Group Sessions during Rehabilitation after Myocardial Infarction

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Myocardial infarction (MI) has been found to be associated with considerable psychosocial morbidity which is persistent in a substantial proportion of cases[1-3]. A number of attempts to reduce the long-term morbidity has been made and in several studies group rehabilitation has been the treatment chosen[4-7]. The issues discussed in these groups have received little attention compared to evaluation of their efficacy by psychiatric and social measures. Ibrahim[3] found that post-coronary patients were unlike ‘usual’ group therapy subjects in that they were resistant to exploring feelings, and shifted discussion to medical and practical problems. Other workers[8, 9] cite discussion of death, sex, dependency and loss of self-esteem as frequently appearing in their groups.

In the present study, a total of 19 patients were seen in three different series of 12 sessions. The patients were assessed using psychosocial measures and the study was controlled. The results of these evaluations will be reported elsewhere[10]. This article is an account of some of the issues raised in the groups and is based on reports written after each session during consultation between the two group leaders.

The Groups

Patient Selection and Organisation of Groups

All the patients were male, under 70 years, married or cohabiting and had suffered a first definite myocardial infarct. The sessions were held weekly in the side room of a general medical ward for 1½ hours in the evening. A group was started when eight members had been recruited but because of irregular attendance each group usually comprised only four or five members. The interval between discharge from hospital and the first session varied from one week to five months.

For the first two series of 12 sessions the group leaders were a doctor (P.R.), and a female clinical psychologist (L.T.), and for the third series the leaders were P.R. and a female psychiatric social worker (E.U.). The approach used in the groups was non-didactic and supportive. Patients were encouraged to discuss the illness and any problems they were having, whether or not related to the heart attack. Mutual support was fostered, as was expression of feelings about their experiences. Information was provided when requested by group members. Before a patient attended his first group he was seen for about half an hour by the group leaders, together with his wife or cohabitee, to explain the nature and aims of the groups and give the couple a chance to ask questions and to discuss different aspects of the heart attack.

Meetings with Patients and Spouses

The wives appeared to value the opportunity to meet the group leader before the course of sessions and it was clear that many of them were very distressed about their husbands and uncertain about how best to help them. Some of the wives described severe tension, exhaustion and depression since the illness. Others had feelings of guilt that they had caused the infarct. This was sometimes linked with the thought ‘it’s my fault so it’s my special responsibility to get him better’. Other women felt anger and in the meeting attacked the husbands for neglecting themselves by, for example, smoking, and for failing to consider their family responsibilities. Others still, often with the patient’s agreement, reported no worry at all about the illness and no concern about the future. The majority of wives were concerned, saw themselves as managing the rehabilitation of their husbands and wanted specific advice on this. They felt anxious that the men would not co-operate with the restrictions, a typical statement being ‘I’ll have to hold him down with chains’. The wives felt that they lacked clear instructions on how much exertion their husbands could safely pursue and although a hospital hand-out on cardiac rehabilitation proved a useful reference, it was felt that additional instruction tailored to each patient should be made available.

Sex was not usually mentioned spontaneously but the subject was introduced deliberately by the group leaders. Several couples had not been sexually active for some years, but other wives had worried that sex might cause damage and had decided to resist sexual advances by their husbands. They seemed particularly relieved when informed that the illness did not preclude sexual intercourse. Some of the women wanted to know if their husbands could stand an argument (‘Should I pamper him or can I have a go at him?’) and advice on when to take action if their husbands had chest pain was requested—(‘How do I tell the difference between a heart attack and angina?’).
Processes Observed in the Groups

Support. The support given by group members to each other was described as especially valuable by several patients. One patient who was still smoking after his MI was strongly encouraged by the group to give up and he managed to change to cigars. Sometimes the help was simply to raise morale, and the presence of one philosophical and humorous Irish patient served to raise the spirits of the whole group.

The most frequently mentioned benefit of group support was that it eased the isolation many patients felt. They reported that they were treated by their families and social contacts as invalids likely to expire and this inhibited them from discussing any physical or emotional problem at home for fear of eliciting restrictions and over-protectiveness. In addition, they felt that their families needed them to continue to be strong and dependable and that any show of weakness would be unacceptable. The group was the only place where they could freely discuss problems and it was particularly valued for this reason.

Difficulties. Our approach did not prove acceptable to all patients. Some wanted a course of lectures and exercise training. They tended to be younger men who disliked discussion of illness and the feelings associated with it and wanted to forget about the infarct. Some patients were so anxious about their hearts that they were unable to tolerate discussion of medical problems. One such individual defaulted from the group and received individual psychiatric treatment.

A few difficulties were encountered in the running of the groups. Some group members gave long-winded accounts of their jobs or medical problems and monopolised the time. Others were persistently discouraging to a group member and sometimes the group leaders were attacked by one or two members. Lastly, it became apparent in later sessions that a degree of dependency on the group had developed, and some care was necessary in negotiating the end of treatment. The final session of one series was complicated by the admission a few hours before of one of the group members with a fatal infarction. Discussion of this naturally dominated the session, leaving little time for terminating the treatment.

Issues Arising in the Sessions

Unlike previous workers, we found little difficulty in encouraging discussion of feelings in our post-infarct patients. In the first few sessions of each series, the men were reluctant to express anything but gratitude for the medical attention they had received, partly out of deference to the doctor present, whom they viewed as a representative of the hospital. Subsequently, however, they were less inhibited. The presence of a female co-leader occasionally seemed to prevent a patient revealing his feelings. One man, who was unable to show any weakness with his family, behaved in a provocative and flirtatious manner with the female co-leader, only admitting to feelings of depression and loss of stature when she was away for a week.

While discussing different phases of the illness, the men described feelings of fear, depression, dependency, gratitude and hostility.

Fear and Anxiety

At the onset of the MI. The most frequently reported feeling was fear. This began at the onset of the chest pain and in several patients was accompanied by denial which was usually only partly successful. For example, a patient with chest pain decided that it was due to indigestion, but that he would go to a hospital some miles away for a check-up. On the way he ran up two flights of stairs thinking that if the pain was cardiac the exercise would be fatal. Having survived, he felt reassured. Some avoidable experiences in hospital served to increase anxiety. One patient, lying in casualty, glimpsed a corpse in the next bay and spent that evening weeping secretly about it. Another developed his MI during an exercise ECG and acquired complete heart block during a painful and unsuccessful attempt at venous cannulation. When the doctor who had presided over both of these misfortunes arrived to insert a temporary pacing wire, the patient was naturally very apprehensive but felt unable to express his worries for fear of antagonising the hospital staff.

After admission. Most patients felt relatively safe once in the coronary care unit, but the move from there to the general ward was attended, in many cases, by a marked increase in anxiety. One man, two days after the move, felt he was not getting enough supervision so he left the ward to call the coronary care unit from the hospital's pay phone, and asked advice from the sister who had cared for him there.

Information and advice, presumably intended to be reassuring, sometimes had the opposite effect. A patient who was told that as only one artery in his heart was blocked he did not need an operation, concluded that, as nothing could stop the other arteries blocking in the same way, the doctor was deceiving him and he was heading for disaster. Another patient was told that he need not worry, as his chest pain was coming from his ribs. This led him to worry about having bone cancer. Two patients who had agreed to coronary bypass surgery which, they were told, could avert or delay further infarcts, were dismayed to learn that they would have to wait up to three months, during which time, they observed, they could have another possibly fatal attack.

After discharge. Most of the men described feelings of vulnerability, especially when going out. In one patient fear of being struck on the heart led him to stay indoors after dark. Another patient, who had been fitted with a permanent pacemaker, said that he was afraid someone could hit and damage it, and that he would like to have a breastplate. This was adopted as a metaphor by the other group members and they described how they protected themselves against stress. Some deliberately withdrew from any potentially upsetting experiences such as an argument, one passed all difficult problems to his wife, and most of the men used denial to some extent. This was
often not effective. Patients would deny being worried by, say, the sudden death of a colleague, only to admit the following week how shocked they had been. Some patients denied that they associated heart attacks with death and said that they deliberately disregarded doctors' advice on diet and exertion. Patients were sometimes able to distance themselves from the experience of the heart attack. One described how, in casualty, he had imagined that the attack was happening to someone else—entering a state of apparent depersonalisation.

Dependence

In coronary care. A feeling linked to anxiety, frequently expressed, was dependence, which occurred at every stage of the illness. In the coronary care unit the men felt safe and protected. One described the cardiac monitoring leads as his 'umbilical cord'. While in this state of dependence, the men were often conscious that they looked and felt quite well and experienced some guilt because of the substantial care and attention they were receiving.

In the general ward. The move to the general ward was received with a mixture of hope about the progress made and apprehension. Some patients were afraid that their beds were too far from the nurses' station, should they collapse during the night. There was a fear that they were being generally less well looked after, exemplified by the patient already referred to who called the coronary care unit, and another who was critical of the standard of the work of the cleaners on the ward.

After discharge. Several patients said that they had not adjusted to the less intense level of nursing care in the general ward when they were told they could leave hospital. They felt unprepared to go and would have welcomed a prolongation of their stay by a few days to adjust to the idea of coping outside. For many the hospital buildings acquired a special protective significance. Patients who were starting to go for walks made sure that the route went round the hospital. One entire session was spent in discussing how each of the group members could get a job in the hospital. As indicated, a degree of dependence on the group developed, partly because it provided a reason for spending time in the hospital, in which the patients felt safe. There was a somewhat idealised belief that once they were within the hospital walls, whatever happened, they would be saved. A patient who had a permanent pacemaker expressed a similar feeling when he said that because of the pacemaker his heart could never stop. The link with the hospital was sometimes represented symbolically. One patient came to the group six weeks after discharge, still wearing his hospital identity bracelet. The nurses had told him to remove it when he got home and he had started to do so several times, but had been unable to. After a short readmission for cardiac catheterisation, he came to the group wearing two bracelets. He admitted to feeling very dependent on the hospital, idealised the medical and nursing staff and always defended them if other patients were critical.

Attitudes to Medical Care

Hospital. Most patients felt very grateful to the hospital and many said that they would have died but for the hospital treatment. They were especially impressed by the efficiency of their initial treatment in hospital, and by the special cardiac investigations that a number had undergone. Some patients remembered comprehensive information and advice being imparted by the doctors, while one said how much he had learnt about his condition while being used as a subject in a consultant's teaching round. There were some expressions of dissatisfaction, ranging from puzzled acceptance of what had happened to fairly marked anger. Some patients complained that they had not had an adequate talk about rehabilitation and that they would have welcomed advice on exertion, work, recreation and sex. Some were given tablets on discharge, but did not appear to know what they were for or whether to have them re-prescribed when the supply ran out. They usually accepted the absence of such information as the inevitable result of doctors being overworked, but expected to have their questions answered at the first out-patient visit. Some were disappointed, however, to meet a hitherto unknown doctor, after a wait which was sometimes prolonged to several hours, and to have a rushed consultation with little opportunity to discuss the matters that were of serious concern to them. One man was surprised to be discharged from the clinic without having discussed returning to work, but was quite pleased, as he was far too apprehensive to consider going back to his stressful job. Another was assured that the coronary bypass operation would allow him to return to work as a milkman; this was somewhat disturbing to the patient, who had entirely attributed his heart attack to the exertion and stress involved in his job. The marked differences in treatment of patients which emerged were a source of some concern to those who felt they had been relatively neglected. One patient wondered why he had not received the hand-out, exercise test, talk from the doctor, or even the identity bracelet, which other patients had described.

General practitioner. Attitudes to family doctors were also diverse. A number of patients felt that it was no use attending the GP without having physical symptoms to talk about, because to do so would run the risk of being labelled 'neurotic and a nuisance'. One patient described how impressed he was at the bulky notes written on him in hospital by no less than three doctors. With this mass of information, he felt, the hospital had a much better chance of sorting out his problems than his GP. Others, however, evidently regarded their family doctors as a more dependable source of information and support than the hospital.

Discussion of Various Aspects of the Infarct

Most patients spent a considerable time in the groups talking about what had caused the heart attack, what the symptoms had been, and how they would prevent another.
Assigning a cause. This seemed most important. One patient commented that if you knew the cause, you could do something about preventing another attack. The patients could be divided according to whom or what they saw as responsible for the MI. Some blamed themselves. One attributed his heart attack to ‘too much alcohol, tobacco and sex’ and felt he had started building up to the illness at the age of 16. Other patients blamed overwork, and one diabetic blamed himself for persistently cheating with his diet. In contrast, another group of patients attributed the MI to forces outside themselves, in some cases spouses, in one case years of persecution in his country of origin.

Physical symptoms. Most of the patients described physical symptoms which worried them. Some had been to see doctors repeatedly, but had not felt reassured. However, a man with palpitations stopped worrying about his symptoms, which actually persisted, when a 24-hour ambulatory ECG tape was pronounced to be normal. Some patients had serious symptoms which they ignored. One fairly young man had prolonged cardiac chest pain while riding. He did not seek advice for this and resumed riding even more vigorously when the pain abated.

Preventing another attack. Prevention was a major concern of the men. Some had already made modifications to their lives such as reducing smoking and cutting down work commitments. Others said that they wished to avoid another attack, but admitted that any instructions from the doctors would be ignored—and might even have the opposite effect. Others felt that the influences which had led to the first attack were still operative and out of their control—and that they were heading inexorably for another infarct. As in the case of assigning the cause of the heart attack, means for preventing a recurrence were seen as residing either within the power of the patient, or outside. The former group relied on changes in their habits and recognised the limited abilities of doctors to restore health. The latter patients, however, relied entirely on the hospital staff, idealised them, and depended on them to make decisions affecting many areas of their lives.

Conclusions
According to the patients, the groups appeared to serve a number of functions. They provided a forum for discussion of problems that was not available elsewhere. Patients were able to learn from the professionals and, to a greater extent, from each other, by exchanging experiences. Exploration of feelings, particularly of anxiety and dependence, was seen by the men as helpful, as was discussion of aspects of medical treatment.

The degree of dependence reported was striking and seemed to be one of the major obstacles to early rehabilitation. In most cases it resolved, but in a few patients it persisted and further psychiatric treatment was required.

The meetings with spouses confirmed that their need for support was at least as great as that of their husbands. It was clear from statements in the group sessions that wives’ participation, either in the groups with the patients, or in separate ‘spouse groups’ would have been welcomed.

The effectiveness of the groups as treatment cannot be assessed in a descriptive account. However, in addition to noting that patients saw the groups as beneficial, it may be said that they provided useful experiences for the group leaders, and could potentially act as a source of consumer feedback for the hospital staff.

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