

STRESS AND THE HEART: A CO-CONSTRUCTION OF NEW LIFESTYLES AFTER CORONARY HEART DISEASE (CHD)

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ABSTRACT

"There are plenty of alternatives in any situation...When you attend a session of group therapy, what on earth are you going to see? That (plenty of alternatives) is what you are there for" (Freedman & Combs, 1996:11).

Using a narrative perspective, the stress construct in the lives of people with coronary heart disease is reconsidered. This permits a shift in focus in the stories of the lives of South African National Defence Force officers from the unhelpful construct of stress to one on their abilities to cope with modern-day complexity and uncertainty, including heart disease. Such reconstructions accommodate both scientific and lay theories of heart disease, and enable people to live more positively.

OPSOMMING

Die konstruk van stres in die lewe van mense met koronêre hartsiekte word deur middel van 'n narratiewe benadering heroorweeg. Dit laat 'n fokus-verandering, in die lewensstories van offisiere van die Suid Afrikaanse Nasionale Weermag, toe. Hierdie skuif vind plaas vanaf die nie helpvolle konstruk van stres na hulle vermoëns om met hedendaagse kompleksiteite en onsekerheid, wat hartsiekte insluit, te leef. Sulke herkonstruksies akkommodeer beide wetenskaplike en leke teorieë van hartsiekte, en bemagtig mense om meer positief te leef.

INTRODUCTION

People with Coronary Heart Disease (CHD) who have experienced a cardiac event (such as a myocardial infarction) and or intervention (such as thrombolysis, angioplasty or coronary artery bypass surgery) attribute it to stress (Rudy, 1980). This results in tension between the sufferers and the medical profession with regard to the secondary prevention of these events. The underlying risk factors (including personal characteristics, patterns of behaviour, metabolic, physiologic, psychosocial aspects and social conditions - Labarthe, 1998) which are equally responsible for the disease (Ornish, Scherwitz, Billings, Gould, Merritt, Sparler, Armstrong, Ports, Kirkeeide, Hogeboom & Brand, 1998) need to be acknowledged by both parties and dealt with. Unless these risk factors are managed, a never-ending

cycle of repeat therapies and interventions continues (Merz & Rozanski, 1996). McKibbin and Wilson (2001) produced a grounded contextual account, based on Kelly's (1955) personal construct theory, of why people do not address these risk factors after a cardiac event, and issue a challenge, based on Kelly's (1955) position of constructive alternativism, to find alternative ways of helping people reconstruct their lives so as to break out of this destructive cycle. Using a social constructionist narrative approach (McNamee & Gergen, 1992), it acknowledges and harnesses these theories to help bridge the gap between lay and professional theories of heart disease. In telling their stories and reconstructing their past, people are helped to co-construct alternative accounts of themselves and their relationships (Freedman & Combs, 1996). This opens up space for them to re-author their lives (White, 1995), including their

health (Strumpfer, 1995). By answering the question *in what ways can people with CHD see "stress" as moving them towards health?* it is hoped that both the medical profession and those suffering from CHD may view stress in a new light in terms of recovery.

A REAPPRAISAL OF THE TRADITIONAL APPROACH

Stress and coronary heart disease within the scientific paradigm

The divide between lay and professional theories of heart disease must be considered in the light of the great seriousness of this problem. CHD remains the leading cause of death in Western countries and is the third leading cause in developing countries (Labarthe, 1998). In South Africa, it remains the biggest killer in all population groups except blacks; even among them risk factors continue to escalate. Current falls in mortality in first-world countries are largely attributable to improved coronary interventions such as thrombolysis and revascularisation techniques, yet the incidence continues to rise worldwide (Walker, 1998; 2000). Hence, the medical profession considers secondary prevention of CHD to be as important a treatment as pharmaceutical and invasive intervention for revascularisation (Merz & Rozanski, 1996).

A confluence of clinical, pathological, experimental and epidemiological evidence attests to the multiplicative and multifactorial contribution of particular lifestyle-related risk factors to CHD. In particular, hypercholesterolaemia, hypertension, smoking and physical inactivity have attained the status of causality, as reviewed by McKibbin (1994). A paucity of valid studies excludes stress from this consideration (Allen & Scheidt, 1996; Yusuf, 2000). However, "lifestyle" alludes to underlying psychosocial factors implicated in CHD and more succinctly describes the stress construct. These relate psychological changes to social and pathophysiological changes (Hemingway & Marmot, 1999) and influence "quality of life" (Julkunen & Saarinen, 1994). Those meeting the scientific criteria for association with CHD include type-A behaviour/ hostility, depression and anxiety, work characteristics and lack of social support (Hemingway & Marmot, 1999).

People's theories of attribution, on the other hand, derive

from personal meanings of lived experience (Kelly, 1955) and become systemically co-constructed and consensually validated over time (Anderson & Goolishian, 1992), providing a sense of coherence (Borden, 1992). This refers to the degree to which one sees the world as comprehensible, manageable and meaningful, reflecting a dynamic balance between stress and one's abilities to cope with it at any particular point in time and space (Antonovsky & Sagy, 1986). Neither paradigm acknowledges the other, and stress as a risk factor continues unabated (McKibbin, 1994).

Stress has become a metaphor for the "modern turmoil of everyday life" (Sowa, 1992:179). No consensus on definition exists, as it varies from person to person. Rather, people "know it when they see it" (Blumenthal, Bradley, Dimsdale, Kasl, Powell & Taylor, 1989).

Stress is subjectively appraised as a precarious balance between perceived demands and the ability to cope with them (Lazarus & Folkman, 1984), incorporating physical, personality, interpersonal and contextual factors in the discourse between society and health (Faller, 1990; Radley, 1988). This imbues people with a sense of helplessness in the face of uncertainty (Schlebusch, 2000). By contrast, Antonovsky's (1987) more fortigenic approach searches among meanings for more positive evaluations, thereby increasing a sense of coherence, or the degree to which people construe their worlds as manageable, comprehensible and, in particular, meaningful.

The experience of a cardiac event or intervention plunges people into a range of intense negative psychological and physical experiences, and undermines their assumptions about themselves and their world, as reviewed by McKibbin and Wilson (2001). Complex, dynamic changes in families follow as rules and patterns of behaviour are disrupted, and the resulting discourse between CHD and social life places far-reaching demands on them in their efforts to regain a sense of control (Stewart, Greenfield, Hays, Wells, Rogers, Berry, McGlynn & Ware, 1989) and diminishes their opportunities to derive greater meaning from the experience (Kruger, 1988). People resort to emotion-focused and problem-solving strategies (Hewson, 1997) and social support (Orth-Gomer, Horsten, Wamala, Mittleman, Kirkeeide, Svane, Ryden & Schenk-

Gustafsson, 1998). The effects of CHD, the importance of risk factor management, and the varied outcomes and responses these provoke, make a strong case for psychosocial intervention (Cardiac Rehabilitation Guideline Panel, 1995).

Stress and coronary heart disease within the postmodern paradigm

Chaos theory gave birth to social constructionism (Van Hesteren, Sawatzky & Zingle, 1982), from which family therapy and narrative methodology derive, and which locates realities in systems rather than discrete elements. Moving beyond the individual location of psychological processes, the self is recognised as "part of a social multiverse" in which perceptions and meanings arise through social interchange. People make, test and revise theories to help make them make sense of their experiences, and depend on the context and network of premises and presuppositions that constitute the co-constructed maps of their world (Gergen, 1985). Social constructionism is concerned with explicating the processes whereby people construct their own life worlds and thereby their understanding, knowledge and experience of it - including themselves.

The stress construct acquires its meanings from its context of usage, sustained by social processes such as communication, negotiation, conflict and rhetoric, and perspectives retained regardless of contrary scientific findings (Gergen, 1985; Sarbin, 1984). In this study the social constructionist approach uses narrative methodology to challenge these social artefacts, and, depending on how their intelligibility is questioned, consensually validates alternative theories (Gergen, 1985).

NARRATIVE METHODOLOGY

White and Epston (1990) describe narratives as existing in two landscapes, the landscape of consciousness (meaning) and the landscape of action. Storying organises events and experiences-influenced by history, culture and context-in time and space. Teller(s) and listener(s) reflexively shape the process in negotiating meanings towards a sense of coherence. People become what they tell, reflecting commitment to discrepant views of self and others and others' views of

self (Borden, 1992; Bruner, 1987). Stories have particular themes, discourse and genre resulting from the personal disruption, which stems from the meaning given to the event (Clark & Mishler, 1992; Lee & Dwyer, 1995). Constructions evolving from collaborative executive functioning have vast creative potential for re-authoring lives (Argyros, 1992). The discourse on stress relates to the participants' constructions of self and others, what is told, and what is done about it as people become the stories they tell (Bruner, 1987).

The narrative process

The therapeutic context is a system of complex interrelationships in which process is followed, working with values, perceptions, beliefs and meanings in the "landscape of consciousness" (White & Epston, 1990) to bring about awareness of the "rules" in patterns of relating (Keeney, 1979). Causality is viewed as circular, such that behaviours influence others whose responses will be reciprocal to those behaviours in influencing the actor and the general overall responses.

This includes the therapist's working philosophy and therapeutic skills which influence the process (Anderson & Goolishian, 1992), acting from outside the group and consciously "joining" it to effect changes on many levels (Keeney, 1983). This demands of the therapist an ethical stance of personal responsibility to the participants and to him/herself (Real, 1990). The "irreverence" which arises from a not-knowing position must be balanced with scientific truths about CHD (Launer, 1996).

Problems arise if difficulties that occur at key transition points, such as illness, are mishandled. They comprise the initial distress as well as whatever accumulates in response to these, and are influenced by fluid views of self and others manifesting in changing patterns of interactions (Eron & Lund, 1993). The resulting "chaos" is variable and uncertain as the therapist facilitates constructions arising from complex situations (Schon, 1987). Increasing awareness of feelings and attitudes, as well as objectively observing them, facilitates integration and change within the various systems (Keeney, 1983).

The uncertainty, chaos and complexity that people with CHD face provide a challenge to the growing body of

literature on regaining control which in itself may be inherently stressful (Langosch, 1994), particularly in relational issues (Gove, 1994). An emerging postmodern view promotes the development of an attitude of "positive uncertainty", and opens opportunities for growth and change (Gelatt, 1989). Reconsidered values, spiritual beliefs, and a more complex orientation to life promote hope and health (Woods & Ironson, 1999).

The higher-order awareness, which accompanies storying, helps reconstruct identity, personality and meaning commitments when there has been a breach between ideals and reality (Hermans, 1999). The process cycles people recursively through awareness and reflexivity in individual and social contexts, tapping alternative stories for different meanings and possibilities in their lives and relationships (Eron & Lund, 1993).

The realm of values facilitates deconstructing the power inherent in institutions as humanness and human phenomena interface at individual and social systems levels (Kriel, 1996), facilitated by externalising conversations (Doan, 1997). Ornish's (1991) programme to reverse heart disease metaphorically implies *opening your heart* to biological and spiritual intervention relating to self, others and a Higher Self, which in turn facilitates the integration of uncertainty into reality (Mishel, 1990).

Narrative methods in data collection and analysis

The research question, *in what ways can people with coronary heart disease see "stress" as moving them towards health?* was developed in narrative group counselling (within family systems therapy) to apply a social constructionist approach heuristically in order to co-construct more helpful, hopeful conversations about stress (Becvar & Becvar, 1996). The model developed by McKibbin and Wilson (2001) to reconstruct past events and new realities was followed. These both threatened various social patterns and offered new, more hopeful opportunities (Bertaux & Kohli, 1984). "Health" is defined as "being confident and positive and able to cope with the ups and downs of life" (Stewart-Brown, 1999:192).

The small group process qualifies as an intervention for the secondary prevention of CHD (Pennebaker, 1993), including the mere telling of stories (Pennebaker &

Seagal, 1999). This contributes to personal and interpersonal health (Eron & Lund, 1993) and establishes a forum for social action (Riessman, 1990), so citing the method in both basic and applied research (Borden, 1992).

The persons who participated in the study had been discharged from 1 Military Hospital, Thabatswane, after a cardiac event and/or intervention, and were at various stages of recovery. Unique to South Africa is "enforced" attendance at a cardiac rehabilitation unit, which, in keeping with world trends, focuses predominantly on exercise training (Merz & Rozanski, 1996).

Purposive (non-random) sampling was employed, in keeping with the commitment of qualitative research to authenticity and context (Maykut & Morehouse, 1994). Grouping in two groups was deemed important to add to the richness and density of the data, to account as much as possible for variation in complex and sensitive phenomena (Glaser & Strauss, 1967).

The participants were predominantly officers from the South African National Defence Force (SANDF). Given the logistical difficulties in obtaining an adequate sample of phase 2 participants (immediately after and up to three months after the cardiac event or intervention), the intervention was extended to include any interested person with CHD from the unit. Some were still working in the SANDF. Others had taken the "retirement" package or been medically boarded, possibly influenced by the demobilisation phase of SANDF transformation (Winkates, 2000).

The participants ranged in age from 50 to 77 years, and their experience of CHD spanned 28 years. Group 1 consisted of six men between the ages of 50 and 75. Group 2 consisted of four men and two women. Of the two women, one (aged 28) had recently experienced a cardiac event and intervention. The other was a spouse who asked to accompany her husband. The oldest participant (aged 77) attended one session only, and seemed to have to have misunderstood the nature and purpose of the sessions. With the exception of the accompanying wife, all participants had experienced a myocardial infarction, and interventions in the form of angioplasty (-ies), stent(s), or coronary artery bypass surgery. Additionally, two participants from the first group

underwent valve replacement surgery.

After obtaining institutional, departmental and personal informed consent, conversations about stress developed within two group processes consisting of six participants each, extending from four 1 1/2 to 2-hour weekly sessions during July and August 2000. With few exceptions - dictated by military, health, family and personal commitments - participants attended every session. This took them through a cycling process of induction, deduction and verification between descriptions (landscapes of action) and interpretations (landscapes of meaning) (Freedman & Combs, 1996). The sessions were audio taped, transcribed, and checked by a colleague. Guidelines to ensure trustworthiness, as outlined by Maykut and Morehouse (1994), were followed.

The grounded theory approach of Glaser and Strauss (1967) was used to generate a more helpful theory of stress. Through the constant comparison of similarities, differences and experiences (in structure, time, cause, context, dimensions, consequences, and relationships), and linking and splitting of properties (concepts describing categories) and categories, patterns or new concepts developed (Strauss & Corbin, 1990). This depended on the frequency of an issue arising, its importance to the group, its uniqueness, or the need for further exploration (Guba & Lincoln, 1981). As such, it was grounded in the participants' worlds (Glaser & Strauss, 1967). The recursive process continued until a point of saturation was reached and a theory evolved to answer the research question (Merriam, 1998).

Interpreting the data was a hermeneutic process to discover meanings embedded in the text (conversations) from the authors' viewpoints presented as a whole, and then to understand in a new way how the parts related to the whole (Neuman, 1997).

ANALYSIS OF THE CONVERSATIONS

Through externalising, conversations were co-constructed differently in the two groups, similar themes emerged from their stories.

Stress-saturated stories in the landscape of action

The overall story of stress was co-constructed as a multi-storied conflict waged on the *"battlegrounds of life"*. Participants' experiences were personally and relationally negotiated within a developing cultural and contextual interpretation of stress in their lives to provide some sense of meaning (Becvar & Becvar, 1996).

Searching for a definition was frustrating - as the participants realised, *"you can't actually define it as it differs from person to person"* (Petch, 1996). But they knew it by experiencing it in everyday things (Blumenthal *et al.* 1989; Petch, 1996). They used the characterisations, *"shit happens, it goes for everybody"* and *"everything is stress"* to describe the pervasive presence of stress in their lives.

This pervasive presence may be symbolised as a boiler. They experienced stress *"building up over a period"*. The build-up of pressure, imposed from outside, required release - as one person expressed it, a *"pressure-release from the stresses that are building up at home, the workplace and in the environment around me... the release is supposed to take place in all the areas"*. This need for a "relief-valve" system with substantial outlets, in their view, included hobbies, noise, sport, and avoidance, which they said, *"relieves some or other stress"* in their efforts to trade one stress off against another. Some of these outlets provided temporary respite only as they perceived stress as subsequently *"catching up with you"*.

Their perceptions mirror Osler's description in 1910 (*in* Allen, 1996), almost a hundred years ago, of a typical cardiac patient as a "keen and ambitious man, the indicator of whose engine is always 'at full speed ahead'". Their constructions blended their medical understanding of "hypertension" with lived experience to formulate what Mabeck and Olesen (1997) term an "ethnomechanic" model. Further validation of this imagery was provided when one person gave the reason for mitral valve surgery he had undergone. He perceived the need for the surgery as due to pressure released during the initial coronary intervention - *"the valve couldn't take the punch"*.

Reconstructions of stress during the conversations developed the idea of stress as a *"bandwagon... onto which everybody jumps, as a nice-to-have"*. The participants began to recognise the role they played in

the life of stress. Stress could be self-imposed; as one member aptly put it, *"Stress is you and you gonna take it with you when you go there"*. In this way stress formed part of a constricted sense of "identity", characterised by self-perception as a "high-stress" person, debilitating and emasculating, and aggravated by CHD. They used terms such as *"label"* and *"stigma"* to depict the seeming injustice of insult heaped upon injury and associated shattered assumptions.

These assumptions alluded to the experience of CHD (McKibbin & Wilson, 2001), which they depicted as a *"hang of a shock for your system"*, particularly in the light of their being fit, *"highly trained"* and competent professional people who had survived war. A participant revealed a keen sense of betrayal in the remark, *"you always feel that this body's dropped me"*. The power vested in the military's provision of medical care was evident over the sessions, and appeared in remarks such as, *"You need periodic but constant checks by instructors. The instructor we assume knows exactly how it should work. He checks this pilot to see what has crept in between... It's a case of hand over your troubles to someone else. Let them look after you. It does work and then you must realise they're doing the best they can to monitor our situation so if there's anything untoward they'll probably know it before we know it. So if they don't whine, nobody will"*.

The biophysical relation to stress further contributed to self-perceptions in several ways. They acknowledged the contribution of family history in CHD, as they described their *"mucked up genes"* and *"things that are missing in us"*. Related uncertainties were evident in, *"something can go wrong because of family history"*. Even stress itself was deemed genetic: one person said, *"My kind of stress is genetic, so I accept it"*.

Constructions of the experience of CHD centred around facing mortality and associated social taboos (Kruger, 1988). They are epitomised in the following poignant responses: a *"kind of hateful type of hallucinations - a hell of a world, of which jy weet nie of jy gaan survive nie"*, and *"I can remember the first week after my heart attack walking around the garden because that was about as much as I could do. And I looked at everything and I was amazed how little had changed. Until I looked at myself. And then I realised that uphill battle that was*

going to take place. Because around me nothing had changed when I had changed". Another member of the group spoke of *"hurdle obstacles"*. These remarks allude to the perceived loneliness and alienation experienced in the uphill battle for recovery-further described by Stewart *et al.* (1989).

Uncertainty

Uncertainty, mounting tensions and experience of loss of time, health, security, civility, discipline, dreams and relationships spilled into all areas of their lives. These were acutely felt; as one participant said, *"They come back and haunts you, you know, like ghosts"*. Their metaphorical use of feeling *"by-passed"* epitomises feelings of redundancy and worthlessness. One of the participants expressed it thus: *"It becomes a very big disappointment because what should be the pinnacle of life are the golden years. And I never believed it and now that I'm there because of stress because of trends or because of habits you allow stress to take place. And instead of entering the golden years, they become gilded years"*.

The role of context in the life of stress

Generally, unsupportive relationships influence and were influenced by the *"hurdle obstacles"* described by the participants. These impede recovery and lifestyle changes (Orth-Gomer *et al.* 1998), and increase uncertainty (Langosch, 1994).

Confirming Radley's (1988) analysis, the participants-particularly those from group 2-considered emotional support to be particularly critical to change. One participant described it thus: *"I think the one thing that is very important is that relationships change. And that's one of the most difficult aspects. Because the relationship before and the relationship after are two different relationships whether we want to accept it or not. I think it's a fact of life... that's close relationships in the smaller... in the family but also in the immediate family around that and even in the wider although the effects become less the wider the circle is drawn. And that's where change is most difficult... I think what happens is that you start spilling over the edges and then it's almost a conscious counter to stop you spilling over the edges if I can put it that way without saying there is a conscious effort"*.

The lack of perceived support by the participants was often expressed in over-protectiveness, further alienating, frustrating and confusing the participants, with concomitant effects on cardiac symptoms. This accumulated additional tensions in relationships, which they acknowledged were beyond their control. Their hard-driving and ambitious need for control conflicted with their constructions of being "introverted" types of people, so adding to the growing personal, interpersonal and contextual uncertainties in what they felt (Bury, 1982) to be already compromised situations.

This applied particularly to work-related stress, which saturated their stories in the landscape of action. War-related stress from the past compounded current stressors. As one officer reflected, *"you start firing on eight pistons"* which later *"backfired"* on health and relationships. This supports current discourse on the negative aspects of stress (Schlebusch, 2000). However, evolving perspectives included insights such as, *"I don't think we can create work in the service environment without stress because we are in the killing industry and we must realise that"*.

Current stress at work was reflected in stories of personal victimisation, which bolstered perceptions of the incivility of a faceless government organisation (Freedman & Combs, 1996). Military personnel took their service seriously, and sacrificed their own priorities and better judgement in favour of those sometimes imposed by *"dumb bosses, for the greater good"*. Incessant and unnecessary meetings, resulting in ennui and a backlog of unfinished projects, were the bane of their lives, and exacerbated the competitive climate of rank climbing and machinations of ambition. Additionally, CHD was a two-edged sword: it both disqualified them from rank (already fraught, given the demobilisation phase of the transformation process) (Winkates, 2000) and was a useful weapon to fend off excessive work. Other strategies adopted by participants in order to cope fuelled uncertainty and feelings of disempowerment; as one participant demonstrated, *"How can I go to the general, say 'Look, bullshit! I'm not attending... this meeting - I've got this to do. You can't throw it. You've got to do everything. That's it!'"* The same participant labelled the military institution a *"sick building syndrome"*, reflecting the seepage of infection into their lives and relationships. Other constructions evolved, depicting the system as a

"vicious circle...of fleas...upon fleas..." and echoed a mounting sense of injustice which they felt as *"victims of nepotism"*. Not only did their sacrifices go unacknowledged, but they even backfired on them. This was illustrated by the acrid remark, *"while you try make success out of a situation, there is the situation ending up with a heart condition"*.

Transformation

The most bitter of all constructions placed on stress, one seen to permeate all personality, socio-political and related economic changes, was that of *transformation*. The participants were acutely aware of what they perceived as an irrevocable dropping of standards and an accompanying loss of national pride; as one person attested: *"now the train took over. Whatever you had to do to the best of your ability, it's stopped now"*. The social constructions of *"the train"* were explicated with descriptions of a changing ethos, exemplified in this remark: *"you get bogged down in the system where brown noses get further than the honest working people, which is very stressful"*.

In the participants' evolving constructions, cultural misunderstanding added to uncertainty. Pertaining to the work place, one person said, *"It's very messy because you don't know when exactly what to do, or when to do it, because it chops and changes every day"*. One person summed up the feelings of the group in this way: *"People doesn't accept transformation. They do what the army says, just put pen to paper and sign. Basically, one gets the feeling that they want the whites to be out of the system. That puts additional stress on the work environment feeling of 'why must I do it?' That's the feeling of the top structure, 'why must I do something about it?'"* The shooting incidents at Tempe and Phalaborwa epitomised their tensions and uncertainties, as they said, *"because no one actually knows where we are going, especially in your own mind"*.

Transformation affects people's intimate relationships, as responses to change are grounded in culture. The white Afrikaner male is no longer guaranteed a job in the public service (Ndebele, 1998). Increasing unemployment forces extended families together. As one participant said, *"In South African society, especially the white families do themselves in for purposes of helping their children"*. Social change caused participants to

regret sacrifices they had made in the past; as one officer reflected, *"It's not possible to catch up the time that you lost with your children and the way that you work with it... with my son there's always this, like, two bulls, you know, clashing... although we're not at such a stage that we don't talk to each other, but it would have been better if I'd gotten involved earlier in life"*.

Social changes seen as embodying normlessness in everyday life were a continual source of conflict, especially violent crime which was contrasted with more carefree times: *"There was no burglar-proof, no steel gates, no horrible rolls on heaps and all that like we live in the present, walking around with a pistol or revolver on your hip. I think it's a more stressful life than they had"*.

Preferred selves in the landscape of consciousness

As the participants thrashed through the contributions of stress to their lives and their contributions to the life of stress, they came to a fuller realisation of how problems accumulate in response to the initial issues and how these impact on their lives and relationships, including their health. As they acknowledged, stress was *"work-related, employer-related, let's say system-related, but also personal-related"* (Becvar & Becvar, 1996).

"Tools" to handle stress became submerged in the conversations, and a developing "knowledge" emerged relating to themes of *responsibility* and *values*. The participants became involved in alternative ways of living, acknowledging (in accordance with Antonovsky's (1987) fortigenic construct) that stress is universal and that people survive it if they work at it.

Preferred selves were seen in terms of Christian beliefs and values (fortigenic in Antonovsky's (*ibid*) terms), and responsible guidelines for living were seen as provided in the Bible, which they considered a *"manual for living"* which helped avoid hurting the self and others. A sense of hope and connectedness was communicated in their beliefs: *"There is this fundamental element faith underlying everything you talk about this life, implying that the other exists. Your faith has got to believe that. We have a job to do here, and when we finished the job we go on to a better life... But still there is that I think*

faith's the fundamental of our beliefs... you've got the faith and then the other things are added too, sort of the old story. You've got the one and then the other stuff is added to you like training, the briefing, information, support and all these other things".

A longing for connectedness was reflected in their conversations about attending cardiac rehabilitation, expressed in the knowledge that *"if you kick a bush about another dozen other heart patients will fall out of the bush to join me"*.

The participants permitted glimpses into their deconstructions of personal, relational, contextual and institutional power. Grand narratives of *"introversion"* - relating to their physical and psychological *"building walls"* and accompanying sense of isolation, and *"producing better under stress"* - hinted at the two-way nature of personal and interpersonal relationships. The infallibility of science was touched on. This was accompanied by discomfort in the group and there was a hasty covering of tracks.

From these conversations emerged reconstructions in relation to self, others and context. For example, fear was reconstructed as a challenge which they could identify and face, using information, attitude, discipline, training, time management, role modelling, professional advice, developing past and new strengths (such as negotiating), and an ability to reframe and choose. In connection with lifestyle changes, one participant explained, *"If you're well trained then you automatically take over, and you realise you can handle it"*. The idea emerged that behaviours develop as habits, and that more collaborative ways of living offered alternative choices. This would involve more flexibility, reciprocity and actualisation of values pertaining to relationships. It also involved risk. One participant proposed, *"I think if we would be more open, take the risk as you say, in other words, open yourself to your close family, your wife or your children, then you could decrease any risk factors that could be increased because then you talk to each other. You communicate. If you don't take the risk, you don't open towards each other, you don't know anything about each other. And you will put the problems on the table. And it's only by doing that that you will ever get problems out in the open"*.

A more fluid and expanding sense of identity began to emerge in storying (Bertaux and Kohli, 1984). Comments ranged from *"you are really what others see you to be"*, to *"no personality is cast in stone"*, to admissions of changing self-perceptions; as one participant confessed, *"I've always thought of myself as psychologically strong 'til I found out how weak I really am"*. Though perceived as weakness, this opens doors to possibility and change, and identities become more distributed (Wilson, 1999). Reconstructing the meanings of their experiences has a pivotal role in creating more complex representations of self (Eron & Lund, 1993).

LIMITATIONS OF THE STUDY

The groups consisted predominantly of white Afrikaner males, in keeping with local socio-political trends of the recent past and the prevalence of CHD. Thus, language played some part in their co-constructions with a white, English-speaking female researcher and therapist. Though findings cannot be generalised to other contexts, similarities in constructions are noted in related studies (Mokhoka, 2000; Van Zyl, 2001).

CONCLUSION AND RECOMMENDATIONS

Preferred views of selves and a greater understanding of stress through storying enabled the participants to construct alternate possibilities, including different conceptions of themselves. The constructions of "knowledge" provided a framework for change and opened the door to "positive uncertainty".

Training for positive uncertainty (within the postmodern paradigm) includes identifying and (proactively) confronting areas of potential certainty that are seen as threatening. Addressing the medically attested risk factors (within the scientific paradigm) diminishes a certain amount of uncertainty associated with CHD. The researcher's paradigm, which incorporates scientific truths about CHD, forms part of the co-constructions. Thus narrative therapy provides a forum for secondary prevention and risk factor management. Likewise, religion (from a premodern paradigm) which adds dimensions of joy, sense of purpose and connectedness - rather than merely the prolongation of life - reaches beyond the reductionism inherent in medical science, and broadens motivations and values which enhance

personal, institutional, organisational and community values in the battle against CHD. These values challenge people to transcend merely ascribing meaning to situations to the further project of searching for meaning for their lives (Chapman, 1986).

Using the participants' framework which evolved from co-constructions, "training for certainty" and positive uncertainty becomes an alternate story in each of the developing themes. Richer understanding of uncertainties in complex situations touches peoples' values and responsibilities, as well as possibilities for social action. Stories are agents of social change and reconstruction towards healing (Argyros, 1992). Arising from family therapy, family/community network therapy provides a forum for action to exploit constructions of "knowledge" in a mutually healing bond in times of crisis (Pilisuk & Hillier Parks, 1986).

The emergent constructions from narrative group therapy provide a springboard for reconstruction and an opportunity for people to "reinvent themselves", thus meeting Petrie, Weinman, Sharpe and Buckley's (1996) appeal for an intervention that targets hope. Ndebele (1998) urges, "let all the stories be told. The gift of our freedom partly lies in our ability to ensure that where oppression is no longer a major defining characteristic of the social environment, the different features of our society will now emerge as aspects of a more complex definition of that environment".

Stress poses a challenge to personal, interpersonal and community health. Instead of uncertainty clouding responses, "knowledge" - through the telling of stories - develops to strengthen certainties and embrace positive uncertainty. Sid Caesar (www.sidvid.com) in Ornish's (1991) *Opening your heart* programme, bases his philosophy on Einstein's theory of relativity - where one person's "now" is another's "was", a good "now" guarantees a good "was" and a good "wanna be". In this way, CHD becomes the "vehicle to carry them on a spiritual journey" (Feste & Anderson, 1995:143).

REFERENCES

- ALLEN, R 1996: Introduction: The Emergence of Cardiac Psychology. (In: Allen, R and Scheidt, S eds. 1996: Heart and Mind. The Practice of Cardiac Psychology. Washington, DC: American Psychological

Association, pp. 3-13.)

ALLEN, R and SCHEIDT, S 1996: Empirical Basis for Cardiac Psychology. (In: Allen, R and Scheidt, S eds. 1996: Heart and Mind. The Practice of Cardiac Psychology. Washington, DC: American Psychological Association, pp. 63-123.)

ANDERSON, H and GOOLISHIAN, H 1992: The Client is the Expert: a Not-Knowing Approach to Therapy. (In: McNamee, S and Gergen, KJ eds. 1992: Therapy as a Social Construction. London: Sage, pp. 25-39.)

ANTONOVSKY, A 1987: Unraveling the Mystery of Health: How People Manage Stress and Stay Well. San Francisco: Jossey-Bass.

ANTONOVSKY, A and SAGY, S 1986: The Development of a Sense of Coherence and its Impact on Responses to Stress Situations. **Journal of Social Psychology**, 126:213-225.

ARGYROS, A 1992: Narrative and Chaos. **New Literary History**, 23:659-673.

BECVAR, DS and BECVAR, RJ 1996: Family Therapy. Needham Heights, Mass.: Allyn and Bacon.

BERTAUX, D and KOHLI, M 1984: The Life Story Approach: A Continental View. **Annual Reviews of Sociology**, 10:215-237.

BLUMENTHAL, JA; BRADLEY, W; DIMSDALE, JE; KASL, SV; POWELL, LH and TAYLOR, CB 1989: Task Force III: Assessment of Psychological Status in Patients with Ischemic Heart Disease. **Journal of the American College of Cardiology**, 14(4):1034-1042.

BORDEN, W 1992: Narrative Perspectives in Psychosocial Interventions Following Adverse Life Events. **Social Work**, 37(2):135-141.

BRUNER, J 1987: Life as Narrative. **Social Research**, 54(1):11-32.

BURY, M 1982: Chronic Illness as Biographical Disruption. **Sociology of Health and Illness**, 4(2):167-182.

CARDIAC REHABILITATION GUIDELINE PANEL 1995: Cardiac Rehabilitation as Secondary Prevention. **American Family Physician**, 52(8):2257-2264.

CHAPMAN, LS 1986: Spiritual Health: a Component Missing from Health Promotion. **American Journal of Health Promotion**, (3):38-42.

CLARK, JA and MISHLER, EG 1992: Attending to Patients' Stories: Reframing the Clinical Task. **Sociology of Health and Illness**, 14(3):344-372.

DOAN, RE 1997: Narrative Therapy, Postmodernism, Social Constructionism, and Constructivism: Discussion and Distinctions. **Transactional Analysis Journal**, 27(2):128-133.

ERON, JB and LUND, TW 1993: How Problems Evolve and Dissolve: Integrating Narrative and Strategic Concepts. **Family Process**, 32(3):291-309.

FALLER, H 1990: Coping with Myocardial Infarction: A Cognitive-Emotional Perspective. **Psychotherapy and Psychosomatics**, 54:8-17.

FESTE, C and ANDERSON, RM 1995: Empowerment: from Philosophy to Practice. **Patient Education and Counselling**, 26:139-144.

FREEDMAN, J and COMBS, G 1996: Narrative Therapy. The Social Construction of Preferred Realities. New York: WW Norton.

GELATT, HB 1989: Positive Uncertainty: A New Decision Making Framework for Counselling. **Journal of Counselling Psychology**, 36:252-256.

GERGEN, KJ 1985: The Social Constructionist Movement in Modern Psychology. **American Psychologist**, 40(3):266-275.

GLASER, BG and STRAUSS, AS 1967: The Discovery of Grounded Theory. Strategies for Qualitative Research. Chicago, Ill.: Aldine.

GOVE, WR 1994: Why We Do What We Do: A Biopsychosocial Theory of Human Motivation. **Social Forces**, 73(2):363-388.

GUBA, EG and LINCOLN, YS 1981: Effective Evaluation. San Francisco: Jossey-Bass.

HEMINGWAY, H and MARMOT, M 1999: Psychosocial Factors in the Aetiology and Prognosis of Coronary Heart Disease: Systematic Review of Prospective Cohort Studies. **British Medical Journal**, 318:1460-1467.

HERMANS, HJ 1999: Self-narrative as Meaning Construction: The Dynamics of Self-investigation. **Journal of Clinical Psychology**, 55(10):1193-1211.

HEWSON, D 1997: Coping with Loss of Ability: "Good Grief" or Episodic Stress Responses? **Social Science Medicine**, 44(8):1129-1139.

JULKUNEN, J and SAARINEN, T 1994: Psychosocial Predictors of Recovery After a Myocardial Infarction: Development of a Comprehensive Assessment Method. **The Irish Journal of Psychology**, 15(1):67-83.

KEENEY, BP 1983: Aesthetics of Change. New York: The Guildford Press.

KEENEY, BP 1979: Ecosystemic Epistemology: An Alternative Paradigm for Diagnosis. **Family Process**, 18(2):117-129.

KELLY, GA 1955: The Psychology of Personal Constructs, Vol. 1: A Theory of Personality. New York: Norton.

KRIEL, JR 1996: Transforming Medicine's Clinical Method. Mini-dissertation submitted in partial fulfilment of the requirements for the degree of Master of Arts in Philosophy at the Rand Afrikaans University, Johannesburg.

KRUGER, D 1988: An Introduction to Phenomenological Psychology; 2nd ed. Cape Town: Juta.

LABARTHE, DR 1998: Epidemiology and Prevention of Cardiovascular Diseases. A Global Challenge. Gaithersburg, Maryland: Aspen Publishers.

LANGOSCH, W 1994: Cardiac Rehabilitation: Need for Psychological Input? **The Irish Journal of Psychology**, 15(1):84-95.

LAUNER, J 1996: 'You're the doctor, Doctor!': Is Social

- Constructionism a Helpful Stance in General Practice Consultations? **Journal of Family Therapy**, 18:255-267.
- LAZARUS, RS and FOLKMAN, S 1984: Stress, Appraisal, and Coping. New York: Springer-Verlag.
- LEE, RE and DWYER, T 1995: Co-constructed Narratives Around Being "Sick": A Minimalist Model. **Contemporary Family Therapy**, 17(1):65-82.
- MABECK, CE and OLESEN, F 1997: Metaphorically Transmitted Diseases. How Do Patients Embody Medical Explanations? **Family Practice**, 14(4):271-279.
- MAYKUT, P and MOREHOUSE, R 1994: Beginning Qualitative Research: a Philosophic and Practical Guide. London: The Falmer Press.
- McKIBBIN, EC 1994: An Analysis of the Risk Factors for Coronary Heart Disease in Patients Aged 55 and Younger with Proven Heart Disease. **Curationis**, 17(3):51-56.
- McKIBBIN, EC and WILSON, KG 2001: Affairs of the Heart: Patients' Personal Constructions of a Cardiac Event and Their Effect on Lifestyle Change. **Curationis**, 24(1):31-39.
- McNAMEE, S and GERGEN, J eds. 1992: Therapy as Social Construction. London: Sage.
- MERRIAM, SB 1998: Qualitative Research and Case Study Applications in Education. San Francisco, CA: Jossey-Bass.
- MERZ, CNB and ROZANSKI, A 1996: Remodelling Cardiac Rehabilitation into Secondary Prevention Programs. **American Heart Journal**, 132(2):418-427.
- MISHEL, MH 1990: Reconceptualization of the Uncertainty in Illness Theory. **Image: Journal of Nursing Scholarship**, 22(4):256-262.
- MOKHOKA, DM 2000: Black Women Diagnosed as HIV-Positive: their Psychological Experiences and Coping Mechanisms. (Unpublished Masters Dissertation. University of Pretoria.)
- NDEBELE, N 1998: Memory, Metaphor, and the Triumph of Narrative. (In: S Nuttall and C Coetzee eds. 1998: Negotiating the Past: The Making of Memory in South Africa. Oxford: Oxford University Press, pp. 19-28).
- NEUMAN, WL 1997: Social Research Methods. Qualitative and Quantitative Approaches; 3rd ed. Boston, Mass: Allyn and Bacon.
- ORNISH, D 1991: Dr. Dean Ornish's Programme for Reversing Heart Disease. London: Century.
- ORNISH, D; SCHERWITZ, LW; BILLINGS, JH; GOULD, KL; MERRITT, TA; SPARLER, S; ARMSTRONG, WT; PORTS, TA; KIRKEEIDE, RL; HOGEBOM, C and BRAND, RJ 1998: Intensive Lifestyle Changes for Reversal of Coronary Heart Disease. **Journal of the American Medical Association**, 280(23):2001-2007.
- ORTH-GOMER, K; HORSTEN, M; WAMALA, SP; MITTLEMAN, MA; KIRKEEIDE, R; SVANE, B; RYDEN, L and SCHENCK-GUSTAFSSON, K 1998: Social Relations and Extent of Coronary Artery Disease. The Stockholm Female Coronary Risk Study. **European Heart Journal**, 19(11):1648-1656.
- PENNEBAKER, JW 1993: Putting Stress into Words: Health, Linguistic, and Therapeutic Implications. **Behavior Research and Therapy**, 31(6):539-548.
- PENNEBAKER, JW and SEAGAL, JD 1999: Forming a Story: The Health Benefits of Narrative. **Journal of Clinical Psychology**, 55(10):1243-1254.
- PETCH, MC 1996: Triggering a Heart Attack. Editorial. **British Medical Journal**, 312:459-461.
- PETRIE, KJ; WEINMAN, J; SHARPE, N and BUCKLEY, J 1996: Role of Patients' View of Their Illness in Predicting Return to Work and Functioning after Myocardial Infarction: Longitudinal Study. **British Medical Journal**, 312:1191-1194.
- PILISUK, M and HILLIER PARKS, S 1986: The Healing Web. Social Networks and Human Survival. London: University Press of New England.
- RADLEY, A 1988: Prospects of Heart Surgery. Psychological Adjustment to Coronary Bypass Grafting. New York: Springer-Verlag.
- REAL, T 1990: The Therapeutic Use of Self in Constructivist/Systemic Therapy. **Family Process**, 29(3):255-272.
- RIESSMAN, CK 1990: Strategic Uses of Narrative in the Presentation of Self and Illness: A Research Note. **Social Science Medicine**, 30(11):1195-1200.
- RUDY, EB 1980: Patients' and Spouses' Causal Explanations of a Myocardial Infarction. **Nursing Research**, 29(6):352-356.
- SARBIN, TR 1984: Emotion: A Contextualist View. Invited address delivered at the meeting of the American Psychological Association, Toronto, Ontario, Canada, August.
- SCHLEBUSCH, L 2000: Mind Shift. Stress Management and your Health. Pietermaritzburg: University of Natal Press.
- SCHON, DA 1987: Educating the Reflective Practitioner. London: Jossey-Bass.
- SOWA, CJ 1992: Understanding Clients' Perceptions of Stress. **Journal of Counselling and Development**, 71:179-183.
- STEWART-BROWN, S 1999: Editorial. Emotional Well-being and its Relation to Health. **British Medical Journal SA Edition**, 7:192-193.
- STEWART, AL; GREENFIELD, S; HAYS, RD; WELLS, K; ROGERS, WH; BERRY, SD; McGLYNN, EA and WARE, JE 1989: Functional Status and Well-being of Patients with Chronic Conditions: Results from the Medical Outcomes Study. **Journal of the American Medical Association**, 262:907-913.
- STRAUSS, A and CORBIN, J 1990: Basics of Qualitative Research. Grounded Theory Procedures and Techniques. Newbury Park, CA.: Sage.
- STRUMPFER, DJW 1995: The Origins of Health and Strength: from 'Salutogenesis' to 'Fortigenesis'. **South African Journal of Psychology**, 25(2):81-89.
- VAN HESTEREN, F; SAWATZKY, DD and ZINGLE, HW 1982:

Conceptual Complexity and the Helping Relationship. **Canadian Counsellor**, 17(1):4-13.

VAN ZYL, A 2001: Die Impak van Koronêre Hartsiekte op die Lewe van Pasiënte: 'n Kwalitatiewe Studie. (Unpublished Masters Dissertation. University of Pretoria).

WALKER, ARP 2000: Editorial. Any Hopes of Coronary Heart Disease Incidence Falling in Western Populations? **Cardiovascular Journal of South Africa**, 11(5):258-260.

WALKER, ARP 1998: The Fascination and Challenges of Epidemiological Research. Editorial. **Cardiovascular Journal of Southern Africa**, (SAMJ Suppl. 1):C7-C8.

WHITE, M 1995: Re-authoring Lives: Interviews and Essays. Adelaide: Dulwich Centre Publications.

WHITE, M and EPSTON, D 1990: Narrative Means to Therapeutic Ends. New York: WW Norton.

WILSON, K 1999: 'The Line in the Sand has Blown Away'. (In: D Hook; K Smith; B Bowman and M Terre Blanche eds. 1999: From Method to Madness: Five Years of Qualitative Inquiry. Johannesburg: Histories of the Present Press. (CD-ROM Publication): 1-6.)

WINKATES, J 2000: The Transformation of the South African National Defence Force: A Good Beginning. **Armed Forces and Society**, 26(3):473-487.

WOODS, TE and IRONSON, GH 1999: Religion and Spirituality in the Face of Illness: How Cancer, Cardiac, and HIV Patients Describe their Spirituality/Religiosity. **Journal of Health Psychology**, 4(3):292-412.

YUSUF, S 2000: The Global Burden of Cardiovascular Disease: Time for a Truly Global Research Agenda. Cardiology at the Limits: State of the Art Lecture. Fourth annual meeting honouring the ongoing collaborative initiative between University College London and the University of Cape Town. 21st October. University of Cape Town.