionally rich in terms of stories shared and the depth of honesty in which both Bev and Sarah communicated their experiences. Consequently, the tone of the session felt deeply intimate and similar to a conversation between four people rather than a group discussion. Unlike other groups, both women had significantly more time to explore their experiences and receive focused feedback thus encouraging a deeper reflective process. I also wondered if Bev and Sarah would have shared what they did about themselves had the rest of the group been present. Nonetheless, I felt that I had a far better understanding of both women's interior worlds and the contexts from which they have come from and currently exist. I was particularly struck by Bev's depiction of her struggle with perfectionism and her efforts to keep this in check.

While I felt concerned that Helen and Sally did not show up tonight, particularly given that this was the last session before the break, both women had left messages by the end of the evening acknowledging their absence.

Following the group, I spent a few minutes debriefing highlights of the session with the facilitator and made arrangements to contact participants in early January. Given that we had already developed the content for the next GA theme, there was little to organize in terms of group planning.

Researcher's Interpretations of Theme Four

To date, the temperament of each research session has been distinctively different depending on which participants have attended the group. Tonight was no exception with only two women present. From the start of the session, both were intently engaged in dialogue as Sarah described her depression and the impact of her changed life. Given that she has typically been quiet in the group unless reading her narrative or giving feedback, I wondered if she felt more comfortable sharing in the context of a smaller group.

Both women revealed parts of themselves that had not previously been discussed. More specifically, Bev openly talked about her perfectionistic tendencies which helped to make sense of some discrepant responses such as minimizing the impact of a distressing event including her concerns about having a second heart attack. In contrast, Sarah appeared more comfortable talking about personal resources and strengths. In doing so, the group saw a quality of strength and determination that was not as evident in previous sessions. Moreover, it was heartening to see Sarah occasionally laughing and smiling as she discussed her hopes for the future. Throughout the session, I was aware of Bev being particularly supportive and empathic towards Sarah and wondered if she saw in her aspects of her 'old critical self.' This session was important to both women in terms of speaking truthfully, clarifying their needs, and in giving and receiving empathy and support around better self-care.

Women's ability to understand their needs and provide self-care within the context of feeling stressed is closely connected to issues of identity (how women see themselves in the world) and their self-esteem, and serves as a template from which each individual conducts her life. In this sense, understanding aspects of this theme may be foundational in looking at the other GA themes. For example, how women see themselves in the world and their sense of self-esteem will dictate their experience of recovery from MI within the context of understanding illness, life work, significant relationships, and attitudes towards death.

In general, various characteristics emerged from women's narratives and the group dialogue. I was struck by the different degree of awareness that women demonstrated towards assessing what constituted a stressful situation. One participant stated "stress was something that I had never really dealt with until I developed diabetes." Curiously, she had described earlier setbacks including serious illness and the fear of losing her children, the death of an infant son, and an abusive relationship but did not refer to these as being stressful. Another woman claimed that while stress has been a big part of her experience, including single parenting while building her career, she managed to get used to it over time. In hindsight, she believes that she was suffering from "long term or chronic stress" at the time of her MI.

Interestingly, most participants identified relational stress as being particularly difficult to cope with. One woman described at length the ongoing and "overwhelming pressure and responsibility" that she (and her husband) currently experience in supporting his 90 year-old mother who is unwilling to admit she is no longer living independently. Feeling "powerless to change the situation," she stated that "I know that this is at times overwhelming for him and then I worry about his deteriorating health as well." Consequently, as a woman in her early fifties, she is now taking care of elderly parents, her husband's health and now her own compromised health.

Two career oriented participants confirmed that relational stress was typically more overwhelming than the stress associated with working hard. One woman acknowledged that "job related things don't seem to create much of a problem for me but relationship dysfunction really causes me to feel uncomfortable and I stew and fret about things when it comes to the people in my life." In contrast, the other participant suggested that "you would think that challenging or threatening things would be the meter that you related to stress, but I find what bothers me the most is... simple little arguments" including another person's expression of upset and frustration, their unwillingness to listen, or a change in their behavior towards me without explanation. Each of these examples represents circumstances beyond her control. Moreover, having a propensity to rescue others is more indicative of her anxiety with the expression of negative affect or indirect communication in others. Given this woman's experience of interpreting stress as 'challenge' and her history of being driven to accomplish and to overcome adversity, I wonder if she has appraised situations requiring self-care and reflection as occasions to aggressively work harder at the cost of ignoring crucial indicators of stress. This might help to explain times in her life where she became sick following a period of very hard work and significant career success. In general, how do we teach women to become more attentive to their bodily and emotional needs when they are so other focused?

Another participant described returning to school and the associated pressures including financial hardship and the strong sense of feeling ill-treated by loan officials as being extremely stressful. These stressors however were embedded within the larger context of ongoing angst surrounding her loss of financial independence and family support and relationships inherent to who she knew herself to be in her country of origin, "I think when I don't produce anything... when I don't make money or I am not in a relationship with anybody... I have no love, I don't feel I am useful anymore." For this woman, the absence of fulfilling a meaningful and satisfying life role appears to have resulted in feelings of low self-worth and likely has contributed to her lasting depression. Perhaps this could be construed as a different kind of relational stress or as a crisis of spirit or identity.

A few women specifically identified aspects of MI they found to be most stressful. One woman, whose angiogram was negative, suggested that "the most stressful part of the whole experience has been not knowing what caused it exactly and if it happened once, it could happen again." Another participant admitted that "I am always under more stress now because I have even less control over my body. Diabetes was bad enough, but now my heart has been damaged I feel so vulnerable." For a woman who has fought to stay in control for much of her life in order to survive many significant losses, it is understandable that she would feel powerless and angry in response to the perception that her body has betrayed her.

Another woman stated "I was always the healthy partner and now I have this and that was not expected." Despite managing high levels of stress within the past several years, Bev is discovering that overextending herself may put her at risk for angina and which could compromise her ability to provide care for others. Given her husband's delicate health, I suspect this would be very stressful for her particularly if she herself required caregiving.

Also evident in two women's narratives was their greater sensitivity or awareness of feeling stress since their MI. One woman suggested that "I did not have a meter to judge this prior to my heart attack, but now I definitely do as I get those little tight feelings in my chest." Another participant indicated that she "Seemed to notice her heart feeling tired or stressed when she is extremely tired" and is now aware that she "can't push herself quite so hard."

As heart patients, both of these women's comments suggest the importance of understanding physical and emotional limits around doing too much. Several women acknowledged how difficult it was to know "what normal amounts of achievement are" particularly when they are feeling good. As one woman mentioned, "when I over exert myself, it takes days to get over it."

In describing the qualities of stress, all participants identified multiple physical, mental and emotional symptoms including "difficulty sleeping," "dizziness," "shortness of breath," "headache," "skin irritation," "obsessive thinking," "agitation," "disappointment," "anger," "decreased concentration" and in four woman, occasional "chest tightness."

While all participants claimed they were taking better care of their physical health since their MI in terms of exercising, eating healthy foods, losing weight, resting and relaxing more, all women also saw the value in taking better care of their emotional and psychological (and for some spiritual) health. Consequently, some participants talked about learning how to detach from relational stress, becoming more assertive and setting boundaries, cultivating more supportive relationships, and exploring spiritual inklings. Altering habitual patterns of relating to others is often significantly more difficult than implementing more tangible forms of self-care behavior such as exercise.

One woman who described herself earlier as being a "rescuer" in relationships is learning to "articulate and express her feelings in a positive way" when issues emerge instead of ignoring feelings and getting busy with work and other activities. She also suggested that "the most profound change" in caring for herself since her MI has been taking her "spiritual journey more seriously." Viewing her MI, as a "wake-up call," Helen admitted being "too busy just surviving and taking care of other's needs" to identify her own including her "dreams for the future." At 3 years into her recovery, she is now identifying new career and life goals.

Another participant who also historically coped with stress by immersing herself in her career has created a regime of daily self-care and is making efforts to slow down. In another session, she reported being aware that others were asking less of her which resulted in having more time for herself. With respect to relational stress, "I used to try and fix everything; now "the biggest thing I try to do when confronted with a situation that upsets me is "let it go or not buy into it. I am not nearly as aggressive as I used to be." She also mentioned earlier that "I won't be in a relationship if it is going to be stressful."

One other participant discussed her ongoing efforts at being less perfectionistic, "I used to feel really guilty if anyone that I loved and cared about was unhappy so I would try my best to rectify the situation, sometimes a great personal cost." While she has "learned to relax more and give herself permission to let go of things which are beyond her control," she also acknowledged "Going back to those horrible old ways" at other times. In dealing with the stress associated with her mother-in-law, this participant identified other forms of self-care including family and social support, spending quality time with her partner, crying, and the strong connection with her religious faith. In each example, women demonstrated attempts to change habitual patterns of self-defeating behavior.

Also evident in some women's narratives was their difficulty in asking for help. One woman adamantly stated "I don't like asking for help" given her deeply-rooted role as caregiver with family and friends. Similarly, another participant, determined to prove to her family and former partner that she has the ability to be "successful" in this country, insisted that "I want to tell them, I survived. I can do everything I want. I don't need you. I don't need anybody's help" despite their offers of support. Interestingly, this woman's belief that "No one wants to help her" further supports her stance of "not needing help from anyone." Failing to receive support, while infarcting on the sea bus, has further entrenched these beliefs. Self-care for this woman meant establishing a positive relationship with a psychologist and joining the current research group to give voice to her experience.

For the heart patient, being uncomfortable or resistant to asking for help can be potentially deadly in terms of assessing unhealthy stress, setting healthy physical and emotional limits, and help seeking behavior.

Guided Autobiography Theme Five

Your Experiences and Ideas about Death and Recovery from MI

The research group reconvened after taking a three-week break over the holidays. The session included a group check-in, readings of the theme autobiographies and group feedback, a brief group check-out, and an introduction to the final session GA theme. Sarah left a

message indicating that she had an employment appointment and was unable to attend the session.

Group Check-In

Most of the research participants described having a good holiday spending time with family and friends. Although Arlene described being quite busy, she reported making a conscious choice about "not being stressed." As a result, she generally has "much more time for herself." Moreover, Arlene suggested that since her heart attack, "life is different as people don't demand as much from me anymore."

I have to look at myself thinking how come I don't feel guilty, because I used to feel guilty, but I don't care any more. If my house is messy I don't care. Before you could eat off the floors but now I don't care. So there's definitely a change of attitude there and I don't know where it came from, but I really like my life more and more.

In dramatic contrast, Sally dominated the group check-in with an unexpected angry outburst. While she initially focused on the "stupidity" of the current theme's sensitizing questions and her resistance to the process of reflection and writing, she also acknowledged her struggle with being assertive and saying no to others. Sally also described her unpleasant holiday which was influenced by the powerlessness she felt spending time with her sister who is in active drug addiction. While most of the check-in time was spent processing Sally's concerns, it was an important opportunity to encourage her authentic voice and to better understand her experience.

Facilitator: One of the questions from last week was how do you know when you're stressed?

Sally: (Angrily throws up her arms) Oh God! When I tell you I'm stressed...I'm stressed. I probably shouldn't hand in the homework because I am stressed.

Facilitator: Did you find it stressful?

Sally: Not as much stressful as stupid

[All participants are now looking at Sally intently].

Sally: We thought the first meeting went so well and it did because that's what we were here for, to share and discuss the heart. And after that I think it got away from the heart attack to be life things and reflection.

Facilitator: You sound angry.

Sally: It's just that where do these questions come from that are supposed to be about your own healing. I think talking about death it's stupid...I'll show you (Sally reviewed and answered each question tersely). You know these are for older people, so maybe when you're older you think more about death.

Facilitator: So I sense your anger and I'm trying to understand what that's about. It sounds like when you looked at the death theme it really did something.

Sally: Well, we didn't die. We all knew we were having a MI (looks at group) so most of us placed it in the doctors. You know, we'll get well. We weren't prepared to die. So all these questions on death aren't about the heart attack. Death's when you're older.

Researcher: For you. That sounds like a belief that you have.

Sally: That's what most people believe. You die after your parents. You get old and have your ninetieth birthday.

Researcher: I think that's how we think life may/should typically evolve, but I think we also believe that women in their forties don't have heart attacks.

Arlene: We didn't die, but there are lots of women and men that have died from a simple heart attack, but we survived. That's quite sobering when you think about it. What we do is we deal with it and move on. We don't dwell on the fact that we had heart attacks, but the whole idea of this group is about getting to our real deep-down emotions about how we truly feel about the fact that we had a heart attack. I think that it's something you have to take time to reflect, to dig down and I don't think you've done that or want to do that because you're thinking, well why? I don't want to deal with it now. And there's absolutely nothing wrong with that.

Sally: I don't want to write an autobiography...ask a question and I'll give an answer. I guess it's just everything is too personal for me to just, I can talk better than blah, blah, blah on a piece of paper. It doesn't require a short answer like dig and get the guts out and I'm not doing that.

Researcher: Not doing that on paper, or not doing that at all?

Sally: I'll do that, but not on paper.

Facilitator: You're saying that you don't even like the writing; you actually think about them but you don't want to write them down? What happens when you write?

Sally: (Nods). There are different ways to write. How do you write it short? I haven't had a lot of time also because I've had too many people who have just been on my doorstep. I don't know how to say no. It just tires me out (refers to friend). I just want to wring her neck. She doesn't listen when I try and help her.

Facilitator: What I'm hearing is that part of it's been hard to get to because you're not in the frame of mind. And even to be in the frame of mind means you have to say no and that's hard to do.

Sally: I'm getting to the point I'm only going to answer the answering machine. When I hear it I can just answer the phone, because I'm not getting anything...like that phone never stops.

Arlene: I think it's really important who you allow into your life. That's what I find, especially since my heart attack. I'm very choosy who I allow into my life and I don't want that kind of stress. I just won't allow it any more. It's not worth it. Those sorts of people I used to have all the time, because I was always the one who could fix everything. Not any more. I just say no.

My Experiences and Ideas about Death and Recovery from MI

In this theme, participants were asked to reflect on their recovery from the potentially life threatening MI event within the context of their experiences with and ideas about death and dying. Sensitizing questions to help participants reflect on this theme and generate self awareness included childhood recollections of death, family attitudes towards death, significant deaths and their impact, feelings about surviving MI, and attitudes and feelings towards their own death.

Five participant narratives have been presented. Although Sally responded to the current theme in the group check-in, I have included her narrative with some personal comments. In her absence, Sarah submitted her narrative by email which has also been included without group feedback.

Helen.

I really don't have much to say about death. I haven't had much experience with it. As a child, my cat died but my parents protected me from this death. I never really was told what happened, but I think I knew. My cat was quite sick but anyway it wasn't really traumatic.

My grand parents died but I wasn't very close to them. My father died about 10 years ago and it was a beautiful experience; it was very emotional and deeply moving, but there was so much beauty in his life and his death was a blessing for him because he was sick. And the whole experience of his passing was gentle and beautiful. I have a very wonderful memory of the ceremony of putting his ashes in the ground and we all had a flower and we were putting them in as well. My Mum was crying hard and I heard a very gentle wind in the trees which I think was my father letting me know he was there and to take care of my Mum. And to this day, often I will feel my dad visit me on a gentle wind and I say "oh it's you dad." His funeral, the only one that I had been to, was a warm, wonderful and spiritual experience for me.

So death really hasn't been part of my life's experience in a big way. I know when I had the heart attack, I really didn't want to die...not yet because I didn't get to see how so many things turned out...like my daughter grown up and what I would become.

I remember in the hospital waking up very early one morning and I was by the window. I was looking out the window as the sun came up for the day and I recalled the beauty of how a rooster calls forth the day.

And each day is such a gift and a wondrous opportunity to be happy and alive again. When I get so busy with life now I forget this except when I go to church and I am reminded of the great love that exists within all of us and all of creation. My heart attack really helped me to become happier inside with just myself and my spirit. I feel quite content most of the time except that I have to figure out a balance with my work and my interests because I can't retire for a few years yet.

When I die, I would really like to live to be old like my 95 year-old mother who is happy, content and peaceful. Everyone loves her and she is a gift, kind of like a new baby is a gift, only she is at the other end of the line. She teaches everyone who comes in contact with her about self reliance, about being content, about being patient, about being compassionate. I think you could say she is truly Christian but she never pushes any of that. I just love her to pieces. Anyway, I hope she dies peacefully in her sleep one of these nights and that is how I would like to die too. She has been such a role model in my life and a violent death would not be fair. But who am I to say what would be fair when it comes to that moment of death.

I don't think about death so much after the heart attack so much as I think about life and the quality of life that one can achieve. I really think music is important to the quality of life we live. Music touches souls and changes lives. Art does too; it's very important. But not going to the museums so much and looking at pictures on the wall, although this can be a remarkable experience...no...it is more to do with creating and expressing oneself.

I truly believe that healing is achieved through our creativity. Perhaps that is one of the reasons why humans are creative in the first place in order to help us heal through our lived experiences in this journey we call living. And so I continue on trying to live as creatively as I can and trying to achieve some balance with my passions.

Facilitator: Despite having a heart attack, you don't have fear of your own death?

Helen: I don't seem to.

Facilitator: I guess I'm just struck with that, obviously because I haven't had that experience. I probably assumed there would be a fear of death in there.

Helen: I assumed, since both my parents are so very old and my mother has had heart problems her whole life, I just assumed that that's how it will go. Although I do remember thinking prior to having the heart attack I was really counting on my old age. I just never

questioned it and then after the heart attack, I started to have a little more reservation about just counting on the fact that I would grow old too. That's why the quality of living has become more of a focus. I could put off a lot of the things I love to do until I retire, but part of me just doesn't want to do that.

Facilitator: So, on some level your assumption about your own life or immortality has changed.

Helen: Yeah, you become aware that your body is fallible after a heart attack although I still count on the fact that I could live to be as old as my mum (laughs). I can't let go of that.

Facilitator: You said in your story that the experience of the MI actually made you think about life. I mean that's the irony, that death is the flip side of life. So you're appreciating your life more and wanting to do more.

Arlene: Well, it was interesting how you turned it around. I really enjoyed it.

Bev: Me too, and actually I really believe that you don't fear death. I think you're continuing to do the things that you find interesting and are really seeking to have a quality of life and hopefully it will be a long one for you. I don't hear any fear in that at all and I think that is a really healthy way to look at life because we all eventually die.

Facilitator: I really appreciate what you were saying about creativity and healing. Can you say more about that for you, what it is?

Helen: I don't know if I can articulate it, but with music and art in the process of creating, and it can be anything that one creates, but in that process of engaging yourself in using your creativity in some way, I think it heals; I think it heals your spirit. It makes you feel better no matter what the issues are around and I think that's one of the big powers of creativity and why human beings endeavor to be creative. Well there are a whole lot of reasons, but I think one of them is that it is intrinsically healing and I think there is work to be done around exploring that. I know it works for me.

Facilitator: There is actually some research on that and it's an area I'm interested in; different things about creative work, but one of them is being able to have a sense of control of something and to actually put something together. It's almost like the writing part too can be that way, when you actually take a jumble of stuff, make something, it's a way to gain some control or mastery or feel powerful about something.

Helen: Well, I think that the product has some merit, but going from A to B in the process is where the healing happens. The product is a by-product when you're looking at creativity as something other than writing or recordings or those sorts of things.

Facilitator: It's the making of it.

Researcher: Like creativity acting as the vehicle for spirit.

Helen: I think it has to do with like almost a whole body connection because your hands are engaged, your head is engaged, when you're involved in the process, you're not thinking, worried about anything really. You're just suspended in time that you get to almost be held in the arms of spirit, just letting you kind of be. And that is what I think enables you to heal. I just think it is very important and we don't understand as much as we will as we continue to explore it and honor it.

Researcher: In terms of creating this piece of artwork, does this process represent another layer of healing?

Helen: It has been. It's willful. I wanted to do this so I took it upon myself to use the group to muck about and I like to draw and stick and glue and color and I have no preset idea where it's going. I just get started and wherever I end up is what it becomes. And that's the process. I knew I wanted to be creative and how I was going to respond to this. I knew that I wanted to take it as an opportunity for me to get involved in this.

Bev.

I grew up on a working ranch. Life and death occurred there on a regular basis. My parents were never happy to lose an animal as they worked very hard to ensure their herds' health, but they accepted death as an inevitable part of ranching life. We had cats and dogs which were like members of our family. When they eventually died we mourned their losses and we remembered all the special times we shared with them and how they enriched our lives and at times kept us safe. We celebrated their companionship and their loyalty.

Recently, when my family and I visited my mom and my siblings and their families for the holiday season, Rex, one of my mom's beloved 15 year-old border collies, had to be euthanized due to cancer. He had such a sweet disposition and we all loved him. We all cried when he made his final journey and his litter mate Sidney missed him too. It was really tough (begins to cry). I didn't think it would bother me so much. He looked for him everywhere and cried at night because he thought that his brother had been left outside by himself.

It was particularly hard for me because after my dad died as these two dogs were my life-line (crying). My mum was hospitalized about 3 weeks after my father died and I had to return. My parent's home is huge and I was glad that the dogs were there with me. I had never been there in my life without my family and it was almost as if I had half a heart when I went there. It was really, really tough and these dogs were just my life-line (still crying). They kept me company when I checked the cattle and did all the chores.

My own death is not frightening to me. I see it as one more step in my journey. I really believe that we live on after physical death in the hearts and minds and stories of those that we have loved and who have loved and cared about us. I do mourn the loss of someone that I have loved by attending their funeral or a celebration of their life. I sometimes cry, not so much for the person who has died, but for my own loss. I talk about my loss with family and friends and try to remember special times and I try to remember even the death itself, because for me that's really important.

The most significant death that I've experienced thus far has been my father's death, although my maternal grandparents' deaths were also very significant to me, as I was very close to both of them. My father had a long and courageous battle with cancer. He suffered great pain that even morphine didn't dull.

After he was hospitalized, my mum and I would go to visit with him every day. We drove about 100 miles each day from the end of May until his death in July, and then we had all these other things to do when we got home. So we were just exhausted. We sometimes had 4 hours of sleep a day and it was really tough. He wanted to die at home and we had arranged for him to come home once the nursing care was established. He died before we could transport him home.

My family and I had several years to prepare for my dad's death but we still found it difficult. I didn't feel helpless as even the best cancer people at the clinic couldn't halt the ravages of cancer (crying). I did my best; I hope he knew that I loved him and that there is hardly a day that goes by that I don't think of him. He loved to be a dad and he was special. Sometimes when I'm shopping or sitting in an audience, I'll see the back of some man's head that reminds me of my dad's. He had a wonderful engaging laugh and sometimes I think that I hear him. He would rush in to tell my mother if he saw a large flock of geese overhead or the first robin in spring. When I see or hear of those things, I remember him.

I am also dreading the day that my mum passes away. I know that that day will come and I only hope that it is later rather than sooner. I am extremely close to my mum (crying) and I have seen her through one critical injury. She has also had breast cancer once and I fear that it may have returned, although she hasn't confirmed that fact with me. I saw tremendous changes in her. I want her to live as long as she is pain free and has some quality of life.

I don't have any fear about dying. I know that everything that lives eventually dies. I hope that my death will be painless. To die in my sleep would be wonderful. I don't want to have my loved ones see me suffer pain. I don't want them to be troubled or burdened

by a long or protracted illness that I might suffer. I also do not want to live if I have no quality of life, or am being kept alive by machines.

Facilitator: Reading that brought up sadness and you were just back home visiting family.

Helen: How old is your mother?

Bev: My mother is seventy-eight, so she's not really getting old, but the accident that she suffered after my dad's death was extremely traumatic. It was really a critical accident and I think it really shortened her life.

Facilitator: What happened to her?

Bev: She was trampled by a 1,800 pound cow and it was a really critical injury. She was in the hospital for quite a while. But she's tough, she's really tough and only because she's always maintained her health, she's just amazing. But I've seen little signs that trouble me. Her short-term memory too is kind of going and I think that was because she had a lot of injuries to her head and she's had cancer in the past and I think it may have returned, because even when I saw her in October, there had been quite a decline, although she's not saying that it's back and I respect that. Whatever she wants to tell us is okay. If she wants to share that if it's there then that's okay; part of me wants to know, part of me doesn't. She's really lived her life the way she wanted to and many of us don't get to do that (crying). We live our lives according to everybody else's plan, but she and my father really loved the life they chose and she still does so many things that bring her great joy.

Facilitator: It sounds like you're already grieving for her.

Bev: Yeah.

Helen: How did your mother respond to your heart attack?

Bev: It was very difficult for her. She was just going to sprint right out here and I'm so glad she didn't because I couldn't have handled it. I was only just in hospital about a day and a half. I really didn't want her to come and I think she heard that and respected that. She came out in October, which was ideal actually. By that time I was actually in good shape and I was able to get out with her and do things and I really needed her to see me strong, not ill. Not that I considered myself to be ill, but I just felt weaker after my heart attack emotionally and physically too, but mostly emotionally. I didn't want her to be burdened by that. So I felt happy with her coming out when she did. It was better for all of us. She has enough to handle without that, but I think she's okay with it now. I think she's always wanted to die before us. I think it would be really tough if one of us went first. I think she sees that as the order of things that parents die and then children do.

Facilitator: That's what I was wondering as you were talking. It's not the natural order of things for her daughter to be suffering a heart attack.

Bev: It would be quite a shock for her I think. In fact, if I didn't call just about every night, she would call me: "I just wondered, I thought you might be in hospital."

Researcher: In that story I just continue to hear your heart connection to being around family including the dogs. It struck a chord for me too because my own dog was almost killed about 4 years ago when she was hit by a car. She is like my daughter and a significant member of my chosen family. I can easily imagine how important those dogs were to you and your heart connection to Rex.

Facilitator: It just reminded me of how so much of what you talk about is loss and grief and what you said was that you cry for your own loss, which is what I think we do. That's the way of honouring the other creatures too. There's this real irony about that. It's like the more you open your heart and are willing to love and connect, of course you feel the loss. That's the risk we all take as human beings. We truly love or open our hearts and there's more at stake but there's more to lose. When I heard the story of your dog I just got this whole picture of your life, the ranch and everything that came with it.

Arlene.

The first experience I had in dealing with death was my sister's pet Pomeranian dog Joey. We had originally bought his brother Teddy on my ninth birthday as the family dog. My older sister then bought Joey for her young family. I felt Joey was neglected because my sister had small children, so I devoted as much time as I could with him.

For some reason, my little girlfriend's family had taken Joey in as he was very ill. They thought they could save him. I would go over to their place before school to say goodbye to Joey, then after school I went straight there to see if he had gotten better. One day when I got there, my girlfriend said "oh, by the way, Joey died." I thought she was kidding me and would not believe her. She took me down the crawl space to the box he was in. I ran my hand down his coat several times. I could not figure out why he was there. Then it hit me and I burst into tears. I couldn't believe it. I don't think I have really ever forgiven my sister for that. That was my first insight into how she can sometimes be a very cruel person.

As a teenager, my grandfather passed over. They were married for 60 years. My grandmother lived to be 95 years-old, but she did not know who we were at the end. I felt their deaths deeply, but accepted them as you expect old people to die.

I was just 19 years-old and home from a long stay in hospital. I had a baby boy. Now I had my family, a beautiful baby girl and now a brother for her. While in hospital, I was so sick and I scared my daughter because my face was paralyzed. I missed her very much and felt I was losing her to caregivers. Stubbornly, I thought that no one

would take my son away. I spent every waking moment with my kids. My marriage was not good as my husband beat me, but I learned not to show him any fear. What an awful way to live.

When I thought things could not get any worse my son died. It must have been my fault. Did I kill him? He was crying all night and would not sleep. Out of sheer exhaustion I put him in the laundry room and put his father's heavy winter coat over him to keep him warm. His father was working night shift so he could not help me.

At seven in the morning, I remember waking slightly. Then when I woke a couple of hours later, the animals were restless and I thought it strange. I went in to check on him and he was dead. He was on his stomach. I picked him up, he was stiff. The blood had settled in the base of his body. I dropped him and screamed.

I called my parents screaming that I had killed my son. Then I thought, "Oh no...my dad has a bad heart, this will upset him" and I didn't want him to have a heart attack so I called back and tried to be more calm. They came to my home it was devastating. I ran around the house. I was crazy with grief. I was begging God to give my son back to me. The police came as did the doctor. I begged the doctor to make him better. To settle me down, he gave me a shot and they took my baby out of the house in a black bag. I did not want to live. I wanted to die too. I was in shock.

That night my husband took me for a drive. There was a bright star in the sky and I knew that Hal was that star and that he would always be with me. He was born on mother's day 33 years ago.

I ended up rejecting my daughter for quite a while and I do not believe that I ever opened my heart completely again. Shortly after that my marriage broke down completely. We were way too young to go through all the catastrophes we had been through.

In my early twenties, I received a call from my mum who was in the States, for the winter with my father. She was concerned and asked if I could come down to help bring my dad back home as he was not well. I asked my brother to join me and we flew down. I do not think we realized just how sick our father was.

Once he was in Canada and he could go to the hospital. The doctor let me listen to his heart. The sound was a swishing noise and I became very scared. Every day I was at the hospital to be with him. He eventually got better, or so we thought, and was released. He was very weak and did not like the fact that he couldn't help Mum carry the groceries, etc.

Even though he was not in the best of health he decided to go down south again when winter came. They had a good trip and were setting up the trailer when my dad had a massive heart attack. Mum heard a bang and ran outside to see dad on the ground. His last words to her were "watch me glasses" (laughs). The paramedics came but they could not revive him. I was so close to my father; his death was very hard on me. I miss him very much.

I was 23 years-old. A single mum and had bought my second home. I had two girls now and decided that we needed a family dog. My aunt's dog had pups, so I was able to get a little girl that my children fell in love with. She was a black multi-poo and as she grew up she turned gray. She was very protective of the girls and always came home on the run to my very loud whistle.

She grew old as my girls grew up. I knew she needed to be euthanized but found it so painful that I just could not do it. We had to make a trip out of town for 4 days, so I decided I would attend to it when I got home. My girls would look after her while I was gone. I did not know that they had decided to take her to the vet to spare me so they made the appointment. They gave her a bath and put her in the back yard to lie in the sun. She gently went to sleep while laying there. What hurt me the most was, and I still find so painful, is her last night was miserable for her. I so wish that I had had the strength to take her to the vet before I went away, then she would not have suffered like she did.

It took years for my Mother and I to become really close, but we are now. She's my best friend. It does not matter what I want to do, or where I want to go. All I have to do is ask her and she is there. I will be so lost when we loose her. I am not ready for that. I am so proud of her and of all her accomplishments. Her hearing is going and I get so upset with myself when I am short or impatient with her. I hate the thought that I would do something to upset her. I hope she lives for many more years to come.

Sometimes I wonder why I have had to go through all these lessons in life. I have still not found total happiness. It always seems to elude me. Is there such a thing? I joked in the hospital when they told me that I had a heart attack, "Have I got a heart?" A heart means love, and I do not know if I am capable of that anymore or is it total trust that I lack? My heart has been broken so many times in ways that it hurts way more than a heart attack.

The thought of death frightens me. Whether there is a heaven or hell is beside the issue. I am greedy for not wanting to leave my family and friends. I don't believe you have a choice. Whether you die in an accident or by failing health, it is out of your hands.

I like to live every moment of my life to the fullest. I would hate to pass over with the thought that there were things that I wanted to do but never did.

Helen: You had an unbelievable experience with your son. Especially for someone who is 20 years-old. You were just a child yourself.

Arlene: When he died I was nineteen. It was hard to celebrate Mother's Day for years.

Facilitator: You are wondering whether you have a heart and if you trust and yet your heart is so there when you talk about your mum and the love.

Arlene: I know that I can love without being hurt. Because every time I've tried to love in the past it's been devastating. It's not been pretty. I've really been hurt.

Facilitator: What you're saying is that you've now had the experience of loving without being hurt.

Arlene: With my mother. I never felt vulnerable about death until I had my heart attack. I've had so much illness in my life, but it never bothered me I just always went on. I don't think the heart attack would bother me either except it's left me weak. That really surprised me. When I was paralyzed I was weak. It took me years to recover. I was in hospital for 5 months. I was young. There are illnesses that you know there is a problem there but you still have some kind of control over what you do. The heart attack left me with no control and weakness and I didn't ever really feel that I'd had a heart attack. They told me I'd had a heart attack and I can't prove it. I was shocked I had a heart attack. I still don't believe I've had a heart attack, except that I am weak.

Helen: Did you have the angiogram and the stents put in?

Arlene: One.

Helen: Well, there's proof. I think it's also harder because when you were young and paralyzed it was hard to recover, but you were younger and more resilient. Being older, everything seems to be harder. You are slower, partly because of the heart attack but also because you're older now and weaker. That's really hard to come to terms with.

Arlene: But the heart attack caused me to feel older faster.

Helen: I think that's where just learning to be content is one of the really important things; learning to be content with the fact that you need to sleep more or that you can only do three ski runs instead of ten.

Researcher: I wonder if ones sense of spirit doesn't age even though our bodies do.

Facilitator: Did you slow down after the heart attack? So you are so busy; you're used to doing probably the work of three people.

Arlene: Yeah I have slowed down. I just felt like I was there for no reason. I like being busy. I'm really creative. I was making Christmas and birthday cards and they're being shipped all over the world through the company. I couldn't have a better job right now

Facilitator: Resilience is how I would describe you. I'm not sure how you do it. How do you do it?

Arlene: I guess I don't know what failure is. It's not part of my vocabulary. The heart attack has caused me to be the closest to failure.

Facilitator: In what sense? I'm curious how you see this as a failure?

Arlene: Oh, because my goals have had to change. Deep down I know they have to change. I don't know if I will ever be a resort manager and make the big bucks. If I didn't have the heart attack, I would already be assistant manager. I know that. Being an administrative assistant is a far easier job for me right now.

Facilitator: It sounds that part of your resilience is being able to reframe your experiences. What you started with is this failure and now what you're saying is that I can create something. It sounds like you are actually enjoying the job.

Arlene: Yeah, I am but it's not totally fulfilling and I'm making it fulfilling because I'm doing all this extra stuff. Whatever you do you can go to work and think "oh what a job" or you can make the job whatever you want it to be.

Facilitator: You're talking about the loss of what you thought you were going to be able to do and you are saying now that "I don't think I'm going to get to do that."

Arlene: I'm angry about it because it seems like there's one illness after another and it's holding me back. And I really get through that one and trudge on and become successful and then I get sick again. This one has really made me weak and I don't know if I can trudge through it. I don't know whether it's the heart I'm worried about or the diabetes. I did nothing wrong to cause it. I lost control of my health a long time ago but never accepted it.

Facilitator: I think there's a question there for you too; "how do I embrace life in the face of death and when I feel that I don't have control of my health?" I still remember you talking about dancing and wanting to live life to the fullest and how do you do that.

Arlene: I think the saddest part of my life is that I have never had a fulfilling relationship. It bothers me that I could never be successful in a relationship. You try to make it successful and then you have to start over again. It's disheartening.

Bev: You have had a highly successful relationship with your mum and dad. You're talking about a partner but sounds like you've had successful relationships there.

Sally.

Although Sally spoke extensively in the group, I have included her brief written submission and a separate letter which I didn't find until several days later. In response, I have offered some brief comments.

I didn't know about death as a child. As I got older it didn't frighten me. We were taught you go to heaven. The first funeral was my sister's 19 years ago. (I can no longer answer anymore stupid, repetitive questions).

Letter accompanying writing:

Dear Michele,

I'll start off by apologizing for being short and abrupt in my homework. The class was not what I expected and from what I gathered, most of us came for you. Yes, the first meeting went well because that is what we came for; sharing our experiences not tree hugging every event in my (our) entire life. If you would like to talk further please call me.

I will attend the next session and if there is another theme I may or may not complete it.

Given that Sally had a transformative experience in the group, I was surprised that she still chose to pass on her note which had the same frustrated and angry tone that she expressed at the beginning of tonight's session. Despite sharing more of her current life experience, Sally spoke little about the death theme beyond offhandedly answering the sensitizing questions. What she did say however, was powerful and suggested that the issue of death represented a difficult personal trigger that resulted in her defensiveness.

Sarah.

I was told that death is not the end it is the start of a new life. Birth is a journey and death is the starting of another journey. If you do good things to others your next journey will be the best and you will have your happiness during your journey and this circulation continues until you understand the real meaning of life. So, I am not scared of death.

Death always was a natural event in my family. The only time I could not deal with it was the death of my brother because I was depressed and I did not have any family support here. The most painful death has been my brother's death. I was in this country and I had nobody to talk to.

I have always had dreams about the bad things that happened to my family. I have known about these things before anything happens. Usually, I have seen the ceremony and the person who is going to die. Even the details have happened exactly like what I saw in the dream. I knew my brother was going to die but I did not want to believe it and still I do not want to face the fact that he is no longer there.

You may never have seen people killed in a group but I have seen this many times. As much as you see this you get stronger. I have lost my friends, my fiancé, and

many of my relatives after the revolution in my country. Every day we were faced with death. It is like our shadows and we are used to it. I really do not remember the first funeral I went to. I never felt guilty about anyone's death because I believe that it will happen whether we want it to or not and nobody can help when the time comes.

I survived from a MI. It means it was not my time to go. I am not afraid of dying because I know I can be with my family who passed away before me. I would like to die before I get too old. I do not want to be stuck in bed and be sick for a long time. So, the best death is to die from a heart attack like both my parents did; it was not painful. My father was not at home when he died. He was able of doing everything by himself and he never needed anyone to take care of him. My brother got cancer. I hate this name and I hear that it is very painful.

Group Check-out

Participants were encouraged to respond to the following question, "Has there been a change that you've made in your life since your heart attack?" Arlene suggested that she is now "taking her diabetes more seriously" and has been "aggressively exercising" understanding that she needs to strengthen her heart. Bev also discussed her commitment to regular exercise and her discomfort with her current weight problem. As well, she acknowledged addressing issues around being a long standing perfectionist.

I have some goals in mind and I hope that I'm able to achieve what I set out to do, but I'm also not going beat myself up any more if I don't. At one time my expectations were so great for myself, and if I didn't achieve what I set out to do, I would become quite disappointed and carry that around. The older I get the less important some of that stuff is. I've learned that the world goes on no matter what.

Similarly, Helen talked about her efforts at finding a reasonable and comfortable balance between her accomplishments and her drive to accomplish; "I still have way too much that is lurking out there that bothers me because I can't get to it or do it the way I want to do it." She suggested however, that her biggest change has been a greater willingness to be alone.

I used to be very afraid of being alone. I didn't understand the concept of doing things alone. I feel more comfortable in my own skin but particularly I'm quite comfortable approaching my life alone. In my twenties, thirties and forties, I was much more urgent to not be alone.

Looking sad and tearful, Sally acknowledged the following insights.

Sally: I enjoy the exercising but I think I'm angry that I'm helping this [friend] because I can't help my sister. I'm scared she's going to die. I know she will with the drug abuse and I can't help that.

Facilitator: I'm struck with how much you care about your family.

Sally: You've only got one family.

Researcher: Sounds like you've lost your sister even though she's still here.

Facilitator: This is a situation that you can't fix and you have already lost one sister who died.

Sally: Guess I'm not angry at the [research] questions. I'm angry with myself.

Facilitator: I think the link you made with your sister is really important.

Sally: I wished she was like she used to be. We were so close. (Reviews in detail the events of Christmas Eve with her sister).

Facilitator: So, Sally, what's happening for you in all this?

Sally: Feeling bad for the kids and disgusted with her. I went over at Christmas because they were so upset with her being high they wanted me to be there.

Facilitator: Sounds like you need to get something back for yourself.

Sally: The drugs have her. She is so different than what she used to be. Even she used to try and cover up and lie; now she doesn't anymore. She doesn't care.

Facilitator: It's hard to watch and I heard you say you don't want her to die.

Sally: No.

Facilitator: And you know you don't have any control over it, nobody does.

Sally: Short of committing her.

Researcher's Process

The session was powerful and dynamic given the nature of the death theme and the unfolding group process. I was impressed with participant's continued authenticity of expression in both their narratives and group dialogue. While I felt somewhat surprised by Sally's abrupt disclosure at the beginning of the evening, I was also aware of her growing frustration with the GA process since week two. I was relieved that she verbalized her experience despite being confrontational at times. Moreover, I felt thankful that Sally was able to receive the support and care that was available to her from the rest of the group. As a result of her willingness to stay with the inquiry process in combination with the group's ability to contain her anger and frustration, she had an important breakthrough experience where she expressed difficult emotions and made some important realizations including her fear around losing her sister.

As facilitators, we did an excellent job of containing Sally's anger, redirecting digressions, encouraging dialogue, and maintaining safety within the group for all participants. This may not have occurred in a group that was facilitated by non professional counsellors. I was also impressed that Arlene took the initiative to provide Sally with honest and direct feedback thus expressing support and care but also naming her unwillingness to engage in the GA process. In terms of group process, it was important that Sally heard this feedback from

another group member.

In terms of women's narratives, I felt particularly moved by Bev's heartfelt story in which she articulated her experience of loss surrounding the death of her father and family pet. Her story easily resonated with my own experience of nearly losing my beloved dog a few years ago after she had being hit by a car and who more recently has served as a "life-line" in my own recovery around a difficult relational loss.

Following the group, I had a sense of completion and closure and did not have the need to debrief the group unlike other weeks. After several days of resonating with the group experience, I eventually contacted the facilitator to review highlights from the group, plan our final session and discuss Sally's note. We decided that she would contact Sally to check with her intentions for the upcoming session and were prepared to ask her not to return to the group unless she was intending to engage in both the group and the GA process. Sally assured the facilitator that she was committed to fully participating in the final session and to disregard her earlier note.

Researcher's Interpretations of Theme Five

In general, most participants returned to the group feeling rejuvenated from their holidays and ready to resume the last few research sessions. The growing cohesiveness of the group was evident as women were extremely engaged and supportive in listening and responding to each other's narratives. For the first time, participants stayed behind after the session ended to continue talking with each other.

The topic of death is rarely talked about between cardiologists and their patients or as a lecture topic in cardiac rehabilitation groups beyond the perfunctory communication of statistics outlining the risks associated with procedures and/or treatment. This code of silence between health professionals and their patients perpetuates the unspeakable nature of death. Consequently, inviting a group of women who have experienced MI to talk about death and dying seemed both unorthodox and yet critical to constructing an understanding of surviving and recovering from a potentially life threatening event. Needless to say, participant's narratives were deeply reflective and suggestive of their beliefs and meaning making processes related to life and death.

I found the process of content analysis very complicated for this theme given the diversity and complexity of women's experiences. Several factors appeared to influence women's behavior and their attitudes towards death including family attitudes and early experiences, cultural beliefs and practices, the closeness and value of relationships, coping styles, individual psychological factors, and personal illness. In general, however participants

demonstrated significant differences in how they talked about death and experienced dying in others.

For example, the occurrence of death was perceived as being natural and common for two women who had respectively grown up on a ranch, "we accepted death as an inevitable part of ranching life," and during a period of political revolution, "every day we faced death, it is like our shadows and we are used to it." In contrast, another woman reported "I haven't had much experience with it."

Several participants expressed mixed reactions to the expected deaths of aged family members including pets. In speaking about her grandparents, one woman suggested "I felt their deaths deeply but accepted them as you expect old people to die," while another woman acknowledged that "despite having several years to prepare for my dad's death we still found it difficult."

There appeared to be a greater intensity of expression in the stories of several women who reported the unexpected and traumatic death of loved ones. In describing the loss of her infant son, one woman acknowledged feeling "crazy with grief" and suicidal. Her son's death evoked feelings of profound guilt and regret and represented only one of many devastating losses over her lifetime. Interestingly, she was the only participant who acknowledged being generally afraid of death and visibly shaken at the prospect of dying from MI. While her descriptions suggested that she had historically tended to minimize aversive events, she was conscious of the seriousness of her recent MI.

In contrast, another woman reported that her sister's suicide had "impacted the whole family" but did not speak directly to her own experience of loss. The absence of expression in her narrative was striking but she acknowledged that death "wasn't something we talked about" in the family. At the same time, she succinctly described the grief associated with the recent loss of her dog as being akin "to losing a baby."

Evident in several women's narratives were ways in which they honoured and coped with the death of loved ones. Some women made reference to nature imagery, "I often feel my dad visit me on a gentle wind," and "I knew that my son was that star and that he would always be with me." Other women talked about the importance of ritual including an infant's "baptism before his funeral," and the ceremony of one woman's father and "putting ashes in the ground and we all had a flower." Women also described mourning death by "crying" about one's loss, "attending funerals or celebrations of life," and "talking with family and friends."

In this sense, most descriptions suggested that the mourning of death brought family and friends together versus pushing them apart. Another participant suggested that "we live on after physical death in the hearts and minds and stories of those that we loved and who have

loved and cared about us." As part of their narratives, several women told colorful stories about loved ones that had died.

Overall, most participants reported they were not afraid of dying although not all women talked about their MI within the context of death. Some women clearly outlined their beliefs about the nature of death. Three women suggested that death is an event that cannot be controlled: "I don't believe you have a choice whether you die in an accident or by failing health...it is out of your hands," and "death will happen whether we want it or not and nobody can help us when that time comes." This 'uncontrollable' quality of death parallels the often sudden and unpredictable nature of MI. Several women spoke to the uncertainty of not knowing if they will suffer another MI.

Another participant suggested that "death is about starting another journey" that could result in greater happiness and a clearer understanding of the "real meaning of life." She understood her own survival from MI as meaning "it was not my time to go." Consequently, she conveyed little anxiety about having another MI. She suggested that if she were to die, "I could be with my family, who passed away before me."

In contrast, another participant, who appeared to demonstrate a healthy attitude toward death and dying, made no reference to her MI in writing about death. Interestingly, she did not consider herself to be "ill" with MI; "I just felt weaker after my heart attack emotionally and physically." Only being hospitalized for a day and a half may have influenced her appraisal of the severity of the event. Embedded within her dialogue however, were concerns about not wanting her mother to "be burdened" by witnessing her feeling weak:

I really needed her to see me strong, not ill. She has enough to handle without that...and I think she's always wanted to die before us. I think she sees that as the order of things that parents die and then children do.

Perhaps for this woman, being seen as ill was synonymous with breaking the family "order of things" whereby children are supposed to die after their parents. Other factors, mentioned in earlier sessions, such as a serious accident that felt more threatening to her than her MI and deeply rooted family rules highlighting the importance of fulfilling responsibilities in spite of adversity may have also influenced her perception of the MI as not being a potentially fatal event.

Similarly, another woman who was also close to her family dismissed the potential severity of her MI, "we weren't prepared to die...death is when you are older." Interestingly, one of her sister's died tragically in her early twenties. Moreover, she had stated previously that she could not die from MI because of the impact on her parents particularly in lieu of her sister's death. Whether her defensive stance stemmed from protecting her caregiving role or from fear or guilt of breaking the family code of silence in relation to misfortune is unknown. While there is

a place for healthy denial in the life of a cardiac patient, particularly in terms of managing anxiety and stress, denial can clearly lead to exacerbated health risks if it gets in the way of help seeking or making healthy choices (e.g. altering unhealthy behavior).

Surprisingly, only two women wrote about looking beyond death to the experience of living life. In talking about her fear of death, one participant acknowledged "I like to live every moment of my life to the fullest and I would hate to pass over with the thought that there were things that I wanted to do but never did." In previous discussions, Arlene viewed her MI as a wake up call around tending to her health. In contrast, the longest MI survivor suggested:

Each day is such a gift and wondrous opportunity to be happy and alive again...my heart attack really helped me to become happier inside with just myself and my spirit. I feel quite content most of the time...I don't think about death so much after the MI as I think about life and the quality of life that one can achieve.

A significant part of this woman's recovery process has been exploring spirituality and her emotional health within the realm of creative expression, "I truly believe that healing is achieved through our creativity." While Helen's journey clearly speaks to her introspective nature and commitment to personal growth, perhaps addressing emotional healing is also reflective of having generally regained a sense of confidence in her body and heart after 3 years of recovery.

Finally, in discussing death, most participants discussed the experience of loss of the death of loved ones. More specifically, three women spoke to the grief of anticipating the death of their aging mothers. Another woman talked about her fear of losing her sister to a drug addiction. As well, a few women spoke to the emotional loss of not having "a close and loving relationship with a partner." One woman acknowledged that "my heart has been broken so many times in ways that hurt more than a heart attack." Moreover, a few women expressed sadness at the thought of not getting to see their children grow up had they died from their MI.

Guided Autobiography Theme Six

A Personal Story of My Recovery from MI

The final GA session comprised of a brief group check-in, reading of the theme autobiographies and group feedback, a closing check-out, and a brief discussion about the subsequent follow-up session. All participants were in attendance.

Group Check-In

Participants briefly reviewed the highlights of their week. While Bev and Sarah reported being very busy with their respective family and school responsibilities, Arlene described feeling "very upset" about a disappointing salary increase. In contrast, Helen reported having a "gentle

week" which included enjoying some unstructured time at work where she felt unhurried and was able to do some important planning and organizing. Finally, Sally acknowledged taking some positive steps towards in talking with a friend who she is having difficulty being assertive with.

Arlene made a point of inviting all group members to the monthly potluck she had organized with other members of her cardiac rehabilitation group.

A Personal Story of My Recovery from MI

In this final theme, participants were asked to look forward between 5 and 7 years to imagine the story they would like to tell about how they experienced their recovery from MI. In this sense, it was an opportunity to look back in time from a future place, similar to constructing a final chapter in a book. Sensitizing questions included exploring what women would like others to read about their experience, the impact and meaning of the MI and recovery experience, challenges and coping strategies, dependable inner and outer resources, resonating metaphors, personal awareness and growth, and the title of women's recovery stories.

Five participant narratives and feedback have been presented.

Bev.

On August 26, 2003, I experienced my first MI. At the beginning, it took time for me to get my head around the fact that my heart had been damaged and repaired with the help of stents. At 53 years of age I didn't feel old; however, here I was experiencing what I had come to think of as something that happens to older people who have led stressful lives, have a "heart history" and who haven't taken very good care of themselves or made wise choices.

In the middle of my recovery, I sought information and began to make changes in my personal life. I joined a Healthy Heart program, joined a walking club program and began to actively reduce the weight that I've gained during the past 5 years. I believe that on August 27, 2003 I drew up a kind of contract. The health care system provided the expertise to "fix" my heart problem, now it was up to me to honour my part of the agreement to exercise, lose weight, and to reduce my stress level. I believe that I am accomplishing the goals that I have set for myself, for the most part, with the help and encouragement of family, friends and health care professionals. It's hard work. Anything that has ever seemed worthwhile is always hard work. The weight loss is the most difficult part. I try not to think of how much weight that I have to lose, rather how far I've come. To do otherwise might cause me to give up and that is not an option.

Other than writing about my MI, I don't think about it much any more. Like every other health concern which has come my way, I try to deal with it and move on. Perhaps I'm nearing the end of my recovery, perhaps not.

The metaphor that comes to mind when I think of my recovery is a river. A river is ever changing. It can be calm and slow moving, seeking a familiar path and its own level, or swift, churning and swirling around obstacles and over rocks. It is the life's blood of a community. Even though it may be only a tributary, the force of the water has the power to change the landscape forever. The river provides a home, shelter and sustenance. I am that river, ever changing. I am calm and certain at times, comfortable. Other times my life is turbulent, moving so swiftly and there seem to be so many obstacles in my way that I sometimes lose sight of the destination. I am powerful and I have the power to change my own landscape, carving out new pathways should old and familiar channels become blocked or no longer viable. I provide a safe haven for those that I love and care about, guiding and guarding them as best that I can.

What does the future hold? I don't know. I don't think about it too much. I want to be comfortable. I don't want to have to worry about having enough money on which to live. I hope that my health doesn't fail too much. I don't want to be frail nor in constant pain. I want there to be joy and happiness. I want to be able to contribute in a meaningful way. Much of the way that I will live in the future is in my hands; some of it is in God's.

Helen: I like the river as a metaphor.

Bev: Thank you. I've always found water to be very comforting. When you look at the ocean it's very tranquil. It's ever changing; you know that the waves are coming into shore, but it still is different every time you look at it. And the same with the river; I grew up not too far from a river and it can be mighty in the spring with the run-off and then it's reduced to this little sludge filled trickle with fish in the deep end trying to survive. And then it's frozen, not moving much at all in the fall and winter months. I have always enjoyed going there, I've always found a little place that I used to go as a child and there were always logs to sit on and I would sit for hours and watch the water go by and watch it make its way around rocks.

Arlene: I like the way you put it altogether, it runs very smoothly. It's funny when you were talking about a river I personally attribute that metaphor in my heart, because of the arteries being like a river.

Bev: I thought about that when I was reading it.

Facilitator: I guess what I got from your story too is to hear how you have come to terms with some things; how you got your MI at the age of 53 and the exact date and that's now in your

memory and the shock of it or something like it couldn't be something that would happen to someone like me. I'm also appreciating your determination and your goals and that you talked about making a contract. There's learning in that for me just in terms of my own health.

Bev: I hear about other people and David Crosby the singer comes to mind again. He had a liver transplant and I don't know that he has changed his lifestyle all that much since. I don't know if I have a right to comment on this, but I will anyway. Someone gave him a very precious gift. Someone obviously died and someone was thoughtful enough to provide a liver so that he could live. I think then it's his responsibility to try the best that he can to appreciate that gift and to really change his lifestyle, so that it reflects not only his gratitude but the fact that he has been given a second chance. So many people never get that opportunity; they die long before that ever happens. I think in my case, nothing was donated to me, but like I said a while ago that money was available so that I could have the procedures that I did and I'm grateful for that. I have no idea how much that costs and I probably really don't want to know, but I have a vague idea of all the procedures that my husband has had over the years and how much that has cost and I'm grateful that that money was available. And so I really feel an obligation to do the best I can with all of this. Some days I feel miserably; there are days when I really think "oh it's raining well, I don't know that I want to go and do these things," and I really have to make myself do it sometimes.

Researcher: Who's the obligation to?

Bev: Primarily to me, because I want to know at the end of the day that I've done all that I can. I don't want to be sniveling and whining about my lot. Basically, it is up to me and it may get to that point where I am incapacitated, but I'll know that I've done all that I can then that is all I can do. But if I haven't done everything and then... I have a friend who has had a couple of MI's and she is enormous she is probably three hundred and some pounds and quite a bit shorter than I am. She doesn't move and has had a leg amputated. She whines and snivels and just lives a miserable existence. She's not really living; she just exists. And that's not what I want for myself.

Arlene: I like the idea of the contract and that you put down what your goals were. It's so much easier to attain goals when you write them down because you made a commitment by writing them.

Researcher: I really like the idea of a contract too. Just as you're talking I'm thinking if you were to give that contract a name what would you call it?

Bev: That's a tough one. I don't know what I would call it. I guess "Caring for Self." It's part of me taking care of me.

Sarah: I see that she always seems happy. I think and she has a good family, probably a good husband who is a good partner. I think that's the best thing you could have.

Bev: That's true, I do have a lot of support. But also I've always tried to see the humorous side of life too. There's humour in everything.

Sarah: You cannot do that if you are depressed. When you are depressed you don't see anything that is funny. Everything you see is the bad side.

Helen: I've been depressed and depression is actually more debilitating than the heart attack. There's no movement at all. You are stopped in your tracks. The physical experience of a heart attack has been, for me, easier and more successful to overcome than the depression.

Bev: I haven't experienced depression as such, but I certainly have a really close friend who has and whom I helped. I supported her for a very long time and continue to do so and I think that is a really tough thing.

Arlene.

Prefacing her narrative, Arlene reported feeling extremely upset by a recent performance review at work where she had received what felt like critical personal feedback from her boss and a very disappointing salary increase. "So I had to take all that and swallow it and say very little about it, which really bothered me. Though I did tell him that I didn't entirely agree with everything he had to say." Given the extent of her responsibilities outside of the original job description Arlene had expected to receive a "substantial" increase.

I'm upset. I don't know how to handle it; I don't think it's fair. If I didn't feel so inadequate because of what I've been going through last year, I probably wouldn't stay. I was really upset. I think he's using me, the company's using me and I don't like it.

After describing her work scenario, Arlene read her theme narrative.

It's very interesting how I feel about my heart attack. I am still angry that my body let me down again. It scares me that I have no control over what happens to me. I feel very vulnerable now and weak. I hate the fact that I have to take so much medication. It scares me that the cost of all this medication might affect me to the point that I may not be able to afford it as I get older and can no longer work and be covered by group insurance.

My family is very supportive. I believe they have been more so because of all the illnesses I have gone through, then the shock of me going through an MI and dealing with heart failure. I believe they feel I do too much and often shake their heads. I tell them that I want to live life to the fullest, and they must understand.

I'm scared to show any weakness as I feel that once I give in I will always be weak. I ache all over and believe the doctors have given me medication that is causing this. I

know exercise is so important but I am finding it harder and harder to keep up. I wouldn't admit this to anybody. This is something that I would never tell anybody.

I believe the Healthy Heart Program has been the biggest help in understanding what has happened to me. Along with the knowledge I have learned about the different exercise equipment and free weights, I have been able to absorb what we talk about weekly in the discussion groups. This is all very interesting. With all this knowledge though, I truly feel very vulnerable about not being able to stop another heart attack from happening in the future. There has been a small support group that has formed that helps me keep in line. I need the constant reminder to look after myself, as I tend to forget.

This research group has really helped me to understand my feelings about what I have gone through in the past. I feel the reflection has been very healthy and has given me some peace.

In my job, I am definitely not as aggressive as I once was. That leaves me with a feeling of loss. I feel I am settling for things and that angers me. I do not have the stamina I had. I don't trust my body anymore. I feel tired all the time.

I feel like I am walking through mud; always a battle and very tiring. I would love to have an Islet transplant. I believe that it would give me a chance for a normal life.

Perhaps with the transplant, my heart won't fail me again.

Facilitator: What was it like to read your story given what you just said about your anger and frustration and that you haven't told anybody yet?

Arlene: Well, interesting. Obviously there is a trust I feel in this group. I don't know how to deal with it.

Helen: I know. I can understand why you don't know how to deal with it.

Arlene: The job situation and the anger I feel; I don't think about it. Therefore, it doesn't bother me, but when I do think about it I'm very angry.

Sally: Because you are worth more than forty-two cents.

Arlene: And the fact that I've got to bite my tongue.

Facilitator: What I really got from your story in this context is that this is really symbolic of your feelings of helplessness and frustration of a heart attack and your body letting you down. I just get this sense that you feel helpless to change anything.

Arlene: But on the other hand, it makes me so angry that things will change, but maybe not with that company. And I'm definitely going to pursue other avenues. Whether it's to reactivate my real estate license again, this is a damn foolish thing to do, to actually work at real estate. To reactivate it would be good for work in retirement, which is why I want to keep it. But to actually

work at it and have to depend on that is a lot of stress without having a partner. If I had a partner and money was coming in, then it would be totally different, because whatever I made would be gravy and I could make thousands of dollars more than I'm making now per month. That's a big step by yourself.

Helen: Something that's not regular, that you can't actually count on all the time.

Arlene: Then there is the group insurance that I have with this company and that's a big thing.

Helen: With all the medical stuff that's happening, you need to feel confident that you do have a medical plan.

Facilitator: I'm just struck too just knowing some of your history about being such a self-starter and making good money, an achiever, that when I hear what you're talking about I wonder if some of the frustrations you feel didn't help that. You're in a different situation; someone else is evaluating you, your boss.

Researcher: That's being the "stuck in mud."

Arlene: Because before you see, if I wanted to make more money it was up to me, the sky was the limit. Nobody dictated my wages.

Facilitator: It's the situation; it seems symbolic of everything to do with your health too. Because I think you said to us earlier, part of the reason that you chose this job was that it was going to be easier and one way as part of your recovery, in the sense that, "I'm used to taking on more and earning more, but this is keeping me maintained."

Arlene: But I'll tell you one thing, if I had my health I would not tolerate this. And I am, I'm biting my tongue, and that's not like me (laughs).

Facilitator: Is it at all helpful to say out loud that it's because of your health that you're biting your tongue?

Arlene: Yes, but it doesn't make it right (laughs).

Researcher: It's like the internal bite. On the one hand, you need some of the things that this position offers you, the medical plan and security, but the feisty part of you is saying "this is so wrong." How do you reconcile those two things?

Arlene: I just can't wait until I'm stronger, healthier. Last time I saw the cardiologist he figured it would take another year, year and a half, because I am having a lot of problems.

Facilitator: So, it is a real consideration.

Helen: So maybe it means having to be accepting of this situation and lay low for now.

Bev: And give yourself permission to do that, for now until you are stronger.

Helen: Only accepting that you are not as strong as you will be in a year and there's not much you can do to change that. If somehow you can find it in your being to, almost in a way, let it go and live within your means and know you have a health plan and get yourself stronger without fighting it. It doesn't matter how hard you fight or how hard you push or how angry you get; it's not going to make it any different that you need about a year, year and a half to achieve a stronger sense of your physical health. I guess I just see the fighting in this situation as causing more stress, more angst and more bad things in your body. So that you can come back swinging.

Bev: I think I'm with you. I would have a really hard time. I would work within that year and a half time frame, but I would have a really difficult time not to say to the person, "you know I'm still feeling that this isn't resolved and I feel really strongly about this. You may not agree, but this is how I feel." I don't know how you will handle it, or what your comfort level is, but I don't think I could let it be if it's going to eat away at you.

Sally: You've always been an over-achiever. You thrive on a lot. Why not just go and get another job?

Arlene: If I could get enough medication stocked away for a 3 month period, I would definitely look at other jobs.

Helen.

So I called this piece the "The Fountain of Forgiveness: The Last Chapter."

Well in some ways a heart attack for me was a wake up call; a calling of spirit telling me to wake up and become more conscious. At the beginning there is a huge sense of loss and sadness. I may not get to live... forever. But as I have mentioned, I'm living or trying to create the qualities that I love in my life. I want to eat and sleep well with exercise being an enjoyable part of every day. I want to be close with my family and spend time with friends who are also conscious. But I also understand loyalty and compassion towards my friends that choose to remain closed hearted and negative towards living. I want beauty around me, not stuff and more stuff. I want to be close to nature drawing upon the qualities of mindfulness like wonder, dreaming, intuition, humour and play, as well as the more serious sides of my intellect that involve achievement.

Finding a sense of spirit has been the most helpful for me and choosing to create my life as I see it or want it myself. For example, I want music in my life so I am playing the fiddle. I want to travel and I have been building confidence each year by going a little further from home and being a little bit more adventurous. There's not much I don't feel okay to do.

I think if I had a metaphor for my recovery it would be a fountain. Because I think the whole experience is about learning to love. That is learning to love in the grandest and most gracious use of the word. That is to be aware and conscious of the ever expanding and constant outpouring of love that is in the universe. That's all there is. There's just love. We're learning about it with every experience that we have. But I believe that we need to become quieter/or perhaps more still within our chattering minds and busy lives in order to hear and see and feel more deeply. Easier said than done!

A good title may be called A Fountain of Forgiveness, because it is in forgiveness that I am able to feel an outpouring of abundance. But forgiving is so hard and I hang on so very tight to all the things that have hurt me. I think life really is a healing journey and the arts provide a process for continued renewal and transformation. Why is it so difficult for our society to embrace, in the face of sports, business, competition and bigger and better and more and smarter and faster and busier. It all seems to be the values that we uphold and I'm just as easily consumed by it all as the next person is. But my body has given me the opportunity to try to see it otherwise. There's not many days that I wake up unhappy. I'm excited about my days. Although I struggle with my desire to do everything and all that I enjoy, I'm trying to stay centered and in the present. I want to become still enough in my daily life so that I can draw closer to my true nature.

As for the future, I want many things but most of all I just want to stay peacefully engaged passionately in my journey.

Researcher: Wow. I'm really struck by the forgiveness piece and what you said about spirit and love and your understanding of the importance of forgiveness.

Helen: Well, I think forgiveness is the biggest lesson we have to learn and it's probably the hardest and it's not that we all of a sudden forgive everything; it's kind of like little miniscule inches. Then some days it's bigger than others and I mean forgiving myself, forgiving people and forgiving circumstances and situations. "I'm going to stay and I'm going to hang on." And I remember when I was clinically depressed for almost 2 years. Boy that was hard work; staying depressed was hard work, but that's what I do and I knew I wanted to stay that angry and that upset and that depressed. Not until after a lot of help and some good antidepressant drugs, I finally went, wow, this is so hard on your body just kind of forgive the fact that all that happened and that you put yourself through this because my goodness. It became easier. Not that I was able to just let it all go but certainly with that understanding that this was forgiving.

Facilitator: I was struck by that too, what you said about "hanging on tight to what is hurting." I was going to ask you what the link was to forgiveness.

Helen: Well, because with forgiveness comes a sense of abundance and a sense of outpouring. You can't access that when you're in the state of not forgiving, because not forgiving is like this (closed gesture) and forgiving is like this (open gesture) and soon as you're like this, there's a flow and an abundance of light, of energy and peace, of wonder, of all those qualities that we all have or we can all be mindful to having. As a matter of fact, maybe that's what heaven is.

Facilitator: Well, I really sense a learning process for you Helen, but it makes me also curious. How did you start to unlock what you're describing now, given that you were clinically depressed for 2 years and then hanging on to that.

Helen: Well, the hanging on would come from a lifetime of disappointments or pain or hurts. That's what life is right? You have a barrage of things that hurt you. They just keep coming at you and as that's happening I think the process of learning to love, which involves forgiveness, is all part of it; dealing with an onslaught of things that keep being hurled at you. So if you are learning to maneuver through that at the same time, when you are engaged in your creative spirit, that's one of the purposes for it in order to deal with all of that and to not hang on so tight to the things that hurt.

Facilitator: Yes, there was something that I also saw in Bev's story about looking to the light or actually seeing that there is wonder in life, or something to gravitate towards. I heard you listing the things you want in life. I was really struck by that.

Helen: I think it's easy to say that we want these things, but without a process how do you transform yourself. That's why I think if you engage your creativity, you're able to go through a process of some kind in order to go from here to there, to make this experience that was painful or even ordinary into something more extraordinary or better; elevate it.

Researcher: I'm just curious, during those 2 years were you doing art?

Helen: No. I was barely surviving. The heart attack may have come closer to killing me, but not in my mind. I was very close to just giving up. I was very scary. Had I had more guts and a reasonable way to kill myself, I would have killed myself (laughs). I couldn't come up with anything that I had the courage to pull through. I was just hanging on. And my daughter was five at the time, so that was my reason to hang on. And every once in a while you would have a real slap across the face that would be like, okay, if you let this go too far you're going to lose her. Try harder. But it still took a long time.

Researcher: I can't imagine given what you just presented in the group and who you are and your connection to creativity and spirit. I can't imagine what that was like for you not being in a creative place for 2 years.

Helen: It was very black. I have a few close friends that do struggle with depression big time and I have lots of empathy for them. It's real tough.

Bev: I'm struck by the forgiveness part of it. When your body lets you down, it's really difficult not to blame yourself and say if I'd only done this or I'd only been there and I think part of loving yourself is forgiving yourself for your short-comings.

Helen: I find it's not even blaming yourself, it's just blaming whoever is out there; how come they get to have it easier? How come they have more money? How come they don't work this hard? Then again, that's the place where you are when you're tight, when you're angry. And as soon as you let that go and say, well, that's not my story, my story is I've had a heart attack, then you forgive that. You forgive the fact that your own story involved this event and you just feel a little bit gentle with yourself.

Arlene: How long did it take you to forgive yourself?

Helen: I'm still working on it. There are days when I feel that I have it all worked out and other days when I feel I haven't learned a single thing. And also just coming to terms with being alone. That's huge. That's been my work probably of the last little while, just becoming comfortable living alone, spending a lot of time alone. At first I would rail against that, I didn't want to be alone, I didn't like being alone. The best cure for loneliness is solitude I think, because you get so that gee it's not so bad and then pretty soon it gets to be quite nice. Then you know you begin to really enjoy the peacefulness of being alone.

Arlene: But still appreciate when company comes.

Helen: Oh yes. I would love to maybe be in relationship again down the road, but there's not this urgency that, oh, I feel really uncomfortable; I need to be in a relationship. I feel great that I've come to a place where I don't feel so urgent about that whole issue. It may be months from now I might feel urgent again, but I feel okay about it now. Maybe I might be alone. I guess I always felt that happiness would be brought to me by somebody else, just like somebody else would bring me music in my life, and somebody else would bring me money in my life, and somebody else would do it. That's kind of the hope and that at some point you realize it's not happening. If I want this to happen to have to do it myself.

Facilitator: So I hear what you're saying about gaining back control and realizing there are things you can affect, even in doing creative work something can happen.

Helen: And making it your mission to control the variables that you can. And the one that you can't, which may be that I'll have another heart attack, well I can't think too much about that. I can think about the ones I can control and that's takes all my time and energy. It's a very good position to come from. I wished I could have learned it when I was twenty, rather than when I was fifty, to take that responsibility.

Sarah.

Having a heart attack did not scare me; I was scared because of people's reactions around me. I told you the saddest story and I do not want tell it again. At the beginning, I was very sad and very angry, because I felt that I was the loneliest woman in the world. After a few days, I used to think that I should never count on others and since then I have never counted on anybody's help. I have experienced that most organizations that are to help people have made more problems for me.

Now I know I am alone and I will be alone for the rest of my life. I am the only person who can help me with my difficulties; unless I go back to my country which I do not want to do.

Although going to school was not easy, it helped me not think about my sad experiences. Keeping myself busy, thinking about my family and not wanting to hurt them has helped me a lot in my recovery.

The most stressful challenge I have had is dealing with the provincial student loan organization and college's financial office. They seem to either not understand my health condition, or if they understand, they do not care about what happened to me. They still have sent me letters asking me to pay back the loan. I have not gotten over from this problem yet.

My recovery is like a sailing ship, sometimes everything is fine and sometimes you have storm. I can name this chapter of my story "Have You Ever Recovered?"

During the heart procedure, I was telling myself "you did not come here to die; you must stay and see your success. You are strong enough to survive, and you have always survived." I did not want to give my family more stress; they have had enough loss. "No you have to stay and you must fight and show them your success not your death. If you loved them you should stay." I was [picturing] them crying and their sadness and their grief and their sorrow. This image made me not want to give up. I have stayed for my family; for people I have loved.

During my recovery the only person who has helped me is my old best friend, who is also my roommate. He did every thing that a brother could do for his sister, and I am so grateful for his help.

I just want to live in peace and be relaxed. I do not want to be worried about anything. I want to have my trust in people; I am suffering from not trusting anybody. I cannot believe people's word; something inside me is broken and it hurts a lot. I want to be happy, hopeful, energetic, and relaxed again. Being worried all the time, having nightmares and feeling bad about people, scares me for my future. In order to get away

from those bad feelings, I need to find my confidence again and I am trying to make it happen.

Helen: I think you'll be successful.

Facilitator: It's very moving to hear you talk about your experience and your desire for your family.

Sarah: They're the only thing that helps me. I don't want to hurt them.

Facilitator: Makes me think that when you've had a loss, or a trauma as you have had with the MI and with the way people reacted, it stirs up other losses. I really get from you how much you miss your family, miss home. Right? That's a big loss. But I also heard some hope in this story this time which I haven't heard before when you said "I didn't come to this country to die" and I plan to see that I'm successful.

Sarah: I came here to have a better life. I came here to be successful. I never was like this. Every time I wanted something I got it. I know myself. I never had to take a course to learn something, I learned everything by myself. I was very satisfied with myself but here no I'm not. I feel that I'm not useful anymore. I'm not busy now.

Arlene: That's definitely a trait I think from having an MI and not feeling good enough, because I definitely feel that way myself.

Sarah: That's not good, because I am scared of going for interview or telling somebody that I have a heart problem. I heard nobody wants an employee or a partner who is sick.

[Arlene nods in agreement].

Sarah: And also my friends at school. I sometimes have chest pains. I had pneumonia and I'm getting better now. It wasn't very hard it was very mild but I am sick of being sick here, because I never was sick before.

Arlene: You're sick and tired of being sick and tired (laughs).

Sarah: Yes. Since I came here, every day I have something. One day its lipids; another day is heart attack; another day is joint pain or chest pain. It wasn't like this. I worked very hard. I usually started at eight o'clock because I was an accountant and we were very busy and sometimes I worked until two in the morning and I slept in office. I managed but I was tired. I was very happy. Now sometimes I can't see myself. I forgot how to laugh. I forgot how to be happy and I don't like it.

Sally: It'll come back.

Sarah: I've been taking medication for 3 years but nothing changes, except I am getting bigger and bigger because I don't like to go out. I don't like to walk. When I am studying or I'm doing my homework that's fine. I'm not thinking. I am busy.

Facilitator: I hear too, that you're thinking and you're worrying a lot and it's so disturbing for you. I also appreciated hearing about your roommate. Your experience of moving from a country to a different country, different language and it's so stressful to do it by yourself. And you know everybody talks about support and what that means. So I'm just glad for you that you have someone like your roommate who is such a caring person.

Sarah: He is very nice. He's the best person I've ever seen. Sometimes I think he is my best friend. When I was in hospital he was there every day after work. When I got home my room was clean, he washed those clothes all my dirty clothes and ironed them because he knew I couldn't do it. He cooked; he doesn't let me do anything. And he helped me financially. He doesn't have much money.

Arlene: And you haven't been able to form any friendships in the 5 years you've been here? Why do you think?

Sarah: I don't know why. First, I cannot speak English, it's difficult. So people get bored by you. Then I started to study, going to school and I tried, but it didn't work. I have friends from my country, but I don't like having friends from my country because...

Arlene: It's too scary for you.

Sarah: I cannot talk to them. I cannot say anything. They pick every word you say and sometimes you don't know. They discover everything about you because they are saying everything. No, I don't feel safe with them. I don't like being around them.

Facilitator: So what has it been like for you to be in this group?

Sarah: Sometimes I don't want to be here because you know sometimes I think I have nothing to do with you because this is your country, your place, you have family, you have friends, you have everything which I don't have. So why should I be here? Why should I talk to you?

Facilitator: So, in a way, are you saying that reminds you that you are different?

Sarah: Yeah, especially after my heart attack. I cannot talk to anybody, I don't like it.

I wasn't like this before. I talked to everybody, I loved everybody. I was talking to my psychologist and she told me "Can you tell your story to your group, because they are not Persian?" I said "no I cannot talk to them, they are not like me."

Facilitator: I think you did talk to us somewhat.

Sarah: Just in a small way. I told you about very small parts of my life. And she is the only person I could talk to and knows about my life; nobody except my friend and her.

Researcher: So, Sarah, I'm just trying to understand, is it that you don't feel comfortable accepting other people, or you don't think other people would be comfortable accepting you?

Sarah: I cannot trust them. I think everybody's [habit of] smiling is not like my culture. If you are angry with somebody, you show it; when you are frightened you say something. It's not [typical] in our culture to always smile. No, if you are angry you show it. Here I see everybody smiles.

Facilitator: So you're saying that culturally, of course, we are different and...

Sarah: Yes, they are smiling at me, but at the same time they are smiling they don't care.

Researcher: So you mean like the sea bus; everyday they smiled and then when you needed their help they didn't help you?

Sarah: Yes, they didn't care.

Researcher: So how do you trust someone that smiles?

Sarah: I cannot because I think "what's wrong?"

Sally.

While Sally did not bring her final narrative to the session, she spent a few minutes discussing the current status of her recovery.

The biggest part is that I'm kind of embarrassed that I had the heart attack because you just don't think that we're going to have it. So to tell someone about it like an employer that might hire you is hard. Sometimes I feel really good and then like last week I felt so drained.

In terms of recovery resources, Sally emphasized the value of the Healthy Heart program but acknowledged her struggle to access inner resources such as her "ability to enjoy life" given ongoing symptoms of depression, "I just feel overwhelmed and climbing out of that. I don't want to get into the black pit but climb out where it's kind of gray..."

Sally submitted her narrative a few weeks following the final GA session. It has been included with some brief observations.

I had a heart attack the end of July 2003. I was contacted by the Healthy Heart Clinic at the hospital where they conducted a series of tests and started me on an exercise program. I never thought I would enjoy it so much but I do. I'm learning about how to do it properly which gives me confidence for the time when I join a gym. I feel the difference and I'm not all the way through yet. It has even helped the arthritis a bit. I'm more flexible now and strong. No, I mean my strength has improved. I just wish I wasn't so tired. I go gung-ho then I'm flat out tired.

My family and friends are wonderful. They are concerned that I don't get too stressed. I'm looking forward to getting back to my old self. That means new things for me. Setting boundaries I guess. That means saying no. That has always been a hard one for me but I have said it a few times even without an excuse just "no, I don't want to." Mind you that's been to my sister; anyway it's a learning process.

My mum and dad and I guess myself used to just think if it's broken the doctor will fix it. So at first, my dad didn't understand why I didn't bounce back after a few days, but since then he has been very supportive. They may not fully understand there was some damage; mind you, it took me a while too.

The nice part of my journey would be to describe my baby (dog). I never thought of her as a dog though. She was a little lady. So I do what she did; I enjoy my walks, smell the roses, take each day slowly one day at a time and love those who love you and trust your instincts. So I misjudged once along the way last year but I'm my own boss now. If this was a chapter it would be "No! That's Hard to Believe."

During my MI, I had faith in the paramedics and God. God has guided me through exercise and information. I could have chosen not to go, but I'm so grateful for the Healthy Heart and the research group. It's been eye-opening as well as emotionally enlightening. I've realized I'm lucky to be alive and that's very scary because other people you hear about don't make it.

So, as for the future I'll do my best for my health. As for meeting someone, who wants someone with a problem? That's what's sad to me. It would be wonderful to grow old with someone because you don't see the differences and illness it is just one of those things. But Vancouver is for the young. My past is the past; my future is Da Da Da Dum. Stay tuned.

I get it now and it's now harder. Friends and family are great but who wants to know about the black days...actually who wants to listen. I've always been a good listener and I hear what people say. I need to talk about my real feeling but trust is a big thing. That being confidentiality. The circumstances in my life have changed so much I feel lost and helpless sometimes...no, actually right now. I must get a grip and sleep 'til it passes or just be quiet and alone.

Although Sally did not share her writing with the group, her final narrative was distinctively different compared to her earlier writings. More specifically, she discussed the impact of her MI in a more integrated, authentic and emotional manner. As the reader, I felt invited to understand her experience and a deep sense of compassion towards her. I was struck by her statement, "I get it now and it's now harder" as though the cost of becoming aware (moving out of denial) was painful and overwhelming. In doing so however, Sally may have become more open to receiving support from others as well as identifying ways to better support herself.

Group Check-out

Participants were encouraged to say a few words about their experience of participating in the research project or something they felt they were either taking away from the group (such as insight) or leaving behind (e.g. an old belief).

Helen highlighted the value of engaging in the reflection process as an extremely meaningful component of the group starting with the life line exercise as a useful tool for visualizing life transitions and significant events and then moving into the guided autobiography. As well, she felt the selected themes contributed to the meaningfulness of the exercise.

Moreover, Helen identified two concerns that she was symbolically leaving behind:

I think I am leaving behind a fear of being alone. And that feels really good like a big weight off my back. Not that I would not want to be in relationship but it just doesn't seem to have the same urgency as it has for all of my life. I also feel that I am leaving behind some anger towards my ex-husband and not just from doing this process but in the last 6 months of my life I have come to a place where I don't think he can hurt me anymore even though we share a child. I have just come to see him in a very different light and I know longer care for him the way I did.

Similarly, Arlene suggested that the group had been "a cleansing for me in that I have been able to get a lot of things off my chest that have been there for years and years and that were never discussed." She identified wanting to leave behind the belief that she "can fix everything" and reported being able to "say 'no' more than ever without feeling guilty." Arlene acknowledged wanting to eventually let go of the "anger" she had towards her body for having the MI.

I would love to let that go and I will eventually when I feel strong but right now I ache all the time so it is really hard to have a lot of energy when you are sore and when you are tired because of it. Pain takes up a lot of energy.

In contrast, Sally acknowledged her difficulties throughout the group, "it took me long enough to get it and I got it and that's why I was fighting the homework and I was angry." She identified an important insight that she had gained by sticking with the process, "to let go more of the shy part in myself and to be a little more assertive" with others.

Bev also described the group as being "very rewarding and really valuable" as a "forum to tell our stories about our experiences and our ideas about our heart attacks." In her exploration of the various GA themes, Bev came to a better understanding of a deeply rooted fear.

I recognize that I am very attached to my own family and parents and my brothers and that I've lost my dad and I will lose my mother I'm sure very soon. That was very difficult for me to think about but something that I really want to work on because it is a reality that we all face. I'm not worried about my own death, I never have been, but I fear losing

people that I love. I feel really good about most other areas of my life but that is one fear that I have and I think when I am able to really look at that and put it into perspective I will be better for it.

While Sarah acknowledged her ongoing struggle with having negative feelings and not wanting to talk in the group, she was able to share various stories including her unforgettable MI experience while on the sea bus. Sarah's statement that "something is leaving me" was suggestive of her efforts to overcome feeling silenced and finding her voice. Several participants confirmed the value of listening to her cultural stories as she "loved" talking about her country and Persian culture.

Both the facilitator and I spent a few minutes offering closing comments about tonight's session and appreciations for participant's contributions over the course of the research project. Finally, the purpose of the follow-up session was discussed (see Appendix G) and scheduled.

Researcher's Process

In general, I felt extremely moved by tonight's final GA session. While I was aware of feeling a sense of completion around this stage of the research process, I also felt somewhat saddened at the prospect of ending the group. This was not surprising given the intensity and duration of the project, my fondness for the participants and my passion for subject matter. Despite tonight's milestone, I was also aware that the recovery process for these women will continue long after the completion of the study and the eventual completion of my dissertation.

Tonight's session continued to be rich in terms of individual discussion and group process as women were deeply engaged in sharing their personal journeys of recovery with authenticity and candor. I was struck with the generosity of interest and support that women offered each other over the course of the evening.

For a brief moment, I was aware of wanting women's final narratives to reflect positions of strength (as defined by me) and resolution. In reality, this was not the case as significant variations existed in the tone and content of women's stories. In hindsight, I simply wanted to believe that each woman would regain a sense of physical and emotional wellness. For example, I felt worried about Arlene given her palpable anger in relation to feeling "betrayed" by her body. At the same time, I wondered if her current dis-ease and new insights around self-care would lead her to making healthier choices for herself. In this sense, perhaps this dissonance was a signal that she was challenging or reorganizing old beliefs or ways of acting in the world.

I particularly resonated with Helen's narrative on accessing spirit and spirituality in her recovery and healing journey and the importance of cultivating forgiveness as a means of releasing oneself from pain and suffering. I have been exploring similar principles in my own

recovery from a difficult personal loss. As well, I was inspired by Bev's notion of constructing a "contract" as a powerful image for exploring the commitment required to facilitate recovery from MI (or any other personal growth or healing).

Researcher's Interpretations of Theme Six

Ending the research sessions with all participants present felt like completion. The group was energetic and highly engaged in both the tellings of their MI stories and group dialogue. I was curious that women's narratives were more concise than in previous themes, perhaps reflecting the fact that they were finished telling their stories.

In general, women's autobiographies were rich and metaphorical in description as they spoke to the variation in experience of both loss and personal growth in their recovery from MI. Interestingly, three women selected images that related to water which may be suggestive of the fluid or changeable nature of illness recovery. (As a counsellor, I see the enormous value of working therapeutically with women's images within the context of healing).

In conducting the content analysis for this theme, I chose to examine each woman's narrative in greater depth rather than their experience of the theme. One woman equated her struggle with recovery from MI to "walking through mud" as she emphasized the enormous sense of loss associated with her perception of "losing control" and feeling "very vulnerable and weak" both physically and emotionally. She admitted feeling "scared to show any weakness as I feel that once I give in I will always be weak." As mentioned elsewhere, her association of showing weakness and vulnerability may translate to feeling like a failure or victim and would understandably elicit feelings of fear, anger and possibly shame.

Moreover, this woman's "battle" to stay in control, now that her body has betrayed her, emphasizes the loss of the belief (illusion) that she (or any of us) has complete physical control to begin with. Her history of significant loss and physical illness would attest to this. Ironically, if she could choose to surrender to the "battle" or find the strength to allow herself to feel weak then she might be able to reframe her experience as taking charge of her recovery rather than being defeated by her body. Interestingly, it appeared that she brought who she knows herself to be into other areas of recovery in terms of assertively seeking treatment, developing an informal cardiac support group and creating a disciplined regime of self-care.

In significant contrast, another woman described her recovery from MI and herself as being "like a river" which corresponds closely to her already existing role of primary caregiver. Like a river, she is able to "provide a safe haven for those that I love and care about, guiding and guarding them as best that I can." Moreover, she viewed herself as having the "power to change her own landscape, carving out new pathways" if necessary. Conceptualizing her recovery from the vantage point of an existing life role may have allowed her to better integrate

the MI experience into her daily living. Moreover, she has been able to access familiar resources and strategies in order to “manage” her recovery as she would other life challenges. In this woman’s story, it appears that she is not questioning who she is following MI as though her identity has subsumed the MI event. Moreover, her “contract” for recovery and “caring for her self” involves the application of principles and values including “commitment” and “doing your best” that guide how she lives the rest of her life.

The experience of MI, for another participant, represented a “wake-up call” or “a calling of spirit telling me to wake up and become more conscious.” Consequently, her recovery process has been focused on initiating her journey of spirit, intentional living, and meaning making which has involved “living or trying to create the qualities that I love in my life” in greater balance. Conceptualizing her recovery, using the image of a “fountain,” reflects her calling of becoming “aware and conscious of the ever expanding and constant outpouring of love that is in the universe.” Integral to this women’s recovery process has been learning how to “forgive” and specifically challenges previous ways of coping and understanding emotional loss. Moreover, integrating her MI recovery into her already existing world of creativity and art has allowed her to also access familiar resources and strengths in the facilitation of her healing and growth.

Other women acknowledged accessing a personal strength or new insight in telling their stories of recovery. One participant told her story of recovery in terms of her struggle to regain a former sense of self as a financially independent and loving and supportive woman, as opposed to regaining the health of her heart (I would argue however, that her story is about healing her spirit or her emotional heart). Ironically, her ongoing financial struggles, lack of social support (and loneliness), and the sense that she is not contributing to the well-being of others, have kept her connected to the profound sense of loss and subsequent depression that she experienced after moving from her country of origin. Her image for recovery as a “sailing ship” interestingly portrays the notion of a journey characterized by both difficult and gentle times. In cultivating positive images of herself, unlike much of her dialogue throughout the group, she managed to more fully access qualities of strength and determination, “I did not come here to die, you must stay and see your success, you are strong enough to survive and you have always survived.” She also expressed enormous gratitude for her supportive roommate who has felt like family to her. Experiencing strength and gratitude in the telling of her story allowed her to reclaim lost parts of herself including a sense of self-worth and openheartedness and may have brought her closer to recognizing the possibilities of achieving her future goals of feeling “peaceful,” “happy” and “trusting” of others.

Finally, one woman who had been previously defended around engaging in the process of reflection and writing, described in response to surviving her MI as feeling “grateful...that I’ve

realized I'm lucky to be alive and that's very scary because other people you hear about don't make it." In experiencing an "emotional enlightening," she reported having a mixture of feelings including greater confidence as a result of feeling stronger physically, but also a greater awareness of feeling "lost and helpless" given the changed circumstances in her life. I equated her comment "I get it now and it's now harder" to experience of a survivor of abuse who after many years of dysfunctional coping starts to emotionally thaw out and feel again and who often becomes overwhelmed as a result. Interestingly, she offered the image of her beloved dog as being connected to the "nice part of her journey" perhaps reflecting her needs for comfort and simplicity given the many challenges of the past year, "so I do what she did; I enjoy my walks, smell the roses, take each day slowly one day at a time, and love those who love you and trust your instincts." Sally also stated,

I'm looking forward to getting back to my old self which means new things for me like setting boundaries. That means saying no. That has always been a hard one for me but I have said it a few times even without an excuse just 'no, I don't want to.'

It would seem that her 'old self' no longer exists given that she has changed as a result of having a heart attack and through the process of becoming 'enlightened,' demonstrating greater awareness of her feelings, gratitude at being alive, and of her need to bring more of who she is into her life.

The Identification of General Themes

The analysis of women's autobiographies and group dialogue demonstrated a complexity and richness of women's histories and personal belief systems, affect and patterns of behavior. Although participants were instructed to respond to the GA themes within the context of recovery from MI, they did not always include specific discussions about recovery. Instead, women wrote about the complexities of their lives including unresolved conflicts, current struggles and future dreams, in passionate, contradictory, defended and in fond ways with emotionality and without feeling and yet all the while, full of meaning making which illustrated how they constructed recovery from MI.

By reporting the data as it unfolded during the research process, my hopes were to engage the reader and bring to life the multiple and fluid interpretations that informed the development of women's stories. While various commonalities and differences emerged from women's tellings, it became evident that recovery was experienced as being much more than the recuperation from physical illness following hospitalization.

Following a detailed review of my interpretations across sessions, categories of analysis were then organized and formulated into a series of general themes that further described women's recovery. The emergent themes include: a) the experience of loss, b) living with

uncertainty, c) changes in self-concept, d) personal needs and self-care, e) care and support, and f) taking care of others. A further discussion of these findings will be presented in Chapter Five.

CHAPTER FIVE

Discussion

Once there is a MI, there never is a 'like there was before the MI,'
because you know that it is always possible. (Helen, 2003)

The focus of this chapter is to further discuss the significance of study findings as they relate to women's recovery from MI. These results will then be discussed within the context of the selected literature review in the area of women and cardiac illness and recovery. The chapter concludes with a discussion of the limitations of this research, recommendations for future research, implications for practice, and a brief personal reflection on conducting this project.

Recovery Themes

Six general themes emerged from women's written autobiographies and the group dialogue including a) the experience of loss, b) living with uncertainty, c) changes in self-concept, d) personal needs and self-care, e) care and support, and f) taking care of others. Although each theme has its own distinguishable features, they frequently overlapped and interacted with each other in a manner that reflects the complexity of women's histories and their constructions of recovery. The uniqueness of each woman was illuminated in the variations in which themes were expressed as women's autobiographies reflected contextual variables including personality (Byrne, 1990) and sociocultural factors (Loustounau & Sobo, 1997). In this section, the six themes will be described and discussed.

The Experience of Loss

The experience of loss was the dominant theme across all participant autobiographies and group dialogue relating to various aspects of their illness experiences and personal histories. Loss in this context suggests the diminishment of or existence without something that has personal meaning. As well, loss directly relates to the unpredictable nature of the MI event which inherently suggests the transition from a place of (presumed) wellness to that of illness or potentially death. The experience of loss tended to overlap with features of other themes and was the overarching theme under which all the other themes unfolded.

In general, women talked about experiencing loss in diverse ways as they each learned to understand how the experience of MI unfolded into their lives while facing challenges specific to their recovery. For some women, loss was experienced as being more dramatic and distressful than for others.

All participants described MI in terms of physical loss and described varying degrees of fatigue, weakness, and chest pain at different times since their MI. While one woman adamantly described the impact of physical symptoms including "weakness," "tiring easily" and "aching all

over," another participant experienced "chest pain" as a result of emotional upset. Several women referred to a loss of physical stamina, "when I over exert myself it takes days to get over it." In this sense, fatigue was a constant indicator of the heart's weakness, and it could be frightening to women who wondered whether their hearts would ever heal and whether they would be able to meet their previous life responsibilities (Kearney, 1999).

A few women reported some improvement in aspects of physical functioning following cardiac treatment. Three months following her MI and angioplasty, one woman stated "I have felt so well...I have energy that I haven't had in a long time. It's like I've been dragging an anvil for a long time and I've gotten rid of that and I'm really happy about that." Another participant attributed improvements in her "strength" and "flexibility" to her exercise program through cardiac rehabilitation although she reported still struggling with debilitating fatigue and symptoms of depression. Three years following her MI, one participant described feeling significantly "more confident" in her body than in the beginning stages of her recovery, "I want to travel and I have been building confidence each year by going a little further from home and being a little bit more adventurous. There's not much I don't feel okay to do."

Participants also revealed experiences related to emotional losses following MI including loss of confidence and control, feelings of vulnerability, and loss of hope, "I've been broken again; how many times can I pick up the pieces...and keep going?" While three women reported suffering from negative changes in mood (e.g. depression), two of these women acknowledged having preexisting depressive symptoms that were exacerbated by MI. Interestingly, all three women spoke to the loss of an imagined life as their hopes for becoming partnered diminished since their heart attack. Two of these women stated, "No one wants a woman who is sick." Four participants acknowledged feeling guilty about either asking for help or not fulfilling most role responsibilities. These findings are similar to those in several other studies where women reported feelings of depression following MI and guilt at the prospect of not fulfilling household responsibilities and resisting help from others (see Boogard, 1984; Dunn, 1985; Johnson & Morse, 1990; LaCharity, 1999).

A few women also spoke to a perceived sense of loss around employment opportunities. One career woman felt that she had lost her chance at being awarded her "dream job" as a result the physical impact of her MI, while another woman questioned whether an employer would hire her knowing she was "sick."

Most of the reviewed literature suggests that psychological distress following MI is often associated with loss or changes in various aspects of physical, social, occupational, and relational functioning (Cohen & Lazarus, 1979) and which may manifest in symptoms of depression and anxiety (Byrne, 1990; MacKenzie, 1993). For example, Dunn (1985) identified

loss to be the dominant experience of participants in a study that examined women's perceptions of their MI experience up to 14 weeks post hospital discharge. More specifically, Dunn reported that women experienced multiple losses related to physical and predominantly emotional functioning including the loss of predictability in their lives, social support from spouses, power and control in their challenges to fulfill social and homemaker roles and uncertainty towards the future. Not surprisingly, these participants did not view attending a physical rehabilitation program as a means to address their losses. Similarly, Johnson and Morse (1990) suggested that loss of control is the fundamental experience of MI and regaining a sense of control is the overriding task in each stage of the adjustment process in both women and men.

Participant's descriptions of loss were also made in reference to their relational worlds due to unresolved family conflict, terminated love relationships, divorce, the death of significant others (including family pets), family illness (e.g. psychological and physical), and immigration. Three women alluded to the grief surrounding non-normative deaths including a younger sister's "suicide," the death of an infant son, and the political "murder" of a fiancé. In these latter tellings, there was more to women's stories than the significant other's loss of life including women's loss of a future self ideal (e.g. as an older sister; mother to a son; and wife) and the loss of a future family identity and associated opportunities and experiences.

Given that four out of five participants had their MI within 8 months of starting the research group, the intensity of emotional and physical disruption and the focus on survival evident in women's descriptions at this early stage of recovery appeared significantly more acute than for the participant who was approaching her third year of recovery. While Helen acknowledged having earlier feelings of "loss and sadness" soon after her MI, her dialogue was strikingly more 'growth and future' oriented than were the stories of other participants. In this sense, this participant appeared to be further along on the recovery continuum and involved with different recovery tasks.

Fleury et al.'s (1995) three-stage model of recovery supports these findings and provides a useful framework for understanding the emotional struggles and tasks that may emerge across the recovery continuum. In contemplating participants in the current study, women who were less than a year into their recovery may be viewed as 'surviving,' the initial phase of recovery where the disruption of MI has shaken up their understanding of themselves and their worlds and has resulted in searching for new meanings to help guide their physical and emotional transitions. This sense of disruption was evident in women's descriptions of angst and uncertainty and their urgency around acquiring medical information. In contrast, at 3 years post MI, Helen appeared to be in 'patterning balance,' what Fleury et al. construed as the

last phase of recovery, where she is moving past the challenges and uncertainty related to the MI event and towards a new self image focused on creating purpose, meaning and greater self-nurturance. This description fits exceptionally well with Helen's commitment to her spiritual journey and the delineation of her dreams. For other group members, Helen was symbolic of the voice of survival and provided them with the hope of recovery and a future life. (I suspect the temperament of the group would have been much different without having Helen to contrast and balance women's early experiences of recovery). The current study also endorses Fleury et al.'s recommendations that self reflection and the communication of feelings in a safe and emotionally supportive women's group is critical to the process of cardiac recovery.

Evident from participant's stories is that the impact of MI was embedded within women's larger life stories of loss. The degree to which these losses affected women's ability to carry out their lives and contributed to their suffering differed amongst individuals. Without understanding women's histories beyond their illness experience, the provision of cardiac rehabilitation may not be all that is required to successfully facilitate their recovery from MI.

Living with Uncertainty

This theme speaks to the dramatic unpredictability associated with MI. Despite women's efforts to make lifestyle changes and follow recovery regimes, a central component of cardiac illness is that women's health remains unpredictable despite their efforts and the efforts of their doctors.

Uncertainty is a powerful stressor in many illness situations. Kearney (1999) suggests that "an unpredictable body robs one of the unconscious, taken-for-granted ease of moving through the world, influencing situations, participating in the eventual rewards of labor, and helping others and replaces it with worry, the shame of dependency, and fear" (p. 18).

Similarly, participant's descriptions often demonstrated feelings of fear or worry at the prospect of experiencing further cardiac symptoms and/or another heart attack. While several participants suspected they were having cardiac related symptoms at the time of their MI, all women reported feeling shocked or surprised they had had a heart attack. One woman stated that her MI "came so unexpectedly...without warning and there is nothing you can do to make it not happen again."

Two other women who had an MI, despite their normal angiograms, felt they were not given 'satisfactory information' to explain the cause of the event, "the most stressful part of the whole experience has been not knowing what caused it exactly and if it happened once, it could happen again." Another woman described her dependence on Nitroglycerin, "I wasn't thinking about having another heart attack but I wasn't leaving the room without having my Nitro in my

hand...I did this for the longest time." This example is akin to the person who suffers from panic attacks and carries Ativan for reassurance.

Participants also described feeling uncertainty towards the future in terms of their quality of life and mortality issues, "I hope that my health doesn't fail too much. I don't want to be frail or in constant pain...I want to be able to contribute in a meaningful way," "I reckon that none of us know how long that we have to live;" and "there are lessons we are to learn in life, will I live long enough to learn all my lessons?" Another woman stated:

I started to have a little more reservation about just counting on the fact that I would grow old. That's why the quality of living has become more of a focus. I could put off a lot of the things I love to do until I retire, but part of me just doesn't want to do that.

Moreover, a few participants felt worried about the impact of MI on future employment opportunities. One woman wondered if she would ever be awarded her "dream job" since having the heart attack, and if not, whether she could adequately support herself in the future as an unpartnered woman, particularly given the high cost of her medications. Another person questioned whether her heart condition would become an obstacle to employment.

Similar to current study findings, there is a great deal of evidence that supports the presence of an overwhelming sense of uncertainty as women (and men) struggle to live with heart disease (Bowers, 1996; Dorion-Maillet & Meagher-Stewart, 2003; Johnson & Morse, 1990; White & Frasure-Smith, 1995). In a recent study, Dorion-Maillet and Meagher-Stewart explored the early recovery experiences of women ages 33-61 years, following MI. The authors found that overwhelming uncertainty was the broad context in which specific recovery themes emerged including "rude awakening" which describes participant's surprise when they learned that they had a heart attack; "disconnected knowing" or the sense of uneasiness or disconnection in relation to MI, and "reconnecting self" describing the integration process that occurred over time. Dorion-Maillet and Meagher-Stewart suggested that the context of time is significant to women's process of recovery. Consequently, women initially experienced a sense of rude awakening and disconnected knowing in hospital (as did most of the women in the current study who expressed a sense of shock and/or disorientation in receiving their MI diagnosis). For the participants in this study, these feelings of uneasiness resurfaced once women re-entered their homes and as they tried to return to their former routines.

According to Byrne (1990), anxiety levels of tend to fluctuate over time depending on the perceived seriousness of the challenge faced at different points in an individual's illness process. Consequently, a patient's anxiety will likely be high soon after symptom onset when the threat to life is the greatest, and again prior to hospital discharge when constant medical attention must be relinquished.

In the current study, participants also described uncertainty in other areas of their lives including their relationships. One woman described feeling “angry” and “powerlessness” because she could not help her drug addicted sister, “I’m scared she’s going to die.” Another participant acknowledged her fear of losing people that she loves, and is anticipating the loss of her aging mother and her husband, “we live with that time bomb because another stroke would probably kill him...it’s just a matter of when.” Another woman wondered if she would ever be on speaking terms with her estranged daughter and grandson. Finally, all of the unpartnered participants questioned whether they would become involved in another relationship or remain single for the rest of their lives.

As with other aspects of the MI and recovery experience, each participant described having a distinctly unique relationship to how she relates to the experience of living with the uncertainty of heart disease. Although Helen reported having almost regained her bodily confidence at 3 years post MI, she also acknowledged knowing that it could happen again. Consequently, in her stories, there is a sense of urgency about living life passionately and to the fullest; almost as though life had become more precious. In contrast, another participant continued to struggle against her perceived loss of control and overwhelming uncertainty related to physical and emotional changes since her MI. Although Arlene is by comparison, in the early stages of recovery, an intensity of emotional suffering is evident in most of her autobiographies.

As acute (e.g. MI) and chronic (e.g. heart disease) illness brings about a new awareness of the impermanence of life, one of the major tasks of recovery appears to involve finding a way to tolerate living with this uncertainty and to trust oneself can adjust over time to future unknowns (Kearney, 1999). This has clear implications for support needs and recovery care.

Changes to Self Concept

(The reader may also want to review the researcher’s interpretations for the sixth research session). Neimeyer (1998) suggests that when significant life events shake up our sense of self and our worlds, we make efforts to interpret them in ways that are consistent with our overall theories and identities through a deeply personal process of meaning making. ‘Changes to self-concept’ illustrates how MI unfolds into women’s lives within the context of physical and emotional disruption. There was a striking parallel between how women performed in their lives, as evidenced in their autobiographies, and how this ‘unfolding process’ took place. Women who conceptualized their recovery from the vantage point of an existing and functional life role may have found navigating this experience as being less disruptive than those women who life roles were less functional. Nonetheless, each participant spoke to some changes in their self concept as a result of MI.

Trained as a business administrator, Bev presented herself as being highly competent and organized. She had returned to her daily routines soon after MI and was adamant about not letting herself "be defined" by the experience. Her "contract" for recovery parallels the principles and values that govern her life including "commitment" and "doing your best." It appeared that she is now managing her recovery as she would other life challenges. Nonetheless, Bev's image of "always being the healthy parent" has been shattered since having her MI. Although she reports to feel more energetic since her "heart was fixed," she is subject to angina if she overextends herself, thus reminding her of an unfamiliar sense of fallibility.

After 3 years of recovery, Helen's experience of MI is unfolding into her already existing world of creativity and passion by way of art and music and allows her to access familiar resources and strengths in the facilitation of her healing and growth. A significant change in her self concept, given her fitness and health, was the stereotype she maintained about who suffers from MI which did not fit with the image she had of herself. Nonetheless, having had the recovery time to regain a greater bodily confidence and to do some emotional exploration, Helen's attention appears to be much more focused on cultivating a passionate life as opposed to being defined by her MI. At the same time, her illness appears to have served as a catalyst in helping her become more clear and committed to how she wants to live her life.

In contrast, Arlene describes the tension between battling to stay in control while feeling "vulnerable" and "weak," and accessing her leadership qualities to assertively seek treatment, develop a cardiac support group and initiate a disciplined regime of self-care. As part of her changed sense of self, Arlene described feeling 'very angry' that her colleagues at work perceive her as now being unhealthy.

While Sarah's primary recovery process has been focused on regaining a former sense of self (as an independent and socially connected woman) she cannot recognize the person she has become since living in Canada (e.g., she refers to herself as dependant, sick, depressed, and isolated). The impact of the traumatic abandonment she experienced at the time of her MI while on the sea bus, may have led to the creation of a trauma narrative further perpetuating the belief that she is unworthy: "No one will want to hire a woman who is sick," and "No one would want to be with a woman who is sick."

Finally, Sally's persona of being a 'dreamer' or 'disappearing' fits well with her initial position of denial acknowledging the severity of having a MI. Interestingly, her efforts to become more assertive in her life have appeared to mirror her shift from denial as she now recognizes she could have died, "I've realized I'm lucky to be alive and that's very scary because other people you hear about don't make it." Given earlier illness challenges, Sally likely experienced changes in her sense of self when her arthritis became debilitating and she was forced to give

up her lifework as a hairdresser. Compounding this loss, she reported feeling sad at the prospect that having a heart attack may have limited her prospects of finding a life partner. Again, these identity/role changes are about losses of a former self.

Kearney (1999) also suggests that as women reflect on the potentially life threatening nature of MI, they worked to integrate this new information about themselves with the person they had been and what they were capable of. Kearney suggests that:

The younger the woman, the greater the impact. The idea of being vulnerable, of having a weak heart, was harder to adjust to for women who had seen themselves as having many years to live and as healthy and taking good care of themselves.

Moreover, it was easier for those who had accepted other illnesses and the unpredictability of their life spans. It became more discouraging for a few who were unable to reconcile this new information with the person they had been and expected to be.

Personal Needs and Self-Care

Based on women's beliefs about the possibility of recovering a valued life, their understanding of what was required to reduce further risk of heart damage, and their degree of commitment to advocate for themselves and their health, women initiated various ways to care for their vulnerable bodies and hearts (Kearney, 1999). Consequently, this theme concerns participant's needs as a result of MI and their efforts at taking care of themselves in terms of enhancing their physical and/or emotional and psychological health and well-being. (For a more detailed review of this theme, I encourage the reader to revisit the researcher's interpretations of Week Four in Chapter Four).

All women reported making various efforts at taking better care of their physical health since MI. For some women this meant implementing more lifestyle changes than for others. Collectively, women described incorporating exercise, changes in eating habits, weight loss, smoking cessation, and greater rest and relaxation into their daily lives. Four out of five participants who had enrolled in a cardiac rehabilitation program after MI found that the information provided was useful in their efforts to accomplish these behavioral changes and contributed to improvements in their physical health.

Participants also talked about the challenges of finding personal limits in terms of pacing themselves physically particularly in the absence of cardiac symptoms. Earlier research suggests that women's return to activity has often been gauged by women's perceptions of family needs and their personal estimates rather than strictly by medical guidelines (Johnson & Morse, 1990). Moreover, in early recovery, women used their fatigue (rather than professional advice) to decide what they considered to be safe and do-able physical activity (Fleury et al., 1995; Hawthorne, 1993). Moreover, progress was often measured by which of their usual

household tasks they were able to perform, although they didn't always consider housework as "work" that should be paced. Cultural expectations of women to maintain their home milieu were reported in these studies. In the current study, women offered mixed reports in terms of feeling obligated to maintain their homes in the same manner as prior to their MI. While some women felt obliged to do so, others reported not having the energy or the motivation to achieve the same standard of care. Perhaps this finding would have been different had more women in the study been partnered. The one homemaker in the group did acknowledge returning to her household responsibilities soon after hospital discharge and tended to feeling guilty if she did not fulfill her commitments.

While most participants realized that they had some warning signs prior to their MI, they spoke to the importance of trusting their bodily knowledge and addressing future cardiac symptoms in a more proactive and timely manner. The health information that women exchanged within the context of the research group appeared to facilitate a greater knowledge and understanding of symptom recognition.

All participants also reported making or needing to make efforts at better caring for their emotional and/or psychological health. Most women talked about learning how to better manage relational stress and/or challenge their often self-defeating (caretaking) behavior by becoming more assertive and communicating personal needs and feelings directly, becoming more comfortable with asking for help from others, boundary setting particularly related to "doing too much" physically and emotionally, and taking less responsibility for others by not engaging in automatic behaviors such as trying to "fix" situations, "rescuing" others, or by putting other's needs first. In doing so, women also talked about letting go of trying to control people and situations as well and dealing with deep-seated feelings of guilt and obligation.

A few participants also spoke to making different choices around the kinds of relationships that they were willing to engage in since their MI. In reference to a highly conflictual former relationship, one woman stated that "I'm not willing to live in a relationship that is that difficult no matter how much I love that person." Similarly, another woman suggested "I won't be in a relationship if it is going to be stressful and I've had some terrible relationships." Both of these women acknowledged feeling increasingly more comfortable with the idea of approaching their lives being on their own.

For most women, self-care also involved talking with and/or spending time with supportive others (e.g. friends, family, or professional caregivers). While participants reported having varying degrees of social support, some women also spoke to the importance of cultivating more supportive connections with others. For one woman, this meant establishing a social/support group from existing members of her rehabilitation and research group with the

intention of continuing to meet beyond the group's completion. This woman suggested that the group "helps me keep in line...I need the constant reminder to look after myself as I tend to forget."

As mentioned previously, for some women, calling upon their religious faith or spirituality was a significant act of self-care and according to these women's descriptions, has served to enhance their emotional (spiritual) health. One woman suggested that "seeking spiritual guidance...has really helped me to feel happy within myself. This has been the most profound change in caring for myself to date." Similarly, another woman acknowledged that "our faith has really enriched our lives and helped define who we are as people." Women's spirituality is also closely connected with their ability to make meaning of their lives and the events that transpire within it such as MI. As one participant suggested, "a heart attack for me was a wake up call...a calling of the spirit telling me to wake up and become more conscious." Three years after her MI, she continues to follow her personal journey of living more intentionally in an openhearted and balanced way, "I feel quite content most of the time...I don't think about death so much after the MI as I think about life and the quality of life that one can achieve."

Two women discussed the importance of goal setting in their MI recovery. From their descriptions, this has helped them to create a greater sense of direction and agency in their recovery as took charged of a situation that otherwise felt disempowering. Similarly, another woman spoke in terms of having identified new goals for her career and has also articulated her dreams for her future and connected her to a sense of commitment to personal growth.

While most of these women may credit the experience of illness as their motivation for turning their attention inwards towards taking better care of themselves, it is evident that their descriptions reflect a process of healing or recovery that involves the unity of both their physical and emotional selves.

Care and Support

This theme concerns the care and support that participants described receiving or not from others within the context of their recovery from MI. For the purposes of this discussion, I refer to care as being the perceived quality of treatment, attentiveness and concern that women received from health care providers. In contrast, support refers to the quality of social support received from family, friends and significant others.

Care from Health Professionals.

In general, women's descriptions suggested that the quality of care received from health professionals varied between participants. Although all women described the importance of receiving "honest" and "forthright" information from health professionals, they acknowledged often feeling dissatisfied about what was available to them regarding various aspects of the MI

and recovery experience (e.g. assessing bodily cues, female specific symptoms, and setting limits on physical activity). Several other studies have documented the lack of female specific health information and inadequate follow-up after hospital discharge (see Arthur et al. 2001; Benson et al. 1997; LaCharity, 1999).

From women's descriptions, the most satisfactory source of information came from the cardiac rehabilitation staff in the form of lectures, discussions, and the exercise classes. Interestingly, only two of the four women who attended rehabilitation were referred by their doctors. This finding supports earlier research demonstrating a gender bias in physician referral of women to CRP (Brezinka, Dusseldorp, & Maes, 1998; Doiron-Maillet & Meagher-Stewart, 2003; Wenger et al. 1993). Not surprisingly, the four participants who were attending rehabilitation at the time of this study found these programs to be very helpful. One woman suggested, "I believe the Healthy Heart program has been the biggest help in understanding what has happened to me." Another woman suggested, "if it wasn't for the Healthy Heart program, I'm sure we would still be feeling very vulnerable." In contrast, having read several books related to heart disease, another participant stated that she hadn't found any resources that spoke to her as a younger woman with MI. Several participants suggested to the researcher that a book be drafted out of the findings from this project.

Although three women had consulted with their doctors regarding suspicious symptoms (e.g. ankle swelling, extreme fatigue, shoulder and arm pain) up to a year before their MI, none of these were diagnosed as being cardiac in origin. One woman stated, "a year before my heart attack, I experienced pain in my shoulder and left arm, but my doctor said it was because of the depression I had." Another woman stated that her female physician was "shocked" to discover that her early undiagnosed symptoms were a precursor to her MI. Several earlier studies have documented women's cardiac symptomology being misdiagnosed or missed by physicians (see Bowers, 1996; Murray, O'Farrell & Huston, 2000) so these findings are not surprising.

While two women used words including "fabulous," "cared for," "taken seriously," and "respected" to describe the treatment received by paramedics at the time of their MI, another participant reported that she was treated negligently as paramedics doubted the authenticity of her MI symptoms which contributed to later symptoms of trauma.

Similarly, a few women acknowledged receiving "good" care from medical professionals while hospitalized and used words such as "wonderful," "friendly," and "kind" to describe the care from both nurses and doctors. One participant also described the excellent care that she received from a psychologist affiliated with the cardiac rehabilitation program she was currently attending, "I am talking now; I feel there is a connection and I am trusting someone, I think it is a good sign."

In contrast, two participants reported feeling “shaken up” by their interactions with health providers. During her hospitalization with MI, one participant felt that although she had received expedited care, she had not been treated very well by some of the doctors and nurses. More specifically, she used words including “miserable,” and “chastising,” to describe her interaction with the angiography nurse. Overall, the haste in which she was released from hospital, the lack of cardiac information and resources, and the absence of compassionate care from health providers became central in her illness narrative as a harmful component of her early recovery experience. Another woman described feeling very upset after having had a conversation with her cardiologist who she felt delivered discouraging information about her heart in a tactless and dismissive manner. Similarly, a third participant also described feeling “put off” and “dismissed” by her doctor because her “case was not viewed as being dramatically acute.”

Each of these women’s stories illustrate ‘iatrogenic suffering,’ (Kuhl, 1999) or the undue suffering of patients caused by the communication style of health care providers. In contrast, Roter et al. (1995) found that when physicians gave clear information to patients, especially when coupled with emotional support, psychological distress was reduced and positive physical and emotional health outcomes were more evident. Consequently, embedded in almost all of the participant’s illness narratives was some degree of suffering as a result of compromised care offered by a health professional. This also begs the question, when does recovery begin for patients? As Roter’s et al. findings suggest, opportunities for healing may begin within the context of initial care interactions between patients and their health providers and may influence the future course of recovery as demonstrated by the woman who had her MI while on the sea bus.

Women’s Social Support.

In general, all participants described receiving strong support from family and/or friends at the time of their MI and later during recovery, although there were considerable variations in the quality and magnitude of women’s resources. While one participant reported receiving primary support from an attentive male roommate another women described having an extensive support network including a loving partner, a diverse circle of friends including a small group of women also living with chronic illness. In contrast, Arlene had experienced the benefits of illness support as a longstanding member of a diabetes support group.

Two participants cited a single example of feeling disappointed by the lack of support from extended family members following MI. For example, one woman stated,

The one area where I was somewhat surprised and disappointed that I didn’t get the support I needed was from my husband’s family and their reaction to my MI. No one from his family called to ask how I was or if I needed anything. I told my husband about

my feelings...he immediately took up my cause and spoke to his mother about our discussion.

Another participant did not receive familial support following MI given her choice not to tell them: "I didn't want them to worry as they couldn't help me."

While some women articulated specifically what comprised support for them in terms of recovery others did not. Participant's descriptions suggested that their support needs changed depending on where they were situated in their recovery process. While hospitalized, one woman felt supported by her sister as she provided constant companionship, emotional reassurance, and assistance with decision making and information seeking. A few months later, she stated that family and friends continued their support by making fewer demands on her thus allowing her to have more time to herself.

In contrast, several months into her recovery, another woman described feeling overwhelmed with the emotional demands placed on her by friends in spite of her compromised health. This highlights Chesney and Darbe's (1998) study finding that suggests social relationships (including marriage) may not be an ideal substitute for social support within the context of women's recovery.

Challenging these findings, the only two study participants who were partnered at the time of their MI described receiving exceptional care from their respective female and male partner in terms of positive emotional support and assistance with activities of daily living. Although several studies have demonstrated that women often do not receive adequate emotional support from their male spouses during cardiac recovery (see LaCharity, 1997; Doiron-Maillet & Meagher-Stewart, 2003; Helpard & Meagher-Stewart, 1998) few comments can be made from this research given that only one woman was male partnered. Moreover, the absence of literature examining lesbian caregiving of female partners with cardiac illness may point to an area for further research.

In addition to the support received from various others, three women spoke to the significance of their religious faith or spirituality as a source of support and strength in their lives, particularly since surviving their MI. From their descriptions, women suggested that their journeys in faith had enhanced their lives by providing them with a sense of guidance, courage, gratitude, and/or understanding of their life purpose.

Other participants talked about support in reference to the emotional sustenance they received from their relationships with their pets. More specifically, three women described their dogs as significant "members of their family" who provided them with companionship and unconditional love. For women living on their own without family, the presence of animals may particularly be an important component of social support and may serve to combat social

isolation and loneliness. Interestingly, Herrald, Tomaka and Medina (2002) found that cardiac patients enrolled in cardiac rehabilitation and who owned pets were more likely to complete their programs compared with non pet owners. Although the specific mechanism for explaining these findings is unclear, results suggested that the supportive companionship of animals tend to improve health outcomes.

Finally, all group members acknowledged that their participation in the research group was important support within the context of their MI recovery and used words such as "healing," "therapeutic," "self-valuing," "validating," and "empathic" to describe their experience. Moreover, women spoke collectively about the benefits gained through sharing stories and experiences with other similarly aged women who also experienced MI including: the value of voicing my experience, gaining relevant knowledge and perspective; developing greater self-awareness; taking the time to value and listen to myself; sharing difficult feelings and receiving validation around the emotional impact of the experience; feeling more grounded; learning how to better care for myself and feeling supported to make changes in my life.

These study findings clearly substantiate other researcher's recommendations for the development of emotionally supportive recovery interventions where women can explore and express their lived experience of cardiac illness (see Arthur et al., 2001; Bowers, 1996; Doiron-Maillet & Meagher-Stewart, 2003; Helpard & Meagher-Stewart, 1998; LaCharity, 1997). As well, the benefits that women described as result of participating in this study provided further support for Fleury et al.'s (1995) previous work highlighting the importance of encouraging women to communicate their illness experience and their needs for closeness, and to express feelings related to personal loss, fear and uncertainty in a safe environment as a means to facilitate 'healing' following a cardiac event.

Looking beyond the field of cardiac health, the pioneering work of Spiegel, Bloom, Kraemer and Gottheil (1989) in the area of women and breast cancer, represents an impressive example of the benefit of providing a program of emotional care and support. The supportive-expressive model emphasizes the development of intense bonds of support among group members and expression of emotions salient to their illness as participants were encouraged to confront their problems, strengthen their relationships, and find enhanced meaning in their lives.

Spiegel and Bloom's early work was heavily influenced by Yalom (1995) who suggests that the group therapy process increases the likelihood of "constructive compassion" amongst group members and which refers to the therapeutic benefits that come from the giving as well as receiving of care and understanding from others. Several women in the current study acknowledged the importance of being able to support each other within the format of the group

as well as participating in the research in order to help other women who will experience MI in future.

While research demonstrates that women with social support do better health wise following a cardiac event it makes sense to develop a program of care specific to women that will facilitate emotional recovery. The current research group provided a pragmatic model for conducting such a group for women in adjunct to conventional rehabilitation.

Taking Care of Others

This theme relates to how women perform in their roles as caretakers and the degree to which they balance their needs for support and compliance with convalescent guidelines within the context of MI recovery. While all participants clearly identified themselves as caregivers in various aspects of their lives, their ability to put other people or commitments first appeared to be both a personal strength and a liability as women often reported ignoring their own needs and feeling "stressed" or "overwhelmed" as a result.

In general, all participants described how they saw themselves in their caretaking roles: "when I was in my country, I always helped people;" "I hate to see my family need anything so I always want to help them with whatever they need;" "I'm a rescuer who likes to fix things and try and make things calm and boring;" "I am a really good listener;" and "I have helped myself by helping others as much as I can or as much as they want me to."

Within the context of recovery, participants also demonstrated the various ways in which they continued to perform as caregivers. Two women identified their efforts at reassuring family members "that they were fine" while hospitalized during the acute phase of MI. Others reported protecting worried family members in other ways. Despite having little social support, one woman chose not to tell her family about her MI, "I don't want to make them worry as they cannot do anything." Another woman discouraged her mother from visiting her until several weeks following hospital discharge, "I really needed her to see me strong, not ill...I didn't want her to be burdened by that."

Three women described feeling responsible or guilty if they did not quickly return to their respective employment and/or familial responsibilities. Despite feeling tired and weak, one woman returned to work within a week of hospital discharge, to set up her boss's office: "the doctor figured I would do myself more damage at home fretting and being upset rather than just going to work." Similarly, another participant returned to the pace of her busy life (as a homemaker, socialite, and part-time entrepreneur) about a week after her MI, "but that's what I have always done so I guess the guilt would be all consuming if I didn't do that because it's so much a part of what I do." She understood her behavior in terms of deeply ingrained family "rules"

around fulfilling commitments. This same woman had a severe angina attack approximately 4 months later which she attributed to overextending herself.

These findings were consistent with several previous studies that demonstrated women returned to their household responsibilities and roles within a week of hospital discharge following MI, often feeling guilty about their role limitations and putting themselves first (Boogard, 1884; Dunn, 1985; LaCharity, 1999). Helpard and Meagher-Stewart (1998) found that while older women's identification with their homemaker and caregiver roles after hospital discharge positively influenced their adaptation to their early recovery but also represented a barrier to following doctor recommended recovery guidelines.

Several women talked about being involved in specific ongoing and chronically stressful relationships in a caretaking capacity. One woman stated, "since my MI, what has been most stressful is anxiety over the deteriorating health conditions of my mother-in-law and even my own mother." Another participant left work prior to her MI because of debilitating arthritis and to care for her sick and aged parents and sister who is in active drug addiction. In contrast, another woman who acknowledged that caretaking others was central to her life in her former country, spoke about her loss of self-worth as a result of no longer having this role, "when I don't produce anything...when I don't make money or I am not in a relationship with anybody...I don't have love...I don't feel I am useful anymore."

In general, the juxtaposition of women's inherent role as caregiver and supporter of others and their need to be supported and cared for while recovering from MI represented a challenging dilemma for these research participants.

Summary

There were six recovery themes that emerged from this study: the experience of loss, living with uncertainty, changes in self-concept, personal need and self-care, care and support, and taking care of others. Although these themes were distinct and identifiable, there were frequent areas of overlap thus reflecting the complexities and uniqueness of women's life stories and their constructions of MI recovery.

The experience of loss was the overarching theme in the study and demonstrated the pervasiveness in which MI impacted women's lives. This meant that participants reported varying degrees of physical, emotional, social, occupational, and psychological loss. The experience of MI appeared to be embedded within women's histories of significant relational loss. Ultimately, women had lost their lives as they knew them; they had lost 'life before MI.' Inherent in the task of recovery was a reorganization of women's personal beliefs and the need to integrate various losses into their understanding of who they were before the MI.

Living with uncertainty highlighted the fear and anxiety associated with the unpredictability of MI. "Will I have another MI?" "Will I experience more cardiac symptoms?" Women wondered how MI would impact other areas of their lives including occupational and relational opportunities; the quality and length of their lives; and their ability to take care of themselves and others. Women also reported living with uncertainty in other areas of their lives.

All women experienced changes in self concept as a result of experiencing a potentially life threatening event. "Who am I as a woman who has had a heart attack?" The guiding question in this theme was "How does the experience of MI unfold into women's lives?" From their descriptions, women tended to experience MI in similar ways as they approached other challenges in their lives. During the early stages of recovery, women saw themselves as changed: 'no longer healthy,' 'no longer aggressive,' or 'no longer desirable.' In all cases, the initial change in self concept was to that of a less positive image.

In addressing personal needs and self-care, all women reported making efforts to take better care of themselves both physically and emotionally. Women reported that making physical changes such as increased exercise, monitoring diet and weight, and resting were important and tangible. As well, they spoke to the importance of changing longstanding relational behavior including efforts to become more assertive, taking less responsibility for others and engaging in healthier relationships.

The theme care and support referred to the support received from both social support and health professionals. In general, all women reported varying degrees of dissatisfaction from their interactions with health providers as well as an absence of satisfactory illness information. In general, participants reported that cardiac rehabilitation provided the most satisfactory source of heart information.

In terms of social support, most participants reported varying degrees of social support from family, partners, friends, or pets during their MI recovery. Interestingly, not all social relationships constituted beneficial support for these women. Participants also highlighted the benefits of talking with other women who had MI and described the group as beneficial and a source of positive emotional support.

Finally, women's taking care of others was a theme in all women's lives and appeared to be a strength and a liability as women sometimes ignored their own needs to the point of detriment. During MI recovery, women continued to care take others, had difficulty not fulfilling their usual roles or receiving help from others. For some this led to feelings of guilt. Some women had difficulty balancing their responsibilities and their needs for care.

In general, women's biographies were rich and complex and influenced how women constructed their MI recovery. Also evident in the expression of the recovery themes were

differences in the stories of women who had their MI within 8 months of participating in the study and the participant who was 3 years post MI. These differences have implications for both care resources and further research examining differences in the needs of women at different points along the trajectory of recovery after MI.

Findings Unique to Younger Women

In addition to the six main themes, several unique findings emerged from the data. In general, the occurrence of MI may be construed as an unlikely or potentially non normative health event for the cohort of women, ages 48 to 53 years, who participated in this study given that women older than 65 are significantly more likely to experience MI (Statistics Canada, 2002).

While several participants suspected they were having a cardiac event at the time of their MI, almost all women sought medical assistance fairly soon after the onset of dramatic symptoms thus challenging current literature that suggests that women persistently delay in seeking treatment for cardiac symptoms (Dempsey, Dracup, and Moser; 1995; Jensen & King, 1997). At the same time, at least three women reported having telltale symptoms up to a year prior to their MI that they or their doctors disregarded as being cardiac in origin.

All participants experienced shock or surprise at being diagnosed with MI and did not consider themselves or each other to fit the stereotype of a "heart attack patient." This supports much of the female specific cardiac literature that indicate women's frequent failure to identify their own symptoms as being cardiac, particularly as a younger woman, thus underestimating their potential risk for having a cardiac event (LaCharity, 1999; Rankin, 2002). Similarly, some participants encountered "dismissive" or "skeptical" reactions from friends, family members, or health professionals who also had difficulty understanding that women's symptoms were cardiac in origin or that the event was as serious as MI. The most dramatic example was Sarah's experience of being "disbelieved" by paramedics after feeling abandoned on the sea bus at the time of her MI. In general, misinformation about cardiac illness and the manifestation of symptoms is demonstrated in the experiences of women at different ages.

In general, this demonstrates the significance of developing educational initiatives for both the public and health care providers outlining the incidence of MI and heart disease in different aged women. This recommendation is substantiated by findings in several other studies (see LaCharity, 1999; Rankin, 2002; Murray et al. 2000).

Female heart patients in their forties and early fifties may be faced with different developmental challenges compared to their older female counterparts. Research participants described juggling multiple responsibilities including work, the care of senior parents and other family and social commitments, and some parenting, and for one woman, school. Four women

described their involvement with their very senior, and for some, ill parents. Three of these women acknowledged that their parent's deaths were looming in the not too distance future. In addition to her homemaker responsibilities and part-time work, Bev is a caregiver to her husband's very senior (and difficult) mother, her own senior (and potentially ill) mother, her husband who has serious health issues as well as focusing on her own cardiac recovery. Likewise, most of the women in this study described themselves as being excessively busy, stressed or overwhelmed for a significant period of time prior to their MI. In contrast, older cohorts of women would likely not have the same breadth of relational or employment responsibilities as their younger counterparts. Similarly, younger women are likely to have greater social support resources than older women (Rankin, 1995, 2002).

LaCharity (1999) also found that a sample of premenopausal women diagnosed with heart disease faced the challenges of managing household and parenting responsibilities with full-time work. In this study, women also returned to work quickly following their diagnoses due to financial considerations as well as a sense of personal identity and meaning associated with their careers. A few women in the group expressed concern about how they would support themselves financially and pay for costly medications if their health conditions deteriorated. This is particularly relevant for women who do not have partners who can provide financial support.

In the current study, all but one participant had joined a cardiac rehabilitation program as a result of either physician or self-referral. While all participants reported feeling grateful for both the exercise and the educational components of CR, three women described feeling "out of place." While one woman felt uncomfortable being assigned to an "all male group," another participant described "feeling excluded" by the conversations of other program members who were discussing retirement issues. Finally, a third woman felt she was "not being taken seriously" because of her age. One woman, who was interviewed for the study but did not participate, was reportedly "mistaken for being the program exercise leader" also because of her younger age. In general, study participants suggested that all female age appropriate cardiac rehabilitation groups may be beneficial. While health providers may not have the resources to create special circumstances outside of the standard co-ed CRP class, program staff could demonstrate greater sensitivity towards women's concerns (e.g. age, cultural) given women's historical propensity to greater nonattendance and dropout rates compared to men (see Hamilton & Seidman, 1993).

In a recent study looking at predictors of women's attendance at a CRP, Gallagher, McKinley and Dracup (2003) identified several factors that may influence women's attendance including a diagnosis of MI, lack of employment, being either younger than 55 years of age or older than 70 years, and the experience of a personal stressful event during follow-up. While

women in the current study reported enjoying and valuing their respective CRP experiences, they may otherwise be at risk for non-completion based on Gallagher's et al.'s reported criteria.

Finally, all participants in the current research expressed a hunger and insistence for relevant cardiac information and treatment resources. Although Helen stated that she had read "everything out there" related to MI, "there was really nothing that spoke to me as a younger woman." Consequently, she constructed her own theory to explain the cause of her MI in the absence of physical findings and satisfactory information from her cardiologist. Younger cohorts of female cardiac patients may be more likely to seek out treatment options in comparison to their older counterparts for several reasons including greater access and skills at information seeking (e.g. internet), different socialization around dealing with health professionals (e.g. more proactive and comfortable questioning authority), and fewer comorbid conditions that may impede women's physical mobility and access to acquiring information (see Rankin, 2002). Examining the specific recovery needs of older and younger women may be explored in future research.

Evaluation of the Research Group

The development of the guided autobiography group for women recovering from MI was an ongoing process of trial and error and revision. Based on participant and peer reviewer accounts, the research group was successful in terms of fulfilling the four criteria used for assessing the trustworthiness of the data, and as a highly supportive and therapeutic recovery experience. While there were several aspects of the group design that worked well, I have also noted a few recommended changes.

More specifically, the duration of the group effectively supported the purpose of the study: to explore how women constructed their recovery of MI. More specifically, the 8-week group was ideal in terms of developing group cohesion and safety and in exploring a breadth of recovery issues. A group that was shorter in duration may not have collaborated in the same way particularly given that there was often weekly participant absenteeism. One group member suggested "the time frame was perfect and I think we were all ready to end [the group]." In planning for future GA groups for women with MI, I would consider an ideal time frame of between 6-10 weeks depending on the needs of the group.

As well, the six GA themes and sensitizing questions adapted from Birren's (1987) earlier work were well suited to explore various aspects of women's lives within the context of MI recovery. Several participants agreed that "the directed questions were very good for getting us to talk about what mattered." I would replicate these themes in future recovery groups with a similar age group. Alternate themes may be selected depending on the participants and the illness group. For example, if I were conducting a GA group with older women following MI, I

might consider developing a theme related to 'unfinished life business' and 'meaning making over lifespan.'

In the current study, the primary facilitator conducted the group while my primary role was that of researcher and co-facilitator. This allowed me to clearly focus on and interact with women's stories and group dialogue and process in terms of the research question without being primarily responsible for group facilitation and addressing group dynamics. While I also participated in the role of co-facilitator, I felt this arrangement strengthened my role as the researcher. Pending resources, I would reiterate this arrangement in future research groups.

In conducting future GA groups, I would provide a more detailed explanation and description of the group experience and participation requirements to interested women to help them make a clear and informed decision around participation. This may include showing examples of a life theme, sensitizing questions, and a two-page autobiography.

Secondly, I would conduct a more rigorous screening interview to explore the suitability of potential group participants. More specifically, I would determine if there were any physical limitations that may inhibit participation in a two hour group as well as the status and stability of women's cardiac health. As well, selective questions addressing emotional readiness and comfort level with group participation would be solicited. Had the screening interview in the current study addressed anxiety and/or depression (versus availability and interest) then I may have determined beforehand that Margaret was not a suitable candidate for participating in the group despite her needs for support. Given the recommended size for conducting GA groups (Birren & Deutchman, 1991) it is important to select individuals that are fully interested and willing to participate in the group.

Thirdly, I would alter the format of the GA sessions to allow for women telling their MI story during the first week. Despite the researcher's agenda in the current study, women were insistent on talking about the details of their MI and hospitalization experience almost immediately upon entering the group and having the opportunity to talk with other women similar in age. This exchange of information was an important component of the group experience.

Fourthly, if future GA groups did have two facilitators, I would ensure that both individuals were involved in the participant screening interviews. In the current study, this did not happen and resulted in an authority imbalance as participants tended to defer to the researcher and exclude the facilitator in dialogue during the first few sessions.

Lastly, questions arise in terms of deciding when is the most beneficial time to offer the GA group to women recovering from MI. What recovery resources are available for women (and men) following the completion of rehabilitation? Offering the GA group following the completion

of cardiac rehabilitation may help participants make this transition more comfortable given some women's anticipatory angst of leaving this highly monitored environment. In future groups, I would explore this option.

Cautions in Conducting GA Groups with Heart Patients

A few cautions should be considered in terms of conducting GA groups with heart patients. As a group, the women that participated in the current study could be construed as a vulnerable population. The time elapsed between their MI and participating in the research group was less than 8 months for all but one participant. For Bev and Sally, this time frame was even shorter at three and 4 months.

Consequently, over the duration of the group all but one woman reported having illness symptoms. The week after Arlene attended the group with unstable blood sugars, she acknowledged wondering if she was having another MI. In contrast, Sarah acknowledged experiencing angina that required medical assistance. She also reported having angina following a group session and attributed this to feeling emotionally upset. On another occasion, Bev also reported having an 'unexpected' angina attack requiring nitroglycerin, a few days before a group session, and also questioned if she was having another MI.

In practical terms, when working with heart patients, it is important to know the signs and symptoms of cardiac distress requiring emergency care. More specifically, it would be advantageous to have cardiopulmonary resuscitation (CPR) training as a standard practice consistent with the qualifications of other health care providers.

As well, this speaks to the importance of making sure that participants are physically and emotionally well enough to participate in the GA group. A screening interview could be used to address women's functional capacity and heart health to make sure they are stable enough for full group participation.

While I was not concerned that the research activities would evoke a MI in study participants, I had concerns that some participants may not be able to 'contain' the intensity of emotion that was evoked through reflecting on earlier life experiences which for some, were still fraught with unresolved emotional pain. Consequently, this indicates the importance of having skilled group facilitators conduct future GA groups. Trained facilitators would be adept at teaching participants' containment strategies and appropriate group behavior as well as providing group support, facilitation skills, the containment of strong emotions or difficult group content and/or process, appropriate challenging and skillful interpretation. In hindsight, Sally's abrupt expression of anger during the sixth research session may not have resulted in such a favorable outcome had the facilitator and myself not been skilled and experienced group leaders.

While it may be ideal to have two facilitators conducting a GA group with heart patients, this may not be cost effective within a hospital setting. Consequently, a counsellor who has suitable knowledge of cardiac health or a cardiac nurse that has sufficient training in counselling skills and group work may be appropriate candidates for conducting these groups. In addition to these considerations, the question of facilitator gender may also be relevant. More specifically, should a male group leader facilitate a GA group with women? (Conversely, should a female facilitator conduct GA groups with men). While intuitively I suggest that the depth of group experience, particularly around relational and support concerns, be better suited to having a female facilitator, perhaps this is a question that could be better answered by further research.

In summary, women's participation in the current research group served to achieve both the goals of action research (including action, investigation, and education) by way of the group process as well as several positive benefits from participating in the process of GA as outlined by Birren and Birren (1996). Based on women's feedback, their efforts to engage deeply in personally relevant history and emotional events in their lives evoked greater self awareness and perspective for the individual and for other group members as recovery stories were constructed and shared within the group. Women's experience of sharing their autobiographies led to the expression of voice and vulnerable feelings, greater reconciliation with past losses and negative feelings, the development of group trust and membership, a greater sense of personal power and hope, the formation of friendships and provision of empathic support to others, problem solving and the exchange of information, goal setting, and the development of new approaches to self-care and coping.

Limitations of the Study

As one of the goals of qualitative research is to examine the fundamental processes of a specific group of individuals, it does not support the generalization of study results to other groups or persons. Consequently, the findings of this study are not generalizable to other women with MI and/or heart disease. However, the themes that emerged from the study may resonate with other women and are worthy of reporting to other women. Moreover, the learning that resulted from reading these women's autobiographies and from conducting the GA group is transferable and may be useful to the reader.

The sample size and selection process was primarily of convenience and undertaken to enhance the participation requirements of the methodology. Convenience factors were influenced by the limited numbers of younger female MI patients and by the presence of only one participant that was not Caucasian. Subsequently, while fulfilling these requirements, the study cannot be considered representative of different cultural perspectives. Study findings may have differed with a sample more diverse in cultural representation (including ethnicity, sexual

orientation, and partner status). Participant differences were also evident in terms of diverse social backgrounds and perspectives, length of recovery time since MI, number of research sessions attended, and a significant variation in women's ability to reflect on and articulate themselves both verbally and through their writing. As well, the self report nature of telling stories from memory and the impact of telling and listening to stories influenced the data generated. Consequently, a different group of women under different circumstances would inevitably influence the nature of the research findings.

The results gained from this autobiographical study were co-constructed by the researcher and research participants. In this sense, an interaction of researcher and participant factors also influenced the outcomes of the study. Moreover, the research process, data analysis and the interpretations were particularly influenced by my own perspectives and experience of working in health care, and understanding of the culture of medicine and cardiac illness in women. While participants provided feedback on the researcher's weekly interpretations and theme analysis, they did not review the six themes that emerged as a result of the across-week analysis due to time constraints.

To address potential biases, I engaged in various practices including a discussion of my personal perspectives on women's recovery, adopted the role of co-facilitator/researcher (while having a primary facilitator conduct the group), ongoing self-reflexive inquiry through journaling and dialogue with several colleagues, numerous consultants, and the attention to issues of validity (these are discussed in greater detail in Chapter Three). Consequently, mindful efforts were taken to present my involvement in the research findings so that readers could evaluate for themselves the rigor and trustworthiness of the results.

Implications for Health Care Providers

This research contributes to the growing body of qualitative studies that explores MI recovery in women. This study has replicated several study findings from earlier research including the recovery themes and various descriptions of participant's experiences. The uniqueness of this study is also grounded in the younger cohort of participants investigated, the methodological framework from which the study was conducted, and the experience and expertise of the researcher who conducted the study.

Study findings demonstrated that women's constructions of recovery are often varied and complex and extend beyond the disease process itself. Although women experienced various losses associated with MI, these were embedded within their larger life stories. Consequently health professionals need to provide women with care that is specific and germane to their experiences. Although most of the participants participated in cardiac rehabilitation, a significant component of cardiac recovery, CR did not specifically address

participant's emotional distress. While women may have completed a cardiac rehabilitation program, they may not feel emotionally well or 'recovered.'

Given that medical professionals do not typically possess expertise in the area of emotional or psychological support it is imperative they work with other care professionals, such as counselling psychologists, who have the skill and expertise in addressing emotional and psychological aspects of dis-ease in women with cardiac illness. Although doctors may not be the providers of this care it is important that they value and support the facilitation of emotional care and recovery within the larger context of recovery from MI in women (and men).

A key implication in this study is the important role of counselling psychologists to assist other health care professionals, particularly doctors and nurses, in the support and care of women and their emotional recovery from MI. This involves highlighting younger women's experience of MI in terms of the recovery themes that emerged in this study as well as direct client care. As peer reviewers suggested, current cardiac rehabilitation services do not have the "luxury (time or place) to explore the personal meaning" associated with their illness. Rather than viewing the exploration of patient's inner worlds as a "luxury," exploring patient's personal biographies and histories will allow care providers to better understand their patients by accessing their belief systems and processes of personal meaning making. As evident in the current research, women's belief systems impacted their perceptions and their behavior and consequently how they constructed their recovery.

Another key implication in this study is the value of medical professionals adopting a personal history or narrative approach to history taking with patients. Moving beyond patient's physical symptoms and physiological readings will represent a step towards more compassionate care as health providers could better understand the depth of their patient's illness experiences. Counselling psychologists are adept in the provision of training to medical professionals in the area of empathic interviewing and communication skill building. More specifically, training in this area will teach health professionals how to respond more humanely to their patients thus allowing them to also understand the potential impact of ineffective communication on others as well as patient's responses and behaviors within the context of their illness and treatment.

The findings of this study also suggest that the participation in an 8-week guided autobiography group was beneficial to a small group of women aged 48-53 years recovering from MI. Given the need for providing greater emotional support to women following a significant cardiac event, including MI, has been well documented in the literature (see Arthur et al., 2001; Bowers, 1996; Doiron-Maillet & Meagher-Stewart, 2003; Helpard & Meagher-Stewart, 1998; LaCharity, 1997) a key implication in this study involves the importance of utilizing the GA

format by skilled facilitators as a means for providing emotional care to women in adjunct to cardiac rehabilitation. In this sense, the current study could be construed as a pilot for future GA groups.

Within the context of the GA group, women may develop greater awareness of their experience, practice behavioral change, and receive support for changing patterns of behavior. Moreover, the telling of women's autobiographies may also further inform women's needs for individual therapy, psychoeducation, information and/or social support outside of the GA group.

A final implication in this study is the importance of developing public education initiatives regarding the incidence of MI in younger women. These initiatives could occur within the format of public service announcements and radio and television interviews, health magazines for the general public, women's health journals, and through professional development targeting health care professionals. Moreover, participants in the research group strongly recommended that the researcher write a book for women based on the study findings.

Implications for Counselling Practice

Findings from this study suggest that women's constructions of MI recovery are varied and complex and typically extend beyond the physical disease process as the emergent recovery themes included issues related to loss, changing self-concept, living with uncertainty, and challenges around women's ability to care for themselves and others.

As well, participants collectively identified an extensive list of individual concerns, each potentially warranting the psychological support of a professional counsellor including grief and loss associated with normative and non normative death; family suicide; family addiction; chronic and acute illness; family mental health issues; relationship conflict; separation; post-traumatic stress disorder; self-esteem; codependency; depression and anxiety; abandonment; sexual identity; immigration and cultural integration; career transition; existential and spiritual crises; and lack of social support. Consequently, Counselling psychologists play a crucial role in providing psychological support within an interdisciplinary team of health professionals that is germane and specific to women's particular issues and needs. The value of providing both individual counselling sessions and group support to women during various stages of their recovery from MI is clearly indicated.

Incorporating the use of personal stories or guided autobiography in counselling practice with clients represents a vehicle for better understanding individual constructions of self and identity. More specifically, developing a program of care specific to women, using individual narratives and/or guided autobiography and group process as a clinical intervention, in adjunct to conventional rehabilitation, would provide a more integrated and holistic approach to cardiac treatment and may further facilitate adjustment to MI and recovery in women.

Counselling psychologists working in the area of medicine may also serve as educators in terms of training doctors and nurses in the area of communication skill building including the use of empathy, and narrative forms of patient history taking. Training opportunities may take place at both the pre service level where medical schools have incorporated patient centered skill building into their training curriculums and at the in service level as professional development for doctors and other medical staff can be implemented.

As well, counsellors knowledgeable in the area of cardiac health can inform other care providers of the psychological and/or emotional needs of female cardiac patients related to the importance of receiving concrete information, empathic communication and compassionate care, and the social, psychological, and various developmental challenges that (different aged) women may face.

Finally, Counselling psychologists may support medical professionals in a therapeutic capacity to address unresolved personal issues that may prevent them from interacting with their patients in a psychologically healthy manner.

Implications for Research

In this study, important information was gathered about the recovery experiences of women under the age of 55 following MI and guided autobiography was utilized as a research method with female cardiac patients. More research will be necessary in order to refine and extend the results of this study.

This research focused on the experiences of five women within 3 years of having their first MI. Given that the results are based on a small sample of participants it is important to study similar (and differently aged) cohorts of women to confirm whether or not current findings reflect the experiences of other individuals who are recovering from MI within a similar time frame. More specifically, replication of this study may reveal whether the identified recovery themes are consistent with the experiences of other women and may allow for the further refinement of these themes.

Given that all but one of the participants in this study was Caucasian, the experiences of these women may not be representative of MI recovery in women from other cultural and ethnic backgrounds. As culture and ethnicity mediates cultural, social and personal meanings associated with illness and gender, further research may explore the recovery of cohorts of women from diverse backgrounds. For example, it would be interesting to replicate this study with Asian, Indo-Canadian, West Indian, and/or lesbian groups of women as well as heterosexual women who are all male partnered.

Although the current study investigated recovery in women diagnosed with MI within the past 3 years, four out of five participants had their heart attack between 3 to 8 months prior to

joining the research group. As indicated, aspects of women's descriptions that were in the earlier stages of recovery often differed from the descriptions of the participant who was 3 years post MI. Whether these differences were attributable to personality variables and/or length of recovery is not clear. Further research might explore the experiences of women who are at different stages of their recovery process. For example, examining women at two, three, five, and ten years post MI may serve to illuminate the experiences and care needs associated with recovery in women over time.

Lastly, conducting research that utilizes the voices and resources of individual participants within the research process challenges traditional methods of health research and serves to model the value of working collaboratively with those who we study. Further research using a guided autobiographical approach may be used to expand our understanding of the emotional recovery male cardiac patients as well as individuals from other illness groups for which we know little about.

Personal Statement

Throughout the course of conducting this research, I have felt very privileged to accompany the five volunteer women on their journey of personal reflection and story telling surrounding their recovery from MI. I am aware that my knowledge and understanding of this complex phenomenon has been significantly enhanced and will influence my clinical work with women (and men) with heart disease as well as other illness groups. Furthermore, this study will serve as a catalyst for the development of a much needed program of emotional care specific to women and for future research initiatives in this area. Finally, the project has further reinforced my understanding of the value of creating women-centered health care, for honoring and encouraging the individual story of those suffering from illness, and confirmation that recovery from MI (and other illness) involves a bringing together of the healing of women's bodies and their emotional, psychological and spiritual selves.

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Appendix C: Brief Telephone Interview

Participation in this initial telephone contact is voluntary. If at any time during the call you decide that you do not want to participate, please feel free to decline. In addition, if you do not want to respond to a specific question, please indicate that you would like to move on to the next question.

Date: _____

1. Name: _____

2. Address: _____

3. Phone Number(s): _____

4. Age: _____

5. When was your heart attack? _____

6. Any previous heart attacks? (how many, when) _____

7. Current cardiac symptoms? _____

8. Describe your experience of participating in a cardiac rehabilitation program? N/A?

9. Have you been hospitalized for any other medical concerns? (describe) _____

10. Education: _____

11. Ethnic Background: _____

12. Family Status: _____

13. Are you currently employed outside of the home? _____

14. Do you know of any other women who have had a heart attack who may be interested in participating in this study?

Appendix D: Initial Interview

Participation in this interview is voluntary. If you do not wish to participate, please feel free to decline. In addition, if you do not want to respond to a specific question please indicate that you would like to move on to the next question.

Date: _____

1. Name: _____

2. Phone Number(s): _____

3. Describe the study. (Provide each woman with a copy of the information sheet).

4. What are your questions about this study?

5. Can you attend the group on a weekly basis?	Yes	No
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6. Have you participated in a group before? If yes, what was it like for you?	Yes	No
--	-----	----

7. Do you have any concerns about the group meetings being taped? If yes, please explain.	Yes	No
--	-----	----

8. How would you feel about participating in the writing exercises and sharing these with the group?

9. What has brought you to want to participate in this study?

10. What does 'recovery' mean to you?

Appendix F: Guided Autobiographical Themes (Weeks 1-6)

Theme #1: Your Health and Experience of MI and Recovery

Your experience of recovering from a heart attack has many aspects, objective features, and subjective feelings. In part, it may involve an implied comparison with other women or men who have had a heart attack, whether you were (are) more or less healthy, stronger or weaker, etc. As well, prior experiences of being hospitalized or witnessing the illness or hospitalization of family and/or friends may also influence how you have perceived your experience of MI and your process of recovery. What has been the history of your health and illness, and now your experience of having a MI?

Guiding Questions

1. What was your health like as a child? Adolescent? Young adult? Older adult? Before you had your heart attack?
2. How was illness dealt with in your family of origin?
3. What health problems have you experienced in your life prior to your heart attack? How did you feel about each of these? How did you handle these problems?
4. What is the story of your heart attack and of your recovery?
5. What was your experience of being hospitalized with MI?
6. How did your body respond to physical exertion before your heart attack and how does it respond now?
7. In what ways does your body react to stress during your recovery? Has this changed since before you had a heart attack? What do you do in response to your body's stress signals?
8. How have you cared for your physical health during your life? How do you care for your physical health during your recovery from heart attack?
9. How has your experience of heart attack altered your sense of health, body image, and/or physical self?

Adapted from: Guided Autobiography. Groups for Older Adults, by James E. Birren & Donna E. Deutchman; The John Hopkins University Press. Baltimore and London, 1991.

Theme #2: Your Major Life Work and Recovery from MI

An individual's career may also be considered their life work. It occupies energy, activity, and time, and may take many forms including work outside the home for pay, or the work involved in being a wife, a parent, religious / spiritual devotion, art, education, or in community services. During recovery from MI, your life work may have been altered or interrupted in some way for a period of time depending on your condition. Consequently, this may or may not have resulted in a disruption of your personal and/or work world.

What has been your major life's work or career?

How has your life work / career been impacted by your experience of MI and throughout the recovery process? How do you feel about this?

Guiding Questions

1. How did you get into your major life work? How did you find it? When did you begin your life work?
2. How early did you formulate your life work / career goals? What did you want to be when you grew up? Which of these goals have you accomplished prior to having your MI? Have you accomplished any of these goals following your MI?
3. How have you managed to fulfill the responsibilities of your life work since you began your recovery from MI? Describe which life work responsibilities that you find more challenging since you began your recovery from MI?
4. Which aspects of your life work / career do you wish you could receive help with?
5. Outside of your MI experience, have there been any major or minor circumstances that have influenced the continuity of your life work / career? How have you coped with these situations? What have been the peaks and valleys, major or minor setbacks, major changes in focus? What are, or have been, the biggest influences in directing the path of your life' work?
6. How has your work provided new options or limited options since you began your recovery from MI?
7. Are you "on time" in your career, or ahead or behind in terms of your expectations? What else are you hoping to do given your current health status?

Adapted from: Guided Autobiography. Groups for Older Adults, by James E. Birren & Donna E. Deutchman; The John Hopkins University Press. Baltimore and London, 1991.

Theme #3: Significant Relationships and Recovery from MI

We have all received messages or rules from our significant relationships (including family) about how to navigate through the world including how we make sense of and respond to major life events, deal with strong emotions, cope with grief or loss, receive and give support, and manage change. Understanding some of these rules may give you some insight into how you have experienced your MI recovery process.

Who represents the significant relationships in your life? These might include your family of origin (including grandparents, parents, brothers and sisters, aunts and uncles), your family of adulthood or chosen family (including your partner, children, or close friends). Significant relationships may also include other individuals including health practitioners, work colleagues, neighbors, pets, etc.

Which significant relationships have had an impact in shaping your MI recovery? Some of these individuals have been important in positive and negative ways. Why? How?

Guiding Questions

1. Which of your relationships are most important to you? Why?
2. What were the rules in your family, the "shoulds" and "oughts" around dealing with difficult times (e.g. illness, conflict, emotions, change, etc).
3. What events and experiences that have created either distance or closeness between significant others (including family).
4. Who has offered support, care, warmth or nurturance during your recovery from MI? Was there someone you found particularly comforting and confided in?
5. What kind of support have you needed in order to move forward in your recovery? What kind of support have you received that has helped you move forward in your recovery? What kind of support have you not received that would your recovery?
6. Which significant relationship have you felt least close to during your recovery? Why? Who should you have been close to but for some reason was not?
7. Have you felt supported during your recovery? How did you know?
8. What have your relationships been like with health care providers during your experience of MI and during your recovery? What feedback would you give to the doctors, nurses, and other health care providers that have been involved in your care during your MI and process of recovery?
9. Challenges of recovery process with respect to your roles as caregivers and nurturers. Does this play a part? What is difficult? What is it like having to focus on yourselves when you are so capable and competent in terms of focusing on others and making sure your environment is working smoothly?

Adapted from: Guided Autobiography. Groups for Older Adults, by James E. Birren & Donna E. Deuchman; The John Hopkins University Press. Baltimore and London, 1991.

Theme #4 – Self-Care: Dealing with Stress & Personal Needs & Recovery from MI

Experiencing a heart attack is a stressful event, and managing stress is part of the recovery process. Stress has been described as a response, a way of coping with an event that requires us to adapt. The event could be a sudden incident, such as an MI, or a chronic hassle that we deal with over time (e.g. negative job environment; excessive noise). Stress can be experienced in the body, mind, the emotions, in relationships, and even spiritually.

We all have our favorite coping styles. Knowing how you typically handle stress may also give you clues about how to take care of yourself, and your personal needs. Taking care of personal needs is a skill that may also help maintain a healthy lifestyle and prevent negative stressful reactions in the future. In order to manage stress and take care of yourself, you need to focus on you. As women, we are often taught that it is “selfish” to put ourselves first and to take care of our needs before others. Knowing how to take of yourself is one of the most caring things you can do, not just for yourself, but for family and friends as well.

Taking care of yourself is easier to do if you know what your needs are, how to ask for what you need, and how to cope positively with stress.

Guiding Questions

1. How have you known (how do you know) when you were (are) stressed? What were the clues: e.g. in your body, the way you think, you feel?
2. How have you historically coped? How have your ways of coping changed over time? Are you more sensitive to the signs of stress now?
3. What kinds of stress do you find overwhelming?
4. What has been most stressful about your experience and your recovery from MI? How have you coped? In what areas of your life have you experienced stress since the heart attack?
5. How do manage your stress during your recovery? What is most helpful? What is the most challenging part of your recovery?
6. Learning to take care of yourself and identifying personal needs may be a healthy way to prevent major life stressors. What needs have stood out for you as you recover from your MI? (e.g. social – support & understanding from others; physical – rest; spiritual – sense of meaning or purpose; mental – information; problem-solving).
7. What did you learn from your family about how to take care of yourself?
8. What did you learning growing up as a woman about taking care of personal needs?
9. What are some ways you are already taking care of yourself, that helps you manage your recovery?
10. What do you need right now? What is it like for you to ask for support?

Adapted from: Guided Autobiography. Groups for Older Adults, by James E. Birren & Donna E. Deutchman; The John Hopkins University Press. Baltimore and London, 1991.

Theme #5: Your Ideas and Experiences about Death and Recovery from MI

Death can affect your life in many ways. Past exposure to the death of others may serve to shape your current beliefs and feelings about death including your own death. In the past, you may have experienced the loss of a beloved pet as a child, lost parents, grandparents, close friends, a spouse, a child, or a sibling. Maybe the death of a political figure affected you profoundly.

More recently, surviving a potentially life threatening event such as MI, may have brought the possibility of your own death closer to your experience.

In general, how has your experiences with death affected your life and your character? How have your reactions to death changed over the years? Has having an MI impacted your views on life? Has this changed at all? How has having an MI impacted your ideas concerning your own death?

Guiding Questions:

1. How did you feel about death when you were a child? Did you lose an animal that was a member of the family? What did you think/feel when your pet died?
2. How was death talked about and treated in your family? Did it frighten you? How did you understand it? How did you grieve?
3. What was the most significant death you have experienced? How did it impact your life?
4. When did you go to your first funeral? How did you react?
5. Do you feel guilty about anyone's death? Helpless? Angry? Resentful? Abandoned? Have you ever felt responsible for anyone's death?
6. How has surviving a potentially life threatening event such as MI impacted your ideas and feelings about your own death? Have these ideas and feelings changed as you progress in your recovery from MI?
7. What kind of death would you like to have?

Adapted from: Guided Autobiography. Groups for Older Adults, by James E. Birren & Donna E. Deutchman; The John Hopkins University Press. Baltimore and London, 1991.

Theme #6: A Personal Story of My Recovery from MI

As adults, many of us have experienced events or made choices that, in retrospect, altered our lives in some way. Through such events, or turning points, we learn to cope, to call on our strengths and resources, and sometimes even to challenge and change the way we think about life, and even what ultimately brings meaning to our lives.

How has the experience of having a MI impacted your life? How do you make sense of this experience, especially if you still feel like you are actively in recovery, and that you are not yet at the “end of the story?”

This is a chance to look forward, and imagine the story you would like to tell about your recovery from MI. Imagine a time in the future, say 5 to 7 years from now. Whatever the timeline is you feel like you’ve reached the “end” of the story of your recovery process.

If this was a story in a book, and this was the “end” chapter, what would others read about your experience, the most challenging parts about it, and what got you through it? Looking back, what story do you want to tell about how you came through this time, in a way that feels satisfying to you now? Another way of approaching this is to ask: what would you like others to say about you?

Guiding Questions

1. How will you describe what happened to you? How did you cope (e.g. at the beginning, during the middle, toward the end)?
2. What has been most helpful to you in your recovery?
3. Were there times that were particularly challenging? Why? What was challenging for you? How did you navigate those obstacles, and move through?
4. If you think of your recovery process as a journey, what metaphor comes to mind to describe it? (e.g. an animal, a mountain, a song, a river, a symbol).
5. If this was the title of a chapter, what would you call it?
6. What dependable inner resources (e.g. strengths, skills, spiritual beliefs, attitudes) and outer resources (e.g. friends, information, or exercise) have helped you at the time of your MI and your recovery?
7. What did you learn about yourself as a result of your MI recovery process?
8. Looking back, what meaning does this experience have for you now? How do you make sense of it? Has it changed your sense of the meaning of your life?
9. What do you want to experience in the future? (think of 1 – 3 things). What do you need to do to make these experiences happen?

Adapted from: Guided Autobiography. Groups for Older Adults, by James E. Birren & Donna E. Deutchman; The John Hopkins University Press. Baltimore and London, 1991.

Appendix G: Follow-up Session Handout

Beckoning the Heart: Women's Cardiac Research Group

Final Follow-up Session

Following our 6-week Guided Autobiography research group, I am hoping to schedule one more group meeting. During this final follow-up session, I will take some time to share with you my understanding of the issues and themes that have emerged from our group discussions and from your written accounts with respect to MI recovery. I will also be asking you whether or not I have accurately understood your experiences and if there is anything else that I have missed or that needs to be added or clarified.

During this final session, I will also be asking you some questions about what it was like for you to participate in the group. As well, I will be asking you whether you think we accomplished what I set out to do in this study. This is also an opportunity to make comments and recommendations about the strengths of the project and areas you believe could be improved. All of this information will be very valuable in evaluating this project and in considering future research and Guided Autobiography. I encourage you to speak openly and honestly about your reactions and impressions during this session.

I have included some questions for you to think about for our follow-up session:

- Was this research experience beneficial for you? In what way(s)? If not, why?
- What would have made this experience more beneficial?
- Did your experience in the group act as a catalyst for greater awareness, personal growth and/or change?
- To what extent do you think the findings of this project will be helpful to others (including other female or male heart patients and health providers)?
- Do you think others would benefit from participating in this kind of group? Explain.
- What was it like for you as a participant in the group?
- Did you feel that individual and group participation was encouraged in the meetings? Did it feel safe to participate?
- What was your experience of the group process? In your mind, what transpired in the group?
- In listening to my understanding of the themes and issues described in the group, do you recognize these as your own? Do these resonate with you?

Appendix H: Table of Participant Demographics

Participant	Age	Age at MI	Relationship status/ children	Education	Employment	Ethnicity	Concurrent health concerns
Bev	53	53	married, 2 children	college	entrepreneur	Canadian	high blood pressure; anemia; overweight
Arlene	52	52	previously married / currently not partnered, 2 children	high school + professional courses	administrative assistant; entrepreneur	Canadian	diabetes (type I); heart failure; fibromyalgia; previous Guillain-Barre syndrome
Helen	51	48	previously married / currently not partnered, 1 child	graduate university	teacher	Canadian	previous depression
Sally	48	48	single	high school	unemployed/ hairstylist	Scottish/ Canadian	depression; arthritis; peripheral vascular disease
Sarah	48	48	single	some university/ college	Student/ unemployed/ accountant	Persian	depression; high cholesterol; lupus