
A Group-Based Program of Emotional Recovery for Younger Women Following Myocardial Infarction

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ABSTRACT

Heart disease is the leading cause of illness, disability, and death among women in Canada. Myocardial infarction (MI) accounts for almost half of these deaths yearly. The purpose of this study was to understand younger women's experience of recovery from MI. A purposive sample consisting of six younger women diagnosed with MI participated in an eight-week guided autobiographical (GA) group intervention where they engaged in weekly reflection, writing, and group dialogue. The experience of loss, uncertainty, changes in self-perception, self-care, health care and support from others, and caring for others emerged from the data analysis. GA was shown to be an effective psychosocial intervention to facilitate emotional recovery following a significant cardiac event as all participants described the GA group as a therapeutic component of their recovery process.

RÉSUMÉ

Les maladies cardiovasculaires sont la principale cause de maladie, de déficience, et de décès chez les femmes au Canada. L'infarctus du myocarde (IM) compte pour près de la moitié de ces décès chaque année. La présente étude avait pour but de comprendre le vécu du rétablissement d'un IM chez des femmes plus jeunes. Un échantillon intentionnel de six femmes relativement jeunes diagnostiquées d'un IM a participé à un groupe d'intervention autobiographique dirigée de huit semaines, participant chaque semaine à la réflexion, la rédaction de journal, et le dialogue en groupe. Des expériences de perte, d'incertitude, de changement de la perception de soi, des auto-soins, des soins de santé, et du soutien des autres ainsi que des soins aux autres ont émergé de l'analyse des données. L'intervention autobiographique dirigée s'est révélée une intervention psychosociale efficace pour faciliter le rétablissement émotionnel suite à un événement cardiaque important puisque toutes les participantes ont décrit le groupe d'intervention autobiographique dirigée comme une composante thérapeutique de leur processus de rétablissement.

Coronary heart disease (CHD) has been 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 despite the fact that mortality rates from MI in women are double that of women dying from breast cancer (Statistics Canada).

Historically, cardiac illness has been viewed as an affliction specific to middle-aged men. While men tend to demonstrate cardiac symptoms on average 10 years earlier than women (Wenger, 1999), women with MI fare less well than their male counterparts, being more likely to die during their hospital stay and during the

first year following an initial MI (Wenger, 2003). Despite the prevalence rates in women, a larger portion of the research on heart disease and MI has been based primarily on studies conducted on men (Agency for Healthcare Research and Quality, 2003; Benson, Arthur, & Rideout, 1997).

The demands for equity in access to biomedical research and appropriate treatment and care for women have existed in the realm of cardiac health as claims challenging women's exclusion and underrepresentation 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 1950s, Thomas and Braus (1998) suggested that early cardiac studies typically excluded women entirely, and if they included women in their study populations, they omitted them from data reports, or added women to their study populations after the studies had been conducted.

While a paucity of cardiac research has been solely devoted to examining women, even fewer psychosocial studies have been conducted in the area of MI recovery (Beckie, 2005; Fleury & Cameron-Go, 1997; Wang, Mittleman, & Orth-Gomer, 2005). Moreover, little distinction has been made between groups of younger and older women recovering from MI (LaCharity, 1997, 1999). Consequently, little is known about younger women's recovery experiences.

In more recent studies, social support has been implicated as a significant factor in women's recovery following MI (Benson et al., 1997; Chesney & Darbes, 1998; Perry & Rosenfeld, 2005). In their study on women with heart disease, Wang et al. (2005) contend that social isolation and lack of emotional support are significant risk factors in disease progression. Despite these findings, there is little evidence that therapeutic resources exist for women outside of conventional rehabilitation programs that focus on physical recuperation.

In general, women have rarely been asked the questions necessary to more fully illuminate their specific needs for psychological treatment and care. Moreover, the research on women's experiences of cardiac illness conducted through survey questionnaires has not been effectively translated into the development of psychosocial interventions to facilitate emotional recovery. Given the magnitude of this health concern, it is critical that research be conducted that highlights women's subjective experiences and knowledge of recovery from MI and that psychosocial recovery interventions and effective counselling programs emerge from this work.

Purpose of the Study

In this research, the following question was addressed: How do women under the age of 55 construct their experience of recovery following myocardial infarction? A Guided Autobiography approach (Birren & Deutchman, 1991) provided a group context in which women engaged in a process of reflection by writing and sharing their life histories and recovery experiences with other female cardiac patients. The researchers sought to understand younger women's recovery experiences from MI and provide recommendations for the future development of psychosocial programs that foster women's recovery. The women's lived experience

of the group process, in fact, served to compose an important component of their recovery experience.

METHOD

Guided Autobiography (GA) 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 group-based life review approaches, Birren developed GA in his work with older adults to promote successful adaptation to aging (Birren & Hedlund, 1987). More recently, Birren and Deutchman (1991) have recommended using GA with other groups facing significant life transitions, disability, health concerns, and those seeking greater self understanding and acceptance. We chose this method over other group process methods, such as psychodrama or expressive methods, because the guided autobiographical method provides time for the group member to review in private what they would like to share and allows group members to monitor the content of their story as well as the length. Additionally, the GA method offers group members time to reflect on their own awareness before the sharing process as opposed to spontaneous emotional processing groups and, therefore, the GA method provides more safety for vulnerable group members, such as women recovering from heart attacks.

The process of GA has two stages: (a) personal writing, and (b) sharing. Groups typically include five or six participants and a group facilitator, with meetings scheduled for a minimum of two hours over 6–10 week periods (Birren & Deutchman, 1991). Each participant is required to write a two-page autobiographical narrative in "solitude" on a pre-selected life theme and share the story within the context of the small confidential group setting. After each oral reading, participants are encouraged to share personal reactions, impressions, thoughts, or feelings evoked by listening to other members' stories. Birren and Deutchman suggest that the "developmental exchange" or mutual sharing of personally important and meaningful experiences is a powerful feature of the GA process.

For the purposes of this study, Birren and Deutchman's (1991) GA theme format was adapted for a more suitable exploration of women's experience of recovery following MI. Accordingly, the guiding themes and sensitizing questions relevant to this group were developed and based on a review of the cardiac literature, our experiences as health professionals and facilitators of GA, and a collaborative discussion with participants. The six revised GA themes were explored within the context of recovery from MI: (a) health and experience of MI, (b) major life work and the impact of MI, (c) significant relationships, d) self-care and managing stress, (e) concerns about death and dying, and (f) a personal story of the meaning of illness and recovery. In the final theme, the participants addressed their understandings of their personal resources and challenges to achieving their recovery goals.

Participants

A sample of six women was recruited for the research group, corresponding to the recommended size for GA groups (Birren & Deutchman, 1991). Volunteer women were eligible if they met all of the following inclusion criteria: (a) were diagnosed with MI within the past 36 months, (b) were between the ages of 30 and 55 years, (c) were medically well enough to attend the group, (d) possessed unimpaired cognitive functioning with an ability to understand the nature of the study, (e) were fluent speakers and writers of English, (f) demonstrated a willingness and ability to commit to the activities required for participation in the GA group, and (g) provided informed consent for study participation.

Five women were recruited from cardiac rehabilitation programs at local hospitals and one woman volunteered as a result of a local radio interview. While the age of participants in this study was relatively homogeneous, their individual health circumstances and life situations were considerably different. Five European North American women and one Middle Eastern woman, between 48 and 53 years of age, reported having a single MI that occurred within 12 months of participation in the study (with the exception of one participant whose MI occurred 3 years prior to the study).

One participant was married, three were divorced, and two were single. Their current occupations were teacher, entrepreneur, administrative assistant, and student, while one was unemployed. Some reported additional health concerns, but all 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.

Procedures for Data Collection

Each participant was interviewed on the telephone and in person prior to the beginning of the GA group to clarify requirements for participation, screen women for study eligibility, and obtain informed consent. The three-month research group consisted of an introductory session, six two-hour group GA sessions, and a follow-up session. The group was facilitated by a professional counsellor with expertise in conducting GA groups and co-facilitated by the primary researcher, also a professional counsellor. Participants submitted a copy of their autobiographical narratives to the researcher after each group meeting. All research sessions were videotaped. The information sources included telephone and initial interviews with participants, videotaped accounts of the research sessions, participants' narratives, and the researcher's field notes.

Data Analysis

Data analysis occurred concurrently with data collection and involved the following process. A comprehensive understanding of the participant's history and previous experiences was obtained by reviewing the data obtained from the participant screening interviews. The next step was to conduct a content analysis

of the participants' written autobiographies. We next completed a thematic analysis of the videotaped group sessions. Once the main themes were constructed from the participants' written biographies and the group sharing sessions, we conducted a participant review of the research themes. In addition we incorporated into our interpretation an in-depth analysis of the researcher's field notes and journal entries as part of the member checking procedures to highlight our interpretations of the data.

Upon completion of the GA group, research participants collectively submitted 32 autobiographies related to six life themes explored within the context of recovery from MI. Following the guidelines for content analysis as outlined by Berg (1995), a separate analysis was conducted on each narrative. Highlighted sections were classified as affect, patterns of behaviour, experience and meaning, and significant statements reflecting women's constructions of their recovery. Between five and seven categories of analysis emerged in each GA theme and provided the basis for the researchers' interpretations.

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 the six most common themes. To ensure that the categories and the identified recovery themes represented the participants' experiences, they were continually evaluated in light of the original autobiographical accounts and other data sources, using a constant comparative format.

RESULTS

Six general themes emerged from women's written autobiographies and the group dialogues. The themes were (a) the experience of loss, (b) living with uncertainty, (c) changes in self-perception, (d) personal needs and self-care, (e) care and support, and (f) taking care of others. Although each theme had distinguishable features, they frequently overlapped and reflected the complexity of participants' histories and their constructions of recovery.

Theme One: The Experience of Loss

The experience of loss was the dominant theme among the narratives and group discussions and was evident in women's illness experiences and their personal histories. Participants told many stories of loss, as they each came to understand how the experience of MI unfolded in their lives while they faced challenges specific to their recovery.

For some women, loss was more dramatic and distressful than for others. All participants described MI as a physical loss resulting in varying degrees of fatigue, weakness, and chest pain since hospitalization. These symptoms hampered their capacity to be physically engaged in their lives as they had before the MI.

Participants also talked about the emotional losses experienced after MI including a loss of confidence, a strong sense of vulnerability, and a loss of hope. All participants reported suffering negative changes in mood and other symptoms

consistent with depression during their recovery. The severity and duration of these symptoms varied among individuals.

Three women spoke to the loss of an imagined life as their hopes for finding a partner felt compromised since their MI: “no one wants a woman who is sick.” Two others felt they had potentially lost employment opportunities: “Will an employer hire me knowing I’m sick?” Other participants described feeling guilty about either asking for help or not fulfilling their responsibilities at home or work. This loss was attached to a sense of being independent and capable as a mother, a worker, and/or a housekeeper.

Participants’ descriptions also referred to the losses evident in unresolved family conflict, terminated love relationships, divorce, the death of significant others (including family pets), family illness, and immigration. Three participants alluded to the grief surrounding unexpected deaths including a younger sister’s suicide, the suffocation of an infant son, and the murder of a fiancé. In these narratives there was more to women’s stories than the death of a significant other. They spoke about the losses in future family identity and lost opportunities and experiences. The impact of MI was embedded within women’s larger life stories of loss. The women differed in the degree to which these losses contributed to their current suffering and affected their ability to carry out their lives. The provision of current treatment resources including cardiac rehabilitation may not be enough to facilitate a woman’s successful recovery from MI without more fully understanding her life history beyond the illness experience and the meaning of the impact of loss in her life.

Theme Two: Living with Uncertainty

All of the participants stressed the dramatic unpredictability associated with MI despite their efforts to make lifestyle changes and follow recovery regimes. Participants stated they felt “fearful” and “worried” at the prospect of experiencing further cardiac symptoms and/or another heart attack. In spite of having normal angiograms, two participants felt they were not given “satisfactory information” to explain the cause of their MI—“the most stressful part of the whole experience has been not knowing what caused it and whether it will happen again.” Participants felt uncertainty about the future in terms of their quality of life and mortality: “I hope that my health doesn’t fail too much ... I want to be able to contribute in a meaningful way.”

Participants also described uncertainty in other areas of their lives including their relationships. One woman felt “powerlessness” because she could not help her drug addicted sister. Another participant anticipated the loss of her aging mother and her chronically ill husband: “We live with that time bomb because another stroke will probably kill him...it’s just a question of when.”

As with other aspects of the recovery process, each participant described having a distinctly unique relationship living with the uncertainty of cardiac illness. As acute (e.g., MI) and chronic (e.g., heart disease) illness may reinforce the awareness of the impermanence of life, one of the major tasks of MI recovery appears

to involve finding ways of enduring this uncertainty and trusting that one can adjust over time to future unknowns.

Theme Three: Changes to Self-Perception

Participants who conceptualized their recovery from the vantage point of an existing and functional life role perceived the MI as being less disruptive because they lived their lives as usual. Nonetheless, each participant spoke of some changes in their self-perception as a result of the illness experience. To illustrate, one participant, a business administrator, returned to her daily routines soon after the MI and was adamant about not letting herself "be defined" by the experience. Her "contract" for recovery paralleled the principles and values that governed her life including "commitment" and "doing your best." She managed her recovery as she did other life challenges.

Another woman described the tension between feeling "vulnerable" and "weak" and battling to stay in control by using her assertiveness skills to gain entry to a rehabilitation program not offered by her physician, develop a cardiac support group and begin a disciplined regime of self-care. As well as an altered sense of self, she felt very angry that her work colleagues now saw her as being unhealthy.

As women reflected on the life-threatening nature of MI, they made efforts to integrate their new self-awareness with whom they knew themselves to be prior to their illness. These identity and/or role changes reflected either a shift from a former sense of self or a recognized effort to maintain a previous sense of self.

Theme Four: Self-Care

Participants spoke about their efforts to take better care of themselves by enhancing their physical, emotional, and/or psychological health and well-being. For some, this meant implementing more lifestyle changes than for others.

All participants made efforts to improve their physical health. Collectively, they incorporated exercise, changes in eating habits, weight loss, smoking cessation, and greater rest and relaxation into their daily lives. All but one woman had enrolled in a cardiac rehabilitation program and found the structure and the information useful in supporting their physical goals.

Participants also described the challenges of physically pacing themselves, particularly in the absence of cardiac symptoms. In making this adjustment, they had to come to terms with a loss of physical stamina despite their perception of being as capable as they were before the MI. As well, women emphasized the importance of trusting their bodily wisdom and attending to future symptoms in a proactive and timely manner.

All women reported starting or needing to start attending to their emotional and psychological well-being, including managing relational stress. They identified the following strategies to support this change: (a) communicating thoughts, feelings, and needs directly to others; (b) setting boundaries particularly related to "doing too much"; (c) taking less responsibility for others; and (d) asking others for help. Some felt that making healthier relationship choices was an important

component of self-care after the MI. One woman stated, "I'm not willing to live in a relationship that is difficult no matter how much I love that person." For others, calling upon their spirituality or religious faith served to enhance their emotional and spiritual well-being, thus helping them make meaning of surviving their MI. While most of these women were motivated by their illness to turn their attention inward and take better care of themselves, their descriptions clearly reflected a process of healing or recovery that involved the unity of their physical, emotional, and relational selves.

Theme Five: Health Care and Support from Others

Participants offered mixed feedback on the quality of care received from health professionals. While some felt their experiences were positive, others did not. Although all participants expressed a need for "honest" and "forthright" medical information, they frequently felt dissatisfied with the information they received, particularly from doctors. They stated that the most satisfactory source of relevant information came from the cardiac rehabilitation staff.

Other participants talked about health professionals' responsiveness to their presentation of symptoms. Although three women had consulted with physicians regarding suspicious symptoms several months before their MI, none of these were concluded to be cardiac in origin. One woman recounted, "A year before my heart attack, I experienced pain in my shoulder and left arm, but my doctor said it was because I was depressed." During her MI, this same woman was forced by paramedics to walk unassisted to a stretcher after spending 20 minutes trying to convince them she was ill. Another participant described several factors that became central in her illness narrative as harmful components of her early recovery experience, including the haste in which she was discharged from hospital, the lack of information and resources provided, and the absence of compassionate care from her health care providers. Each of these stories illustrate "iatrogenic suffering" (Kuhl, 1999), or the undue suffering and harm to patients caused by health professionals, commonly, but not exclusively, by physicians. Embedded in all of the participants' narratives was some degree of iatrogenic suffering.

All participants described receiving strong social support from family and/or friends during their illness and recovery, although there were considerable variations in the quality and extent of their support. While one woman received support from a loving partner and a large circle of friends, including other women living with chronic illness, someone else was cared for by a close family friend given her choice not to "upset" her own family—"I didn't want them to worry as they couldn't help me." Only a few women were able to articulate what comprised support and suggested that their needs changed depending on their progress through recovery. Collectively, women identified various support needs including companionship, assistance with decision making, information seeking, and advocacy with health care providers, selected help with role responsibilities, and, most importantly, emotional reassurance and understanding.

In addition to receiving support from others, four women acknowledged the

emotional sustenance they had received from their religious faith or spirituality and from their pets. Finally, all group members acknowledged the value of participating in the GA group and used words such as “healing,” “therapeutic,” “self-valuing,” “validating,” and “empathic” to describe their experiences.

Theme Six: Caring for Others

This theme relates to how women balanced their roles as caregivers, their needs for support, and compliance with convalescent guidelines during their MI recovery. While all participants clearly identified themselves as caregivers in different areas of their lives, their ability to put other people or commitments first was both a personal strength and a liability as women often ignored their own needs, which left them feeling “stressed” or “overwhelmed.”

All participants described the various ways in which they continued to perform as caregivers despite being ill. Women talked about protecting worried family members in various ways. Three women reassured family members “that they were fine” while hospitalized during the acute phase of their MI. Another participant discouraged her mother from visiting 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.” Despite having very little social support, one woman chose not to tell her family about her illness because she “didn’t want to make them worried.”

Three women described feeling “guilty” if they did not return quickly to their employment and/or familial responsibilities. Although exhausted, one woman returned to work within a week of hospital discharge to organize 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.” The juxtaposition of women’s inherent role as caregiver and supporter of others and their need to convalesce during their recovery represented a challenging and potentially dangerous dilemma.

DISCUSSION

The original purpose of this study was to develop a better understanding of women’s experience of recovery from MI. The GA group process, as a tool for investigating this phenomenon, was instrumental in the participants’ recovery. One of the most important findings in this research was the profound experience of loss created after the illness event. The experience of loss was the overarching theme in the study and demonstrated the pervasiveness with which MI impacted women’s lives. This meant that participants reported varying degrees of physical, emotional, relational, psychological, and occupational loss. Ultimately, women had lost their lives as they knew them—meaning they had lost the sense of 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 after the MI. The autobiographical approach provided a group process in which the women could explore their fears and losses, and create meaning out of their MI experience in order to reconstruct a new sense of self.

A second significant finding in the study is that an autobiographical group approach provided a container for the exploration of the underlying emotional and relational conflicts and struggles that women stated were at the heart of their cardiac illness experience and recovery and which are often silenced in medical settings. For example, participants spoke about health professionals investigating physical health and symptomology to the exclusion of inquiring about their emotional and relational worlds. This finding is significant in that it provides evidence to support change in current medical practices. The voices of the women in this study represented a starting point for changing how medicine manages recovery in women after MI. Health professionals need to broaden their perspective on understanding the complexity of health issues by expanding current models of health delivery and incorporating more comprehensive biopsychosocial frameworks. These broader frameworks would have a significant impact on the delivery of recovery programs following a significant cardiac event. A group-based autobiographical counselling approach holds promise for delivering a biopsychosocial model of recovery for women following MI.

Findings Unique to Younger Women

Several unique findings emerged from the data with respect to the occurrence of MI as an unlikely event for younger women (aged 48–53 years). 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 acute symptoms, thus challenging current literature that suggests that women persistently delay in seeking treatment for cardiac symptoms (Jensen & King, 1997; Moser & Dracup, 1993). At the same time, at least three women reported suspicious 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 that they had suffered an 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 an MI.

Female heart patients in their 40s and early 50s may be faced with different lifestyle challenges compared to their older female counterparts. Research participants described juggling multiple responsibilities including work, caring for their senior parents, and other familial and social commitments. Most of the women in this study described being excessively busy and overwhelmed for a significant period of time prior to their MI. In contrast, older cohorts of women may not have the same breadth of responsibilities as younger women.

All participants in the current research expressed a hunger and insistence for

cardiac information and treatment resources specific to women. One participant stated that she had read "everything out there" related to MI but "there was really nothing that spoke to me as a younger woman." Younger female cardiac patients may be more likely to seek out treatment options in comparison to older women due to greater access and skills at information seeking, different socialization related to communicating with health professionals, and fewer comorbid conditions that may impede women's physical mobility and access to information.

These findings demonstrate the significance of developing educational initiatives for both the public and health professionals that outline the incidence of MI and heart disease in different aged women. This recommendation has been substantiated by findings in several other studies (LaCharity, 1999; Murray, O'Farrell, & Huston, 2000; Rankin, 2002).

Implications for Professional Practice

This research contributed to the growing body of qualitative studies that explores MI recovery in women, as participants had the opportunity to give voice to their lived experience of illness in a supportive group environment. 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 counselling experience and expertise of the researchers collecting the group data.

Given that medical professionals do not typically possess expertise in the area of emotional or psychological support, it is imperative that they work with other care professionals, such as counselling professionals, who are trained in addressing emotional and psychological aspects of 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 for both women and men.

A key implication in this study is the important role of counsellors assisting 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 experiences in terms of the recovery themes that emerged in this study. Current cardiac rehabilitation services do not have the resources to explore the personal meaning associated with illness. Viewing patients' illness experiences within the context of their biographies and life histories will allow care providers to better understand the complexities of patients' belief systems and processes of meaning making. As evidenced in the current research, women's belief systems impacted their perceptions and behaviour and how they constructed their recovery.

Another key implication in this study is the value of health care professionals taking a narrative approach to personal history taking and making genuine contact with patients/clients. Moving beyond physical symptoms and physiological appraisals represents a step toward more "humane, ethical, and effective health care" as medical professionals attempt to better understand the depth of their

client's/patient's illness experiences (Charon, 2006). As counselling professionals are adept in the provision of training health care providers in the area of empathic interviewing and communication skill building, we recommend that more medical professionals receive effective communication skills training in their work with patients recovering from MI. We also recommend to those advocating for GA groups as part of a recovery program to be attentive to screening protocols for the group, maintain limits on group size to a maximum of six members, and offer a setting that is easily accessible, centrally located, and private. We caution those working with vulnerable populations about the length of recovery involved for clients with chronic illnesses and the variability in members' ability to attend all sessions. In terms of research outcomes, the setting and membership size do influence the findings; therefore, consideration should be given to these factors in planning future GA groups.

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, radio and television interviews, health magazines for the general public, women's health journals, and professional development activities targeting medical professionals. Moreover, the participants in this research group strongly recommended that the researchers continue to investigate this topic and expand on the resources available to women in recovery from MI. Further, it is important to note that women who are able to recover fully from MI will provide a considerable cost saving to society and our current health care crisis; therefore, psychosocial interventions such as this could be influential in cost recovery efforts.

Finally, while this research demonstrates the natural link between counselling psychology and medicine in the understanding and treatment of illness through biopsychosocial models of disease, counselling practitioners continue to face dilemmas and challenges in conducting qualitative research and innovative psychological interventions that are accepted as "scientific" in many areas of medicine. These difficulties reflect cultural and paradigmatic differences in values and beliefs about notions of "good science" and influence knowledge regarding concepts of wellness, what comprises credible research, and how research funding is prioritized within the human sciences. Continued research in this area will contribute to a growing body of work that calls for a fundamental shift in expanding models of research and health care practices, including mental health by way of counselling practitioners, that value the patient's voice and highlight the need for transdisciplinary approaches to health care.

Research Considerations

As one of the goals of qualitative research is to examine the fundamental processes of a specific group of individuals, it does not provide 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. Moreover, the learning that resulted from reading these women's autobiographies and from conducting the GA group is transferable and may be useful to readers in broader contexts.

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 number 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 on recovery from MI. Study findings may have differed with a sample more diverse in cultural representativeness. Additionally, 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.

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