

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

Danielle Groleau^{a,b,*}, Rob Whitley^c, François Lespérance^c, and Laurence J. Kirmayer^{a,b}

^aDivision of Social and Transcultural Psychiatry, McGill University, Montréal, Qué., Canada

^bCulture & Mental Health Research Unit, Institute of Community & Family Psychiatry, Sir Mortimer B. Davis, Jewish General Hospital, Montréal, Qué., Canada

^cDepartment of Psychiatry, Faculty of Medicine, University of Montréal, Centre Hospitalier de l'Université de Montréal, Montréal, Qué., Canada

Abstract

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

Keywords

Myocardial infarction; Place; Spirituality; Identity; Culture; Recovery

1. Introduction

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

*Corresponding author at: Institute of Community & Family Psychiatry, 4333 Côte-Sainte-Catherine Road, Montréal, Qué., Canada H3T 1E4., Tel.: +514 340 8222x3989; fax: +514 340 7503., danielle.groleau@mcgill.ca (D. Groleau).

Experiencing an MI can be traumatic for many patients and their family, and correspondingly, many studies have also focused on negative psychological reactions such as fear, anxiety, depression and post-traumatic stress disorder (Al-Hassan and Sagr, 2002; Ginzburg, 2006; Shemesh et al., 2006). However, other authors have suggested that responses to life-threatening events are not necessarily negative and may actually result in positive changes reflecting resilience or post-traumatic growth (Barakat et al., 2006; Hassani et al., 2009; Tedeschi and Calhoun, 2004). These positive responses can contribute to well-being and adaptation to illness (Linley and Joseph, 2004; McBride et al., 1998; Walton, 1999; Woods and Ironson, 1999). Some patients facing life-threatening illness also experience an increase in spirituality or religiosity, which are associated with successful coping with stress (Graham et al., 2001) and with positive global appraisals of well-being (McBride et al., 1998; Woods and Ironson, 1999).

Medical practitioners and educators have become increasingly aware that spirituality constitutes an important component of comprehensive patient care (Clark et al., 2003; Tang et al., 2002). Spirituality has been defined as a construct with multiple dimensions (George et al., 2000) with focus given to one or other dimensions depending on the researcher. Example of these dimensions summarized in a review by Doster and colleagues include: “a way of being in the world, an innate feature of a human being, meaning and purpose in life, interconnectedness between the spiritual person and a higher power and/or other persons, beliefs and values about reverence for life, for human rights and for dignity and the transcendence of self or finiteness of human experience (Doster et al., 2002).” While the number of studies exploring spirituality and well-being among patients with heart disease has increased since 1990 (Doster et al., 2002), studies on post-MI spirituality have tended to use quantitative scales to explore correlations between one or more extrinsic constructs of spirituality, and specific health outcomes such as post-MI depression, cholesterol and triglyceride levels (Bekelman et al., 2007; Blumenthal et al., 2007). Although these scales and components of spirituality can be useful to predict health outcomes, some have argued that they ignore other dimensions of spirituality (i.e. forgiveness, mindfulness) that may play an important role in post-MI patient’s well-being and health behavior (Blumenthal et al., 2007; Brown and Ryan, 2003; McCullough et al., 2000). Similarly, the theoretical concepts of spirituality implicit in these scales also does not reflect the fact that constructions of spirituality are embedded in various local contexts, and determined by situated factors such as religion, history, politics and cultural models of illness. As such, grounded concepts of spirituality are dynamic, in flux, and change depending on local and global events as well as individual experience (Sacks, 2005; Whitley and Kirmayer, 2008). In other words, *place* matters when conceptualizing and exploring factors such as spirituality.

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

of Walton (1999, 2002) in the United States, there is also little research that addresses spiritual experience following an MI from the patient's perspective (Cherrington et al., 2004; Havranek, 2001).

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

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

2. Methodology

Participants—The study sample was comprised of 51 French Canadian men and women living in the province of Quebec, between the ages of 23 and 70, presenting a range of socioeconomic backgrounds and levels of education. Patients were recruited from five hospital coronary care units in the cities of Montreal and Laval. They were purposively selected to represent the following criteria: (1) having experienced a first diagnosed MI during the last three months; (2) born in Canada and (3) self-defining as French Canadian or *Québécois*.¹ Of 60 patients referred to us by clinical or research coordinators of participating hospitals, 57 agreed to participate. The three who refused to participate simply mentioned not having enough time or not being interested. Six of the recruited patients died before their first ethnographic interview could be scheduled, which reduced the sample to 51. Our sample was limited to this cultural community as it represents the majority ethnocultural

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

group in the province. This focus on a single ethnocultural group was chosen to allow us to understand how a specific cultural group configures the post-MI experience. The research protocol and consent forms were approved by the research ethics review boards of the five participating hospitals. All participants read and signed a consent form just before the first interview was conducted.

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

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

3. Results

The majority of participants were men (39/51) with most of them having 14 years of education or more in total (46/51).³ Most participants were over 50 years old, while a minority (14/51) were between 40 and 49 years of age. Slightly more than half of the sample was married or in union with a partner, while the rest lived alone (either single, divorced, separated or widowed). Although most participants were reluctant to declare their religious denomination at the first contact, all declared themselves to be Roman Catholic, though only a few regularly attended church. Annual salaries ranged from \$20,000 to 60,000 Cdn, though with most in the \$21,000–40,000 range. Among the 51 participants, most had more than one risk factor: 38 had hypercholesterolemia, 12 diabetes, 29 hypertension and 20 were smokers prior to their MI.

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

³In Quebec (Canada) elementary school lasts 6 years, secondary school 5 years and state-funded collegial education lasts 2 years if students intend to move on to university, or 3 years if they are registered in a technical program without intending to go to university. Hence, our sample on average had completed college-level education.

In the sections that follow, we present the common explanatory models and prototypes contained in participant's post-MI narratives. In the second section, we examine how these narratives were linked to a popular theory of illness shared by participants. Finally, we present common themes contained in the chain of events (chain complex) evoked in the narratives. The focus of this third section is mainly on participants' MI and post-MI experience as a turning point in their lives, especially with regard to change in values and issues of spirituality.

3.1. Explanatory models and illness prototypes

Before the interview started, all patients were asked to show the interviewer the medication they were currently taking and to explain why they took each pill. From this exercise, it appeared that all patients suffering from hypercholesterolemia, hypertension and diabetes were aware of their condition and the corresponding prescribed medication. Furthermore, because of the illness prototypes they offered, it was clear that they were well aware of the fact that these medical conditions constitute important risk factors for MI. Indeed, in probing for prototypes, we asked patients if they knew someone who had an illness similar to their own. Most mentioned a family member, friend or colleague who had a heart problem. To access their analogical reasoning, we then asked them how their own heart problem was different from or similar to the problem of the person they had identified. Strikingly, in response to this question, a majority mentioned that their *own* MI was due to stress while the heart problem of the others was due to either to: high cholesterol, hypertension, diabetes or smoking. They thus discounted the impact of risk factors in their own case (Table 1).

Later on in the interview, with the objective of probing for the *explanatory models* of their own MI; we asked participants to describe what had caused their own heart attack. Again, stress was presented as a central perceived cause of their MI. Moreover, none of the diabetic or hypertensive patients attributed their own MI to their condition, even though they were well aware of their condition, having declared it to the interviewer just a few minutes earlier in the interview. Only about one-third (13/38) of the patients with hypercholesterolemia considered their condition a contributing cause of their MI. Less than half of the smokers (8/20) attributed their MI to their smoking habit. This is a puzzling result, considering that these patients knew they were suffering from one or more of these recognized risk factors and that they had themselves acknowledged the etiological role of these factors in the heart disease of others. As an example:

Jean-Charles: "I felt like a walking bomb in the end... because I was absorbing it all when I should of been thinking that these things would resolve themselves. I felt like I had a lot, you know, it's an accumulation of stress, anguish and all sorts of things that are linked and didn't work. Yes, that didn't work well for me at that time [referring to a new position he had applied for at his work and had not obtained]. A lot of deception, and absence of recognition. Yes, all these things."

Heredity was recognized as an underlying cause of their MI by a few patients. Interestingly, most smokers considered stress a cause of their MI (15/20), while the fact that they smoked (8/20) was recognized as a cause by less than half of them. But clearly, with the exception of the patients with diabetes (who considered that their MI was caused by either heredity or

diet), stress remained the most common perceived cause of their MI for patients. A closer look at the illness narratives enabled us to unpack the complexity of meaning underlying the label of “stress” as a dominant perceived cause of their MI, and helps clarify why these post-MI patients were able to recognize the etiological role of risk factors for other’s heart problems but not for their own.

3.2. Popular theories of health linked to an MI

Below we first examine the abundant metaphors used in these illness narratives suggesting that the heart is perceived not just as a physiological organ but has broader psychological and symbolic significance. The metaphors that patients used to explain and describe their MI ranged from mechanical models of blocked tubes and malfunctioning motors to the heart as a receptacle of good and bad emotions or stressful, intense and traumatic experiences.

Albert: “According to me, it’s the accumulation of efforts, stress and intensity of emotions that provoked my heart attack. Well selling my house, having a new partner, losing my job and break-ups, you know. You accumulate all this and that’s what makes your arteries get stuck with dirt, with a bad way of eating and not enough exercise. Its like a scar [*cicatrice*] that opens up and stays that way. My personality too, well ...is part of it. I always want to do more and more and get better and better at what I do... You know, this thing with performance...”

Lucie: “I had a ‘heart like a sponge’; I always lived that way.”

Having a heart “like a sponge” is a common metaphor in Quebec meaning that one keeps all emotions inside, and does not express or share difficult or negative feeling with others. Many patients used the cultural idiom “*pris du coeur*” (literally: “taken by the heart”) to describe their new condition. While “*pris du coeur*” did not correspond to any medical diagnosis, participants explained that *pris du coeur* mean having an irreversible chronic condition that places important limitations restricting one’s physical activities and geographical mobility. In particular, one who is *pris du coeur*, cannot engage in activities that would take one away from easy access to hospital services, such as going on a fishing or hunting expedition or spending the winter in a southern country (a common pattern of sojourning for many Québécois who can afford such travel). Thus, *pris du coeur* is associated with a spatial (re)organization of identity in which there is an ongoing awareness and gauging of one’s distance from the emergency medical care of the hospital. In fact, those who had a chronic heart problem diagnosed prior to their first MI, (i.e. angina) considered themselves *pris du coeur* even before their first MI had occurred.

Francois: “Since I was young, I was always taken by the heart, [*pris du coeur*]. I always said I was taken by the heart. That is part of my identity. But since my heart attack, I have to listen a bit more to my body.”

Other considered themselves *pris du coeur* only since this first MI, indicating that being “pris du Coeur” can reflect a change in identity that occurs later in life.

Claire: “I am taken by the heart. I think a lot about death since my heart attack. I am afraid of having another one. I take my medication exactly as I should. Now I am a bit afraid. I would not want to have another one like I just did.”

Many participants that perceived themselves *pris du coeur* since this first MI explained that they had to undergo a period of mourning in order to accept their new identity, especially with regards to the limitations placed on mobility and activity. Others simply acknowledged that since this first MI they considered they had acquired a new identity: “I am now a cardiac patient” (“*je suis cardiaque*”) but did not consider this new identity to place major limitations in their life. However while some considered themselves *pris du coeur* following this first MI, many considered that medical technology nowadays could change this because it allows doctors “to repair their heart.” The few patients who underwent coronary artery bypass surgery or angioplasty for example, considered themselves no longer *pris du coeur* since their post-MI operation. Of the 27 patients who used the expression “*pris du coeur*” during their illness narrative, seven identified themselves as permanently handicapped and vulnerable, whereas 13 remained ambivalent as to whether or not they were still *pris du coeur*. This ambiguity may be due to the power they attribute to medical technology that they considered has cured them from a disease initially considered to be chronic.

Turning points and spirituality—Most patients were able to make sense of their MI, not primarily in biomedical terms, but mainly by recognizing that their illness constituted a landmark or turning point in a chain of events in their lives. Their MI was seen as an experience that projected them into a “state of limbo,” a “time-out” while at the hospital or at home recovering, where they engaged in prolonged reflection on the meaning and direction of their lives.

Francine: “Well I spent a lot of time thinking, reflecting at the hospital and when I came back home. I never thought it would happen to me. I always thought that this type of problem happens to others. I used to see myself as protected.... But when it happened well ...I did a lot of thinking. Things started to change. I am a Catholic but I don’t practice. But I thought a lot about that [referring to religious thoughts] and it helped me a lot.”

Following this period of reflection, many expressed the need for changing the way they perceived their own lives, accompanied by a shift in values, responsibilities and identity. Most participants saw themselves as more humanistic and more altruistic since their MI, while being more critical of the materialistic, individualistic and “speed of life” aspects of North American society. By doing so they expressed a shift from dominant North American individualistic values traditionally known to correspond to a Protestant ethic (Weber, 1958b) toward a more collectivist worldview historically associated with Roman Catholicism in Quebec.

Julie: “Now I want to get more involved and help others. I am part of a bowling club. There are others there that had serious health problems...some with their heart worse than me, some with cancer. They still go bowling but sometimes they are not there because of treatment or things like that... I go and visit them when they can’t come to play. We talk about their health problems. I am more attentive to others. I have changed.”

Some patients stated that the experience had also awakened in them a new interest in the health and well-being of others, in particular of people their own age. For many, particularly

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

Linda: “My faith really helps me through meditation. That’s important, that’s the motor for us all—it’s our electricity.”

Nicole: “Well, the Virgin Mary gives me hope...I feel protected with my prayers. She’s like a mother. You know?”

For many, the motivation to stay alive and take better care of themselves was fueled by the love and responsibility they felt toward their children and grandchildren.

Michel: “After my heart attack, I spent a lot of time at my house because I was not allowed to go back driving my truck. I did a lot of thinking about getting closer to my daughter and granddaughter. During my time with my previous partner I had departed from them. I want to stay alive so I can enjoy more time with them... Especially my little girl. She is so small.... I want to see her growing up.”

For others, this return to “life’s essence” was expressed in personal rather than spiritual terms.

Nicole: “I think that everybody runs and runs like crazy. I try not to follow this. I work on myself now to take things in a more relaxed way. There are no more limits nowadays. Like for example, nobody ever forced me to smoke. I did that by myself. But things are different now. I don’t get upset anymore at others, I don’t get angry with others like I used to. I am less nervous. I got caught in this speed of life, that other were living by around me. I realize it now. The way people live nowadays is stress, nerves. I am trying to take things as they come, more relaxed you know, at my own rhythm.”

However, close to half of the participants mentioned that their MI gave them a clear sense of their own mortality and that they considered their spirituality as a source of support. Whether practiced in a private or community level, as seen in the previous extracts, the spiritual dimension of their lives provided them with the courage and motivation to adapt to their new health situation leading to a heightened awareness of their mortality. Most participants mentioned having an individual and personal relationship with God even if they were not churchgoers. Modes of expressing faith varied from having religious thoughts to praying actively or having an ongoing spiritual relationship with a deceased member of the family.

Élise: “My faith really helped me during this time. I prayed a lot and it made me feel better. I told him [God], I would say like... “Oh God, don’t abandon me like that!” I prayed, yes I prayed.”

Several patients added that praying to a deceased member of the family made them feel better and more protected. A few patients, whose religious practice had intensified, either through more frequent prayers or church attendance, mentioned changes in spiritual or religious activity. However, no one mentioned having discussions with a priest as a source of support. Others stated that, although their faith had grown since their MI, they still felt critical about their religion as an institution, i.e. the Roman Catholic Church. Despite this criticism of organized religion (which reflects a wider phenomenon in Quebec society as discussed later), when a relationship with God was mentioned, it was always in positive terms, mainly expressing gratitude to God for allowing them to stay alive or return to life. In other words, healing power or agency was attributed to God, not to religion, religious services or religious leaders.

Mathieu: “Even if I am disgusted with religion, I still consider myself to be a Catholic, I am still a Christian. I believe in some things but I don’t go for the Bible and all that stuff. I often talk to my father [who is dead] and it helps me. If I feel better today it is because of the support of my father. I asked my father to help me find myself. I found myself, maybe not 100%, but I made a big change.”

Overall, most participants noted an intensification of religious and spiritual feelings since their MI. Many patients also mentioned a change in their values. In general, the narratives of the majority reflected an upheaval in life brought about by the alarming experience of an MI. Their personal stories of a succession of difficult events that led to the crisis projected by the MI experience were often followed by a profound shift in identity and values. Their narratives situated their MI experience within a web of integrated meanings connecting the spiritual aspect of their lives with values that stepped away from an individualistic definition of self to adopt a more collectivistic position that many were still negotiating for themselves.

4. Discussion

We have presented the illness explanations of a group of people adapting to the health event of a myocardial infarction (MI). Our results show the ways in which illness explanations reflect a re-orientation of selfhood and identity that draws from local, spatially organized notions of identity. In this section we discuss the cultural context of the explanatory models and prototypes presented by our participants. We then outline how the experience of an MI transforms identity, values and sense of self in the context of a specific culture (French Canadian) and place (Quebec), paying particular attention to issues of spirituality and secularization. We discuss how spirituality can be central both to illness meaning and the reconstruction of identity after a life-threatening event, even if secularization is recognized as a core value of local cultural identity. Finally, we argue that to understand the specificity of this form of spiritual experience and how it relates to illness and well-being, it is necessary to consider the religious context, both past and present, of the place in which individuals’ illness experience is situated.

Most people in our sample shared an exploratory model according to which their MI was caused by the accumulation of stress, ordeals and familial traumas in their lives. In the light of this explanatory model, it makes sense that these participants felt the common need to re-evaluate their values and “slow-down” their lifestyle. While drawing on personal

biographical events, this explanatory model is also echoed in popular culture. Indeed, while the heart is described biomedically as a mechanical pump, it has long been considered a vital organ in relation to feelings and emotion in the Western tradition (Emslie et al., 2001), and our results suggest that biomedical concepts have not entirely displaced this broader symbolic meaning. This observation is similar to findings in other cultural contexts with German, Turkish, Iranian and Chinese patients (Good, 1977; Good et al., 1985; Kaminer et al., 1978; Kleinman, 1986; Tung, 1994; Weiner, 1985).

Folk and biomedical representations of the heart co-exist in our participants' narratives, but their "own" heart is mainly thought of as symbolic rather than biological, more specifically as "an organ of emotion" sensitive to the ongoing events and experiences in their lives. Patient narratives also made it clear that the symbolic meaning they linked to their MI, was not idiosyncratic but fit with a culturally recognized metaphor for distress in Quebec: *pris du coeur*. In this sense, because such representations are echoed in popular culture, talk about an MI may serve as an "idiom of distress," a culturally acceptable way for people to express emotional distress in an oblique way (Nichter, 1981).

That is to say, it is socially acceptable to speak about one's MI and perhaps evoke concern and attentiveness from others. As an idiom of distress, talking about their MI gave some patients the legitimacy and power to negotiate changes in their social roles and responsibilities that required the cooperation of close ones that went beyond the medically prescribed regimen (e.g.: diet changes, smoking cessation, decrease in responsibility at home or at work) to include new facets of identity. This newly integrated identity, sometimes expressed through the cultural idiom *pris de coeur* ("taken by heart," "heart-struck"), involved a form of culturally mediated acceptance by the social environment as the patient adapted to their new health status.

Narratives of heart disease describe stressful ordeals and events that put participants at a crossroads of their lives, suggesting that, for the majority, the experience of an MI corresponds for to a "rite of passage" in the anthropological sense. According to Van Gennep, a rite of passage is a socially ritualized procedure in which the individual is isolated from society (separation), subjected to a test or an ordeal which he or she survives (liminality), and is then re-integrated into society (integration) with a new identity (Van Gennep, 2004). Medical intervention and the experience of hospitalization as a kind of liminal space transforms what might otherwise be a chaotic event, into a highly ritualized process. Many of the patients referred to their MI as a trial they survived, while referring to their convalescence as a retreat from social life, a time during which they reflected on the idea of their mortality, their values and their life. Although none used the phrase "rite of passage" *per se*, the MI was described as a turning point in their lives, involving a period "outside" their usual life spaces (in hospital) and accompanied by a change in identity and values (during convalescence) before reentering the wider social arena. For many, recovery was regarded as a symbol of redemption, described in explicitly religious terms.

Although the importance of spirituality and religion in adaptation to life-threatening illness is widely recognized, the importance given to religion in the participants' narratives was somewhat surprising given that Quebec has undergone radical secularization during the last

fifty years. To fully understand the significance of these findings, it is necessary to briefly trace the history of Quebec. Quebec is a province of Canada and principal home of one of the two major linguistic cultural communities of the country. French Canadians represent the vast majority of the population of the province. Quebec was settled by French colonists in the early seventeenth century and from its inception was strongly influenced by the Roman Catholic Church. France lost this colony to Britain in 1762. After the British conquest, Quebec evolved largely independently of French influence. At the same time, because of its linguistic difference with the rest of Canada and Great Britain, Quebec also remained relatively isolated from Anglophone influence. As such the culture of Quebec has developed a distinct character, with significant differences from that of France and of English speaking Canadians (Bouchard and Lamonde, 1995; Dickenson and Young, 2003). For example, Quebec was unaffected by the secularizing tendencies of the French Revolution, and the influence of the Church continued unabated in the territory. Indeed as Quebec developed as a Province in Canada in the nineteenth and twentieth century, the Roman Catholic Church was a binding institution that provided officially-sanctioned educational and health services to French Canadians. Church going rates remained high throughout the nineteenth and early twentieth century.

In Quebec, ethnic identity, language and religious denomination have traditionally been closely linked if not coterminous. Quebec as a place was unique to the rest of North America in two key aspects: first, it was the only French-speaking territory; secondly, it was the only territory where the Roman Catholic religion was so pervasively practiced and socially and culturally influential. The conflation of culture, religion and geographic place thus became especially important for French Canadian identity. Quebec was perceived as the only place where French Canadians could speak their tongue and practice in full their revered religion. As such, for generations, place, religion and language have intertwined in the formulation, expression and transmission of French Canadian identity. However, this tight linkage became decoupled during the twentieth century, with religion (apparently) shrinking rapidly in its importance for collective identity and individuals' sense of self.

Many French Canadians abandoned formal Roman Catholic religious practice during the 1960s and 1970s. In line with trends elsewhere in the Western world, church attendance dropped significantly during this period in Quebec (Bruce, 2002; Taylor, 2007). During the 1960s institutions and macro-level social structures also became much more secular in orientation. The Roman Catholic Church lost much of its influence in hospitals, schools, politics, government and charity organizations. Families and individuals became less concerned with the teachings of the Church on reproduction and family life. Along with accessibility to the contraceptive pill this was associated with a massive reduction in fertility rates in Quebec and the tendency of unmarried couples to co-habit and remain unmarried (Statistics Canada, 2007). This era is commonly referred to as *La Revolution Tranquille* ("The Quiet Revolution") in Quebec, and is a source of pride among many French Canadians, reflected in local cultural narratives of identity (Berger, 1999). Most Quebecois now see themselves as part of a highly secular society and view this as one of the key elements of their collective identity (Taylor, 2007). This reflects a shift to a diametrically opposite position compared to previous sources of identity: in times past, French Canadians were proud of Quebec the place, the French language spoken therein, and the Roman

Catholic Church that bound the inhabitants together as a people. Today, great pride remains in the place and the language, but the church (and religion) has been replaced by pride in active *rejection* of the traditional hegemony of the church (and religion).

Reflecting this cultural narrative, most participants were very reluctant to give their religious denomination when recruited on the phone and asked about basic information. However, when asked at the end of the interview if their MI had changed the way they see their lives, the majority made explicit reference to religious ideas associated with Roman Catholicism (e.g. praying to a relative or the Virgin Mary) and produced a spiritual narrative about personal transformation that was clearly culturally located. These references to spirituality were initiated by the patients themselves, and were central to the meaning they attributed to their MI and their new life. Faith thus was clearly central to the ways they were re-configuring their lives. While identified as a source of support, this spirituality remained a private matter because of the positive value participants attributed to the secularization of society.

As part of this spiritual turn, many participants expressed criticism of North American values such as individualism and materialism—values that historically were corollaries of Protestantism and its emphasis on the individual (Durkheim, 1952; Weber, 1958a), but that have become part of broader currents in North American society (Bellah et al., 1985; Kasser and Ryan, 1996). While a Roman Catholic inflected spirituality was voluntarily reaffirmed as an individual matter, most mentioned, since their MI, wanting to depart from individualist values and priorities in their lives, by focusing more on others and on human relationships. The change in identity mentioned by post-MI patients thus evokes and reaffirms “pre-revolution tranquille” values of family, humanism and spiritual worldviews. These constitute a move away from the individualism associated with modernity that permeates Quebec society. As such, their critique of individualism emphasizes the positive value of connectedness to others including immaterial beings such as God, angels and deceased relatives to whom they prayed for support and protection. This intrinsic aspect of spirituality, as a connection to others whether alive, dead or representing a deity or a higher spiritual beings (Virgin Mary, angels) can be linked to a Roman Catholic worldview that influences the locally grounded manifestations of spirituality seen in this study.

This local definition of spirituality as interconnectedness between the person and a higher power such as God and/or other persons our participants referred to were not only alive but also included dead close ones, mainly family members. Our study also supports the argument that spirituality overlaps with religiosity (Westgate, 1996). To understand the specificity of this spiritual experience and how it relates to illness and well-being, we need to consider the religious contexts, both past and present, of the place under study.

Some scholars have suggested that the secularization thesis, both in Quebec and elsewhere in the world, has been severely overstated (Berger, 1999; Sacks, 2005). It is argued that overt displays of religious activity may have decreased and religion may have withdrawn from the institutional sphere. However long-held religious beliefs and traditions may persist under the surface, reappearing at nodal points in the life trajectory of an individual or a society (Sacks, 2005). Maintaining a secular society constitutes a cultural ideology that is part of the self-

reflective understanding of Quebecois identity, even if many engage in a spiritual/religious worldviews at the individual and private level. These types of sensibilities may endure in apparently secular populations that were once characterized by intense religiosity, and whose identity was strongly linked to their religious affiliation. It should be restated that in this regard, Quebec is the only province in Canada that was resolutely Roman Catholic for most of its history. Surrounded by a sea of Anglophone Protestants, many French Canadians perceived their Catholicism alongside with language as defining factors of their identity and difference from the rest of North America. Given this framing of identity, it is less surprising to discover that this Catholic identity is revived among individuals facing a life threatening experience like an MI.

Some studies have suggested that patients may experience spiritual benefits after an MI such as changes in philosophy of life, values and religious views (Affleck et al., 1987). However, to our knowledge no previous studies have explored the relationship between spirituality and connection to others during recovery after an MI. Our results suggest the possibility that having a spiritual life and a renewed connection to others, including spiritual others, such as deceased family members, may act as a source of support for recovery, adaptation and well-being in post-MI. But the form and content of such increased spirituality may vary according to place and local spiritual and religious dynamics. These aspects deserve greater attention from researchers interested in adaptation and well-being after MI.

Furthermore, by turning our attention to the narratives of patients experiencing an MI and following their subsequent adaptation, we can better understand how post-MI patients interpret their reality through the use of collectively shared spiritual meanings that allow them to renegotiate their identity. Ricoeur (1991, 1996) argues that individuals constantly reconstruct their selves through a process of narration expressed in a “narrative identity” (*identité narrative*). For Ricoeur, narrative identity is constantly renewed by a dialectic tension exposed in narratives as a contrast between the part of self that is viewed as permanent and not changing (*idem*) and the part that changes (*ipse*) as a result of biographical experiences as well as by drawing from narratives provided by tradition and literature. The philosopher Taylor (1992) also emphasizes the cultural and historical horizon from which the self draws its sources. The analysis of post-MI narratives reveals that for French Canadians a core aspect of their recent cultural identity is being part of a secular society, defined by “public spaces that have been allegedly emptied of God, or of any reference to ultimate reality” (Taylor, 2007: p. 2). This recent aspect of their identity remains part of the constant “idem” even after experiencing a life-threatening disease that however uncovers the emergence of a more transformative “ipse” dimension of their identity with a renewed strong spiritual component.

Every place-based cultural group has its own history, core values and ways of life that play an essential role in the constant construction and reconstruction of self. This underscores the need to address the spiritual dimension of illness experience in the contexts of place and culture even so, in secular societies, to better understanding post-MI wellness and correspondingly, development of appropriate models of health care. As is common practice in qualitative studies, we offer an in-depth understanding of the meaning and experience of participants. However, our sample is purposive and non-randomized and therefore warrants

caution in generalizing. We know from numerous previous studies that spiritual practices and worldview contribute to wellness and adaptation to life-threatening illness. However, the narratives of participants in this study spoke less to acute crises than a rethinking of priorities and transformed identities. There is a need to replicate our findings about identity change, well-being and connection to others with a larger longitudinal sample to see if the phenomenon is sustained over time, as anxiety about having a life-threatening disease subsides. We also need to examine if this identity change and spiritual worldview exist in post-MI patients, living in Canada and other secular societies, but of different religious background.

5. Conclusion

Biomedical care after an MI is focused on controlling risk factors to reduce the risk of recurrence. However, as our study shows, patients' experiences of an MI are associated with a complex set of meanings and forms of reasoning that include social, moral and spiritual implications and transformations of values and identity. These transformations of values and identity are locally inflected and their consequences depend on the social context in which patients adapt to their new health status. To elicit and respond to the specific meanings that govern patients' adaptation to illness, health professionals must engage in extended dialogue with patients to explore ideas of the causes of heart disease, its impact on identity, the consequences of facing one's mortality, and connectedness to family and spirituality. The meanings that patients give to their disease emerge from a matrix of local knowledge that is experienced-based and echoed in popular culture, history, metaphors, and idioms of distress. Health care professionals involved in cardiac rehabilitation should not take for granted that all patients reason the same way professionals do, such as when using information relating to risk factors. Exploring patients' layers of meaning, including the spiritual dimension relative to their illness experience, can give important clues to improving adaptation to illness, well-being and identify personal and social concerns that deserve attention. Constructs of spirituality and identity are deeply embedded in place and culture and are important to consider in relation to patient's well-being after a myocardial infarction.

Acknowledgments

The authors wish to thank Colleen Rheault for interviewing many of the patients, the Fond de Recherche en Santé du Québec (FRSQ), Fond Québécois de Recherche sur la Société et la Culture (FQRSC) and the Fondation Québécoise Des Maladies du Coeur (FQMC) for their support, and Jeff Freedman for his revision of a first version of this paper.

The first author wishes to dedicate this paper to our friends and colleagues: feu Claude Beaudoin who encouraged us to do this study and feu Marcel Simard who made the film "Coeur à Bout" (Heart Burst) based on this study.

References

- Adams-Weber JR. Differentiation and sociality in terms of elicited and provided constructs. *Psychological Science*. 1998; 9:499–501.
- Affleck G, Tennen H, Croog S, Levine S. Causal attribution, perceived benefits, and morbidity after a heart attack: an 8-year study. *Journal of Consulting and Clinical Psychology*. 1987; 55(1):29–35. [PubMed: 3571655]

- Al-Hassan M, Sagr L. Stress and stressors of myocardial infarction patients in the early period after discharge. *Journal of Advanced Nursing*. 2002; 40(2):181–188. [PubMed: 12366648]
- Barakat LP, Alderfer MA, Kazak AE. Posttraumatic growth in adolescent survivors of cancer and their mothers and fathers. *Journal of Pediatric Psychology*. 2006; 31(4):413–419. [PubMed: 16093518]
- Bekelman DB, Dy SM, Becker DM, Wittstein IS, Hendricks DE, Yamashita TE, et al. Spiritual well-being and depression in patients with heart failure. *Journal of General Internal Medicine*. 2007; 22(4):470–477. [PubMed: 17372795]
- Bellah, RN., et al. *Individualism and Commitment in American Life*. University of California Press; London, England: 1985. *Habits of the Heart*.
- Berger, OPL., editor. *Resurgent Religion and World Politics*. Wm.B. Eerdmans Pub. Co; Grand Rapids, MI: 1999. *The Desecularization of the World*.
- Berger, PL. *Ethics and Public Policy Center*. Ww B. Eerdmans Pub. Co; Grand Rapids, MI: 1999. *The Desecularization of the World*.
- Blumenthal JA, Babyak MA, Ironson G, Thoresen C, Powell L, Czajkowski S, et al. Spirituality, religion and clinical outcomes in patients recovery from an acute myocardial infarction. *Psychosomatic Medicine*. 2007; 69:501–508. [PubMed: 17636153]
- Bouchard, G., Lamonde, Y. *Québécois et Américains, la culture Québécoise aux XIX ième et XXièmes siècles*; Montréal, Éditions Fides. 1995.
- Brown KW, Ryan RM. The benefits of being present: mindfulness and its role in psychological well-being. *Journal of Personality and Social Psychology*. 2003; 84:822–824. [PubMed: 12703651]
- Bruce, S. *Secularization in the West*. Blackwell Publishing Ltd; Oxford: 2002. *Good is Dead*.
- Cameron C. Patient compliance: recognition of factors involved and suggestions for promoting compliance with therapeutic regimens. *Journal of Advanced Nursing*. 1996; 24(2):244–250. [PubMed: 8858426]
- Cherrington CC, Moser DK, Lennie TA, Kennedy CW. Illness representation after acute myocardial infarction: impact on in-hospital recovery. *American Journal of Critical Care*. 2004; 13:136–145. [PubMed: 15043241]
- Clark PA, Drain M, Malone MP. Addressing patients' emotional and spiritual needs. *Joint Commission Journal on Quality and Safety*. 2003; 29(12):659–670. [PubMed: 14679869]
- Dickenson, J., Young, B. *A Short History of Québec*. McGill-Queen's University Press; Montréal: 2003.
- Doster JA, Harvey MB, Riley CE, Goven AJ, Moorefield R. Spirituality and cardiovascular risk. *Journal of Religion and Health*. 2002; 41(1):69–79.
- Durkheim, E. *Suicide—A Study in Sociology*. Routledge & Kegan; London: 1952.
- Emslie C, Hunt K, Watt G. Invisible women? The importance of gender in lay beliefs about heart problems. *Sociology of Health and Illness*. 2001; 23(2):203–233.
- George LK, Larson DB, Koenig HG, McCullough ME. Spirituality and health: what we know, what we need to know. *Journal of Social and Clinical Psychology*. 2000; 19:102–116.
- Ginzburg K. Life events and adjustment following myocardial infarction: a longitudinal study. *Social Psychiatry and Psychiatric Epidemiology*. 2006; 41(1):825–831. [PubMed: 16896517]
- Good BJ. The heart of what's the matter: the semantics of illness in Iran. *Culture, Medicine and Psychiatry*. 1977; 1(1):25–58.
- Good, BJ., Good, MD., Moradi, R. The interpretation of Iranian depressive illness and dysphoric affect. In: Kleinman, A., Good, BJ., editors. *Culture and Depression*. University of California Press; Berkeley: 1985. p. 369-428.
- Graham S, Furr S, Flowers C, Burke MT. Religion and spirituality in coping with stress. *Counseling and Values*. 2001; 46(1):2–13.
- Groleau D, Cabral IE, Zelkowitz P. Enhancing generalizability: moving from an intimate to a political voice. *Qualitative Health Research*. 2009; 9(3):416–426.
- Groleau D, Kirmayer LJ, Young A. The McGill Illness Narrative Interview (MINI): An interview schedule to explore different meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry*. 2006a; 43(4):697–717.

- Groleau, D., Rodriguez, C. Breastfeeding and poverty: Negotiating cultural change and symbolic capital of motherhood in Québec, Canada. In: Dykes, F., Hall Moran, V., editors. *Infant and Young Child Feeding: Challenges to Implementing a Global Strategy*. Wiley-Blackwell; Oxford: 2009. p. 240p. 80-98.
- Groleau D, Soulière M, Kirmayer LJ. Breastfeeding and the cultural configuration of social space among Vietnamese immigrant woman. *Health & Place*. 2006b; 12(4):516–526. [PubMed: 16157504]
- Hassani P, Afrasiabifard A, Khoshknab MF, Yaqhmaei F. Perceived positive effects of illness following acute myocardial infarction. *International Journal of Nursing and Midwifery*. 2009; 1(1):001–005.
- Havranek EP. A health perception score predicts cardiac events in patients with heart failure: results from the IMPRESS trial. *Journal of Cardiac Failure*. 2001; 7:153–157. [PubMed: 11420767]
- ICIS. Institut Canadien d'Information sur la Santé, Statistique Canada. 2002. *Les soins de santé au Canada*. Rapport
- Kaminer I, Munitz H, Tyano S, Wijsenbeek H. The heart image as a model to internal-organ body image. *Psychotherapy and Psychosomatics*. 1978; 30(3–4):187–192. [PubMed: 740846]
- Kasser T, Ryan RM. Further examining the American dream: differential correlates of intrinsic and extrinsic goals. *Pers Soc Psychol Bull*. 1996; 22:280–287.
- Kleinman, A. *Social Origins of Distress and Disease*. Yale University Press; New Haven: 1986.
- Linley PA, Joseph S. Positive change following trauma and adversity: a review. *Journal of Traumatic Stress*. 2004; 17(1):11–21. [PubMed: 15027788]
- Mackay, J., Mensah, GA. *The Atlas of Heart Disease and Stroke*. WHO Editors; Geneva: 2004.
- McBride JL, Arthur G, Brooks R, Pilkington L. The relationship between a patient's spirituality and health experiences. *Family Medicine*. 1998; 30:122–126. [PubMed: 9494803]
- McCullough, ME., Paragament, KI., Thoresen, CE. The psychology of forgiveness. In: McCullough, ME., Paragament, KI., Thoresen, CE., editors. *Forgiveness: Theory, Research and Practice*. Guilford; New York: 2000. p. 1-16.
- Nichter M. Idioms of distress: alternatives in the expression of psychological distress: a case study from South India. *Culture, Medicine and Psychiatry*. 1981; 5(4):379–408.
- Ricoeur, P. *Temps et récit III: Le temps raconté*. Éditions du Seuil. 1991.
- Ricoeur, P. *Soi-même comme autre*. Éditions du Seuil. 1996.
- Sacks, J. *Religion, Mortality & Society in a Secular Age*. Continuum; London, New York: 2005. *The Persistence of Faith*.
- Schroeder K, Fahey T, Ebrahim S. How can we improve adherence to blood pressure-lowering medication in ambulatory care? systematic review of randomized controlled trials. *Archives of Internal Medicine*. 2004; 164:722–732. [PubMed: 15078641]
- Shemesh E, Koren-Michowitz M, Yehuda R, Milo-Cotter O, Murdock E, Vered Z, et al. Symptoms of post-traumatic stress disorder in patients who have had a myocardial infarction. *Psychosomatics*. 2006; 47:231–239. [PubMed: 16684940]
- Statistics Canada. *Vital Statistics—Birth database: Detailed information for 2005*. 2007. Retrieved from
- Stern L, Kirmayer LJ. Knowledge structure in illness narratives: development and reliability of a coding scheme. *Transcultural Psychiatry*. 2004; 41(1):130–142. [PubMed: 15171211]
- Tang TS, White CB, Gruppen LD. Does spirituality matter in Patient Care? Establishing relevance and generating skills. *Academic Medicine*. 2002; 77(5):470–471. [PubMed: 12010732]
- Taylor, C. *Source of the Self: The Making of Modern Identity*. Cambridge University Press; Cambridge: 1992.
- Taylor, C. *A Secular Age*. Harvard University Press; Boston: 2007.
- Tedeschi RG, Calhoun LG. Posttraumatic growth: conceptual foundations and empirical evidence. *Psychological Inquiry*. 2004; 15(1):1–18.
- Terre L. Behavioral medicine review: the lifestyle factor. *American Journal of Lifestyle Medicine*. 2007; 1(3):181–184.
- Tung MPM. Symbolic meanings of the body in Chinese culture and “somatization”. *Culture, Medicine and Psychiatry*. 1994; 18(4):483–492.

- Van Gennep, A. Routledge Library Editions, Anthropology and Ethnography (first published in 1960). London, UK: 2004. *The Rites of Passage*.
- Walton J. Spirituality of patients recovering from acute myocardial infarction: a grounded theory study. *Journal of Holistic Nursing*. 1999; 17(1):34–53. [PubMed: 10373841]
- Walton J. Discovering meaning and purpose during recovery from acute myocardial infarction. *Dimensions of Critical Care Nursing*. 2002; 21(1):36–43. [PubMed: 11887280]
- Weber, M. *The Protestant Ethic and the Spirit of Capitalism*. Parsons, TbT, translator. Scribner; New York: 1958a.
- Weber, M. *The Protestant Ethics and the Spirit of Capitalism*. Charles Scriber and Sons; New York: 1958b.
- Weiner B. “Spontaneous” causal thinking. *Psychological Bulletin*. 1985; 97(1):74–84. [PubMed: 3983298]
- Westgate CE. Spiritual wellness and depression. *Journal of Counseling and Development*. 1996; 75:26–35.
- Whitley R, Kirmayer LJ. Perceived stigmatisation of young mothers: an exploratory study of psychological and social experience. *Social Science and Medicine*. 2008; 66:339–348. [PubMed: 17983698]
- Wong PTP, Weiner B. When people ask ‘why’ questions, and the heuristics of attributional search. *Journal of Personality and Social Psychology*. 1981; 40(4):650–663.
- Woods TE, Ironson GH. Religion and spirituality in the face of illness. *Journal of Health Psychology*. 1999; 4:393–412. [PubMed: 22021606]
- Young A. When rational men fall sick: an inquiry into some assumptions made by medical anthropologists. *Culture, Medicine and Psychiatry*. 1981; 5(4):317–335.
- Yusuf S, Hawken S, Ounpuu S, Dans T, Avezum A, Lanas F, et al. Effect of potentially modifiable risk factors associated with myocardial infarction in 52 countries (the INTERHEART study): case-control study. *The Lancet*. 2004; 364(9438):937–952.

Table 1

Participants' perceived causes of their MI ($N=51$).

Patients' explanatory models	Patients' prior risk factors ^a			
	Hypercholesterolemia $n=38$	Hypertension $n=29$	Diabetes $n=12$	Smoking $n=20$
Stress	20/38	9/29	0	15/20
Heredity	11/38	6/29	4/12	6/20
Smoking	8/38	0	0	8/20
Diet	8/38	6/29	4/12	4/20
High cholesterol	13/38	0	0	3/20
Hypertension	0	0	0	0
Diabetes	0	0	0	0

^aPatients with multiple risk factors are included in multiple columns.