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**THE MEANING OF SOCIAL SUPPORT:
THE PERSPECTIVE OF ARAB CANADIANS
WITH CONGESTIVE HEART FAILURE**

By:

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Thesis submitted to the School of Graduate Studies and
Research in partial fulfillment of the requirements for the
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ABSTRACT

The incidence of congestive heart failure (CHF) rises annually and, despite advances in medical treatments, the prognosis remains poor. Since CHF has no cure, the treatment is mostly supportive symptom management and prevention of exacerbation. Studies examining the impact of social support on CHF have found that social support helps to prevent hospitalization and helps patients with CHF adhere to the prescribed medication and lifestyle changes. The purpose of this study was to explore the meaning of social support to Arab Canadians with CHF. The Arab immigrant population is at risk of many health problems because of traumas associated with the immigration experience and limited knowledge of a complex health care system. The qualitative method of particularistic ethnography was used to gain a better understanding of the meaning of support in this cultural group. In depth, semi-structured, audio-taped interviews were conducted with a sample of 7 Lebanese Christian participants. The data analysis revealed 3 themes: "My family will take care of me"; "I rely on God"; and The illness is not important. Nursing implications and recommendations have been proposed to address the needs of this cultural group.

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CHAPTER 1: INTRODUCTION

1.1 Background to the study

Congestive heart failure (CHF) is a complex clinical syndrome that results from the inadequacy of the pumping action of the heart to supply the metabolic needs of the body (Shapiro & Brundage, 1994). The resulting clinical symptoms include shortness of breath, fatigue and fluid retention. These symptoms affect the functional capacity and quality of life of individuals with CHF. In most cases, CHF progresses to become chronic and increasingly severe until symptoms appear at rest or with minimal exertion (Advisory Council To Improve Outcomes Nationwide in Heart Failure [ACTION HF], 1999).

The incidence of CHF rises annually and, despite advances in medical treatments, the prognosis remains poor. Annual mortality rates range from 10% in stable patients to 50% in patients with advanced, progressive symptoms (Agency for Health Care Policy and Research [AHCPR], 1998). Since CHF has no cure, the treatment is mostly supportive symptom management and prevention of exacerbation.

Social support has been studied extensively by various disciplines during the past three decades and there is evidence to suggest that perception of social support can

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influence psychosocial adjustment to illness (Lazarus & Folkman, 1984). Cohen and Wills (1985) described several components of social support that include emotional, instrumental, informational, and appraisal support, while Oxman and Berkman (1990) examined the structure and composition of the social networks.

Social support has been studied in patients with various cardiovascular diseases. Lack of social support has been found to contribute to psychological deterioration and illness (Schaefer, Coyne, & Lazarus, 1981), increased risk of mortality after a myocardial infarction (Berkman, Leo-Summers, & Horwitz, 1992), and increased early readmission or death in patients with congestive heart failure (Chin & Goldman, 1997; Jaarsma, Halfens, and Huijjer-Abu Saad, 1996). "When clinical prognostic indicators of survival were controlled, patients without support had three times the mortality risk of those with at least one supportive person" (Berkman et al., 1992, p.1005).

In a selected review of the literature on social support, stress, and illness, social support was found to help prevent hospitalization (Oka, Gortner, Stotts, & Haskell, 1996) and to promote adherence to the prescribed medication and lifestyle changes (Backeland & Lundwall, 1975; Happ, Naylor, & Roe-Prior, 1997; Stromberg, Brostrom, Dahlstrom, & Fridlund,

1999). However, because these studies reflect the effects of social support on patients from Western cultures, it makes it difficult to draw any firm conclusions about other cultures and ethnic groups.

One such group is the Arab Canadian immigrant population. This population is at risk for many health problems because of traumas associated with the immigration experiences, cultural conflicts, loss of social support systems, and limited knowledge of a complex health care system (Laffrey, Meleis, Lipson, Solomon, & Omidian, 1989).

The researcher is Arab Canadian and was especially interested in the health beliefs and perceptions of this ethnic group. Arabs bring with them many cultural beliefs, attitudes, language expressions, perceptions, and patterns of communication that arise from within the context of their own culture that might not correspond to the Western Canadian context.

Fridlund, Stener-Bengtsson & Wannman (1993) citing Kaplan (1977) state, "the social network and social support form a safeguard against ill health and disease - the greater the number of links in the network, the greater the health protectiveness of social support and the greater the support functions of the links, the more health protective the network" (p.88). However, with respect to Arab Canadian

immigrants, little is known about their perception of social support when facing illness.

Nurses are being challenged daily to care for patients from parts of the world where cultural values and beliefs may differ from those of Western cultures. In order to provide culturally competent care, nurses need to recognize that although they are knowledgeable about the health care system, clients are experts in terms of their own cultures and what makes them comfortable (Lipson & Meleis, 1985).

1.2 Purpose of the study

The purpose of this qualitative inquiry was to explore the meaning of social support to the Arab Canadian patient with congestive heart failure. The researcher, being a cardiac nurse of Arabic origin, was interested in the meaning that participants attached to social support and heart failure, as well as whom they included in their support network and what interactions they considered supportive.

CHAPTER 2: REVIEW OF THE LITERATURE

This chapter will begin with an overview of the Arab immigrant population of Canada. A selected review of the literature on CHF, social support, and culture will follow.

2.1 Arab Canadians

According to Statistics Canada (1998), the 1996 census revealed that 44.6% of the population of Canada is not of English or French origin, and by the year 2000, one in every five Canadians will represent a visible minority. Ottawa-Hull, considered by Statistics Canada one of the most culturally diverse populations of the nation, is home to 12% of the visible minority population of Canada.

One of these groups is the Arab Canadian population. In 1996, this population numbered 120,000 in Ontario alone, representing 52% of the Arab Canadian population of Canada, more than 26,000 of whom lived in the Ottawa-Hull area (Statistics Canada, 1998). However, unofficial sources at the Lebanese and Arab Social Services Agency in Ottawa revealed that these numbers would be higher if they were to capture many of those who have acquired the Canadian citizenship and assimilated into the culture. Statistics Canada (1998) also reported that, after English and French, Arabic is the third

most spoken language in Ottawa-Hull.

An Arab is defined as "any person who resides in the area stretching from Morocco to the Gulf of Oman, who speaks Arabic, and who takes pride in the Arabic culture and the Arab's historical accomplishments" (Luna, 1995, p.319). Arabic countries, that belong to the League of Arab states (See Appendix A: Map of North Africa and the Middle East), include: Algeria, Arab Emirates, Bahrain, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, and Yemen (Hourani, 1991). Even though 90% of Arabs are Muslim, they represent only 25% of the Muslim population of the world and, thus, being a Muslim should not be equated with being an Arab (Naff, 1980). Arab Christians, such as the Maronites of Lebanon, the Copts of Egypt and the Chaldeans of Iraq constitute 10% of the population of the Arab countries. Arab Canadians are those of Arabic descent who speak Arabic and identify with the Arabic Culture. Their view of the world around them is directly affected by their cultural values and expressions (Luna, 1995).

Of interest, most of the literature that talks about Arabs in North America concentrates on Arab Muslims such as the works of Luna (1995) and AbuGharbieh (1998). However, Naff (1983) identified that 90% of Arab immigrants to North America

were Christian and 10% were Muslim.

Naff (1983) divided the pattern of immigration from the Arab world to the Americas into three waves. Many of the ancestors of the current third and fourth generation Arab Canadians constituted the first wave of immigrants. They arrived into North America in the late nineteenth century and early twentieth century to escape the Ottoman Empire. The second wave of immigrants was after the Second World War following the partition of Palestine. The third wave of immigration was after the 1967 Arab-Israeli war and during the civil war in Lebanon in the 1970s and 1980s.

2.2 Congestive heart failure

According to Health Canada (1997), cardiovascular diseases accounted for 38% of the deaths in Canada in 1994. Heart failure accounted for 7% of deaths in women and 4% in men with cardiovascular disease. In 1994, in Canada, hospitalization due to cardiovascular disease accounted for the highest cost in health care with women spending 3.1 million days in hospital and men 3.4 million days (Health Canada, 1997).

2.2.1. Etiology

In describing the etiology of heart failure, ACTION HF

(1999) stated, "Heart failure is a complex clinical syndrome that can result from any cardiac disorder that impairs the ability of the ventricle to eject blood" (p.2A). Coronary artery disease is recognized as the cause in two-thirds of the patients with this syndrome. Eighty to ninety percent of patients with heart failure have symptoms such as dyspnea, fluid retention, and fatigue that are caused by impaired left ventricular function (ACTION HF, 1999).

2.2.2. Management

ACTION HF (1999) outlined general measures for the management of CHF to include the following:

1. Measures to decrease the risk of new cardiac injury.

These include cessation of smoking; weight reduction for obese patients; control of hypertension, hyperlipidemia, and diabetes mellitus through diet and medication; and discontinuation of alcohol use.

2. Measures to maintain fluid balance. These encompass salt restrictions in the diet and diuretics.

3. Measures to improve physical conditioning. These include moderate physical activity and exercise.

4. Other Measures. These relate to specific measures for select patients such as the use of anticoagulation therapy, coronary re-vascularization, treatment of

arrhythmias, avoidance of certain pharmacological treatments, influenza and pneumococcal immunization, and close outpatient follow-up.

2.2.3. Research studies

The section will begin with an overview of studies describing the process of becoming a patient with CHF, and end with an examination of the problem of high re-admission rates.

A grounded theory study examined the process of becoming a patient with heart failure. Twenty-one patients were selected from an outpatient cardiology department in northeast Ohio (Stull, Starling, Haas, & Young, 1999) and were interviewed in the clinics during routine visits to their cardiologists. The study revealed that the process of becoming a patient with heart failure is gradual and includes five distinct phases of identity formation: i) a crisis event, ii) the diagnosis, iii) the patient's and family's response to the diagnosis, iv) the acceptance and adjustment to life with this condition, and v) the making of the decision to get on with life.

As part of getting on with life, patients with CHF need to engage in some self-care practices such as daily moderate exercise and low-salt diets. A non-experimental correlational study conducted with 209 patients diagnosed with CHF in six

hospitals in southern California revealed that patients with higher education and those who were symptomatic were more likely to engage in self-care practices (Rockwell & Riegel, 2001).

A phenomenological study, which looked at how patients with congestive heart failure conceived their sleep situation, was conducted with twenty participants in a medical ward, a cardiology ward, and a specialist clinic (Bromstrom, Stromberg, Dahlstrom & Fridlund, 2001). The interviews revealed that patients' sleep patterns were affected by their daily activities, the disease itself and cardiac symptoms. This caused the patients to feel fatigue, listlessness, loss of concentration, and loss of temper. The study also concluded that patients handled their sleep disturbances, through support from their psychosocial environment, by adjusting their patterns of daily living.

Heart failure is the most common discharge diagnosis for patients over 65 years of age (Happ et al., 1997). Vinson, Rich, Sperry, Shah and McNamara (1990) reported that hospital readmission rates for persons with CHF were as high as 47%, three to six months after discharge. They also reported that 53% of these readmissions were preventable and might have been affected by such factors as non-compliance with medications, non-adherence to diets, failure to seek help early, inadequate

discharge planning, inadequate follow-up, and inadequate social support.

Jaarsma et al. (1996) conducted a review of the literature on factors associated with hospital readmission of older patients with heart failure. The review concluded that socio-demographic and medical factors had a direct effect on re-hospitalization. These factors included age, gender, severity of the illness, premature discharge, failing support system, medication-related problems, and non-compliance with treatment regimens.

A study was conducted by Tsuchihashi et al. (2001) with 230 patients in Hiroshima, Japan, discharged from the hospital with a diagnosis of CHF. The study identified poor follow-up visits, previous admission with CHF, no occupation, longer hospital stay, and hypertension as significant predictors of readmission.

The readmission rate was found to be the same in men and women in a retrospective study conducted with 2445 patients admitted with congestive heart failure to 18 hospitals in Connecticut in 1994 and 1995 (Vaccarino, Chen, Wang, Radford, & Krumholz, 1999). The study revealed that men and women hospitalized with heart failure had similar hospital course, treatment pattern, and re-admission rates but women lived longer than men. However, Bennett, Baker, and Huster (1998)

found that women who reported greater physical symptom impact and poorer perception of their health status had a lower quality of life.

The literature review will continue with a focus on social support and its impact on health and illness.

2.3 Social support

This section will begin with a review of selected definitions of social support, followed by a review of theoretical underpinnings, types of social support, and the impact of social support on health and illness.

2.3.1. Theoretical underpinnings of social support

Social support has been studied extensively by various disciplines during the past three decades from the perspective of its role in altering susceptibility to illness and its influence on treatment and rehabilitative efforts after diagnosis (McCauley, 1995). However, "although there are areas of agreement regarding definitional aspects of social support, no single definition is completely agreed upon by writers in this field" (Dimond & Jones, 1983, p. 235).

Cobb (1976) conceived social support as information leading the individual to believe he or she is cared for and loved, is esteemed and valued, and belongs to a network of communication and mutual support. Cobb's definition implies

reciprocity where the individual might feel obligated to return the supportive interaction at some time in the future.

Social support has also been defined as the expression of positive affect of one person towards another (emotional); the affirmation or endorsement of another person's behaviors, perceptions or expressed views (esteem); and/or the giving of symbolic or material aid to one another (material) (Antonucci, 1985; Kahn & Antonucci, 1980). These authors also stressed that personal networks change throughout the life span.

Dimond and Jones (1983), in a review of the literature on social support, were also able to summarize and organize social support into four major definitional categories. These described support as relational provisions, information, structure, and interaction.

Cohen and Wills (1985) and Langford, Bowsher, Maloney and Lillis (1997) conducted a conceptual analysis of social support. They were able to identify four defining attributes of social support, under which all acts of support can be assigned. These are:

- Emotional support, or affective assistance that involves the provision of caring, empathy, love and trust;
- Instrumental support, or concrete assistance, the provision of tangible goods, services, and aid;
- Informational support, the information provided to another

during a time of stress in order to assist in problem solving; and

- Appraisal support, or affirmational support, the communication of information that is relevant to self-evaluation rather than problem solving.

Barrera (1986), on the other hand, distinguished between two aspects of social support: the cognitive or perceived aspect and the behavioral or received aspect. Callaghan and Morrissey (1993), in a review of the literature on social support, found that the perception of its availability was more valuable than the reality of it actually being received. The perceived availability of social support was actually believed to reflect a latent dimension of coping since it tended to govern the behavior when a situation was perceived as stressful (Gibson, 1992). Stewart (1989, p. 272) defines perceived social support as "the cognitive appraisal of being reliably connected to others".

Furthermore, Oxman and Berkman (1990) concluded that the dimensions to social relationships include the quantitative structure and composition of the social network, the type and amount of social support functions the network provides, and the qualitative perceived adequacy of that support.

For the sake of this study, social support is defined as

"interactions with family members, friends, peers, and health care providers that communicate information, esteem, aid, and reliable alliance. When these communications are perceived as supportive, they may enhance coping, moderate the impact of stressors, and promote health. Social support occurs as a byproduct of people's ongoing interactions" (Stewart et al, 1997, p.95).

Langford et al. (1997) reviewed the social support literature for the most frequently used theories. Using the process of concept analysis designed by Walker and Avant (1995), they reviewed 85 articles. The theoretical foundation they concluded from their search included three theories.

Social Comparison Theory

According to Swann and Brown (1990), persons develop their self-concept by comparing themselves to others in their chosen reference group. This aids in the development of self-concept, and enhances coping abilities, emotional adjustment, self-esteem and psychological well being (Stewart, 1993).

Social Exchange Theory

Stevens (1992) identified a positive relationship between life satisfaction and the receiving and giving of social support. This implies some degree of social competence.

Social Competence Theory

Stewart (1993) suggests that social competence, the ability to effectively interact with the environment, is essential to the formation and maintenance of relationships, which are an essential part of social health. "If social competence is decreased or inadequate, a sense of social isolation may ensue, only to produce a state of negative psychological and, subsequently, physiological health" (Langford et al., 1997, p.96).

Gibson's (1992) conceptualization of social support was built on the premise that "very few people can live without some kind of social relationship with others, and that the need for social support is universal, to deal not only with day-to-day events but also with times of crisis, change and transition" (Gibson, 1992, p. 147). She viewed social support as a multidimensional concept with functional, structural and interactional properties. Functional social support, whether verbal or instrumental, addresses the individual's perceptions of adequacy of resources provided by others. Structural aspects include size, homogeneity, stability, and degree of closeness, while the interactional properties examine the relationship between the individual's perceived need for social support and the actual support received. Stressing the fact that social support cannot be viewed as a separate

entity, Gibson conceptualized social support in terms of personal and situational characteristics as well as stressful life events and coping. These concepts affect and are affected by each other.

Key personal characteristics in this framework include age, gender, culture, religion, marital status, socioeconomic status, as well as personality traits such as social competence, sense of control, self-esteem, and coping style. These personal characteristics have a direct influence on resources available in a certain stressful situation or the perceived demands of that situation. Gibson called these demands and resources "Situational Characteristics".

Gibson also stressed that an important aspect of social support is how it is perceived and evaluated. Thus, social support has an influence on one's appraisal of the health process and, consequently, on well-being as an outcome.

2.3.2. Impact of social support on health and illness

Regardless of how social support is defined, it is generally agreed that it functions to buffer or protect individuals from the effects of many kinds of life stresses. "Individuals with strong social support are thought to be more able to cope with stressful life events than those with weaker social support who are thought to be vulnerable" (Callaghan &

Morrissey, 1993, p 206).

The social support of a patient plays an integral part in his/her recovery, adaptation, and rehabilitation. "A large body of literature is accumulating that demonstrates both main and interactive associations between stressful life events and social support. Taken alone, no one study is completely convincing. Taken together, the results are impressive and sufficiently encouraging to warrant further investigation" (Dimond & Jones, 1983, p.241).

A complete review of studies on social support prior to 1983 was conducted by Cohen and Wills (1985). The purpose of the review was to consider the process by which social support affects well-being. The authors organized the studies as to whether they assess the existence of supportive relationships and the extent to which these relationships provide particular resources as well as the degree of specificity of the scale used. The researchers were especially interested in whether each of the studies recognized that support protects or buffers persons from potential stressful events (buffering model) or whether support has a beneficial effect regardless of the presence of stress (main-effect model). The review concluded that both models could be supported by the literature. There is evidence that support has a generalized beneficial effect when the person receives regular positive

and stable experiences from the support network. Furthermore, adequate or perceived support acts by preventing or alleviating the impact of stress, thus, buffering its effect.

The impact of social support on chronic illness in general will be highlighted with a review of recent studies. White, Richter, and Fry (1992) conducted a study into the impact of potential stressors, coping strategies and perceived social support on the psychosocial adaptation of women with diabetes mellitus. One hundred and fifty eight women completed a combination of instruments that measured stressful life events (Family Inventory of Life Events), health (instrument developed by researchers), coping strategies (Ways of Coping Questionnaire), social support (Personal Resource Questionnaire), and psychosocial adaptation (Psychosocial Adjustment to Illness). The results showed that the greater the perceived social support, the better the psychosocial adjustment to the illness; and that lack of social support might contribute to deterioration in health.

These findings were confirmed in a descriptive study conducted by Hellman & Stewart (1994) who interviewed 57 recently discharged home health care clients who were elderly to examine aspects of their instrumental social support. One of the purposes of the study was to investigate whether the sources of support were associated with physical and mental

health outcomes. The study revealed that there was a trend towards positive mental and physical health outcomes, such as improved mental health, when family and friends provided social support.

The social support networks of patients awaiting cardiac transplantation were explored in a study conducted with thirty-one individuals in four Canadian transplant centers (Hirth & Stewart, 1994). The participants completed questionnaires regarding social support (Norbeck Social Support Questionnaire), hope (Miller Hope Scale), and coping (Jalowiec Coping Scale). The study revealed that the patients were found to utilize their social support as a coping mechanism during the waiting period. Family and friends were the most commonly reported sources of support, followed by health professionals, previous transplant recipients and clergy.

2.3.3. Impact of social support on heart failure

The impact of social support was also well studied within the context of a diagnosis of congestive heart failure. Some of these studies are presented below.

Stromberg et al. (1999) conducted a qualitative research study to identify factors influencing compliance with prescribed treatments in patients with congestive heart

failure. They interviewed 25 patients selected from a primary health care clinic, a medical ward and a specialist clinic. The researchers were able to identify two main areas that affected compliance: inward factors and outward factors. Inward factors described how the disease, the treatment, and the personality of the patient influenced compliance. Outward factors included social relationships, social activities, and health care providers.

Evangelista, Berg, and Dracup (2001) attempted to examine the relationship of social support to compliance with treatment regimens of congestive heart failure. Eighty-two participants were recruited from an outpatient clinic in Los Angeles. The researchers interviewed the participants using the Heart Failure Compliance Questionnaire. Five additional instruments, used to gather data on patients' psychosocial health status and perceived social support, were given to the participants to complete at home and mail back to the researcher. The researchers could not draw conclusions about the effects of social support as more than 90% of the patients lived with a significant other and the results of the social support questionnaire revealed that all patients had a strong support system.

Friedman & King (1994), however, found that tangible and emotional support affected the psychological well-being of a

sample of eighty older women with heart failure. For this qualitative study, the participants were interviewed in their homes following hospitalization for heart failure. Emotional and tangible support were found to have a direct effect on the psychological well-being of the patients. The patients, however, did not seek informational support from family and friends. Most women felt they were the best judge of their abilities and indicated that the best source of information was the health care provider.

Friedman (1997) went on to study the sources of support among older women with heart failure and the continuity of the support over time. In a longitudinal study, the researcher interviewed 57 older women after their discharge from the hospital. The patients identified spouses as the most stable source of emotional and tangible support. Women with children also identified their children as a stable source of support. In addition, the study showed that older women with heart failure who did lose a source of primary support, frequently attempted to replace the lost source with another from their informal support network.

On the other hand, the lack of social support was found to have negative health outcomes in a sample of 194 elderly patients after a myocardial infarction (Berkman et al., 1992). In a prospective, community-based cohort study, social

support, age, gender, race, education, marital status, living arrangements, presence of depression, smoking history, weight, and physical function were assessed using questionnaires. The study revealed that patients who did not have anyone to rely on for emotional support, had twice the risk of death compared to those who had two or more sources of support.

Happ et al. (1997) also examined the negative effects of the lack of social support. They conducted a qualitative data analysis of the charts of a sample of 16 elderly patients with heart failure admitted to an acute care facility. The researchers reviewed Advanced Practice Nurses (APN) logs, physicians' notes, and medical record summaries. The study revealed that the lack of social support contributed to non-adherence to treatment regimens. On the other hand, supportive family and friends and individual motivation emerged as factors preventing non-adherence and re-hospitalization.

These findings confirmed Jaarsma et al.'s (1996) findings that a failing social support system contributes to increased re-hospitalization.

The next section examines culture and its relationship to health and social support.

2.4 Culture

More people are experiencing firsthand what global living

and multicultural communities mean, as immigration and migration become a normal way of life in many parts of the world. Multicultural living has sensitized us to consider that there are different worldviews and realities. Culture is defined by Leininger (1995, p.60) as, "the learned, shared and transmitted knowledge of values, beliefs, norms, and lifeways of a particular group that guides an individual or group in their thinking, decisions, and actions in patterned ways".

Meleis (1991) found that members of the host culture for the most part did not understand the immigrant's ways of acting and reacting, and usually did not support immigrants' attempts to cling to their values and beliefs. Immigrants were also under careful scrutiny by their own communities. Members of their country of origin carefully monitored actions and reactions, judging them to be fit or unfit to belong to that group based on whether or not they were able to maintain and guard their original identity.

As health professionals deal increasingly with a varied ethnic clientele, there is heightened sensitivity that everything from disease risk to compliance with drug regimens is directly affected by cultural background. Many studies have contributed to a growing body of evidence that supports the influence of cultural or ethnic beliefs and values on health and illness. These studies will be explored in this section

following the introduction of the Theory of Cultural Care.

2.4.1. The Theory of Cultural Care

Nurses are being challenged daily to care for patients from parts of the world where cultural values and beliefs may differ from the profession's values in Western cultures. Providing care that is culturally sensitive is no longer a luxury; it is fast becoming a necessity demanded by patients and their advocates (Meleis, 1996). Daddy and Clegg (2001) defined cultural sensitivity in nursing as "the provision of care that is sensitive to the needs of clients from all cultures" (p. 39).

Through experience and personal observation, Leininger (1998) realized that cultural diversity between patients and nurses can affect the therapeutic relationship and, consequently, make a difference in health outcomes. For example, Luna (1989) found that "care in the hospital context reflected several areas of cultural incongruities between Lebanese Muslim clients and professional health personnel especially with respect to gender role differences" (p. 189). Health personnel viewed the protective care pattern of the husband towards the wife in a negative way. Similarly, in a retrospective chart review of 180 adults with uncomplicated appendectomies, McDonald (1994) found that more postoperative

analgesics were administered to men and ethnic majorities than to women and ethnic minorities.

Leininger developed the Theory of Cultural Care to link the concepts of human care and culture. The purpose of the theory was to examine cultural care in order to use that knowledge in providing congruent care to people of other ethnic backgrounds (Leininger, 1998).

Leininger began by defining care, the noun, as "the provision of personalized and necessary service to help man maintain his health state or to recover from illness" (Reynolds & Leininger, 1993, p.6). Leininger went on to define cultural care as,

"the subjectively and objectively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable another individual or group to maintain their well-being and health, to improve their human condition and lifeway, or to deal with illness, handicap, or death" (Leininger, 1991, p.47).

Leininger maintained, "care and culture were inextricably linked together and could not be separated in nursing care actions and decisions" (Leininger, 1988, p.153).

Reynolds & Leininger (1993), in discussing the theory of cultural care, proposed that the theory could be used to study and discover cultural care differences and similarities. This

knowledge can guide nurses to focus on the diverse cultural factors that influence client well-being and plan more culturally congruent (sensitive) care and avoid cultural imposition (Reynolds & Leininger, 1993).

Leininger's Theory of Culture Care explained the effect of kinship and social factors on a patient's health and well-being. The theory maintained that kinship and social factors, as one dimension of the cultural and social structure, influence and are influenced by care expressions, patterns and practices which in turn have a direct effect on the health and well-being of individuals, families, groups and communities as an outcome.

"Folk, professional, and nursing care values, beliefs, and practices as well as institutional norms, can be identified and explained by the theory" (Leininger, 1985a, p.210). These in turn might have a direct effect on cultural care nursing decisions and actions regarding planned interventions, and consequently, will determine the congruency of care delivered. Congruent cultural care refers to those cognitively based acts or decisions that are tailor made to fit with a culture's values, beliefs, and lifeways in order to provide meaningful, beneficial, and satisfying health care, or well-being services (Reynolds & Leininger, 1993).

2.4.2. Culture and health

The cultural background of individuals has been found to affect their perception of health status and reactions to the illness experience. Rosenbaum (1991) found that health for Greek Canadian widows meant a state of well-being, ability to perform daily role activities, and avoidance of pain and illness. Greek Canadian widows practiced a repertoire of folk remedies, and believed in the "evil eye".

Higgins and Learn (1999) conducted an ethnographic study into the health practices of Hispanic American women. The Hispanic women were found to perceive health as related to lifestyle. They partook of and believed in the effects of herbal remedies.

Similarly, Boone (1985) found that culture was one among several factors including migrant status, smoking, previous poor pregnancy outcome, violence, weak social support systems, and poor social and psychological adjustments which contributed to low birth weight infants among disadvantaged inner city Black women.

Literature confirms that there is a strong correlation between health status and immigration. Those immigrants who are in the stage of transition, and not yet settled in the host country, are at a higher risk of illness. Literature suggests that the higher the magnitude of the change the

bigger the risk of illness (Lipson & Meleis, 1985). A survey of 47 Arab immigrants to California (Laffrey et al., 1989) revealed that the five most prevalent health problems were upper respiratory problems (36%), cardiovascular disease and hypertension (23%), diabetes (15%), emotional (17%), and social and family stress (13%). Similarly, Reizian and Meleis (1987) reported that the second highest number of symptoms reported by Arab immigrant patients on the Cornell Medical Index (CMI) concerned the cardiovascular system and included angina, tachycardia, and dyspnea.

The susceptibility of Arab immigrants to illness was confirmed by an ethnographic study of the illness perceptions and practices of Yemeni Arabs in Michigan (Kulwicki, 1996). The themes that emerged from the study included susceptibility to disease based on gender, reliance on health care providers, belief in an omnipotent deity who was the cause of all that is, belief in magic and demons, and desirability of adapting to change. The informants were found to rely heavily on religious explanations of illness practices.

Within professional health care settings, there is the potential for the health care provider to misinterpret or distort messages when care beliefs and perceptions are not understood within the cultural group context or may be deemed less than adequate (Lipson & Meleis, 1985). For example,

Lipson and Meleis (1983) identified some of the Middle-Eastern beliefs and practices related to health and illness which might conflict with Western beliefs. Although not refuting the germ theory, Middle-Easterners were found to believe in alternate disease etiologies. One etiology is the "Evil Eye" [EIN AL HASSOUD] that is attributed to power of the eyes of a jealous person to inflict negative events on the fortunate person being envied.

Another etiology of disease is the mixing of "Hot" foods, such as honey or walnuts, with "Cold" foods, such as cucumbers and yogurt. Planning ahead is not practiced because it is considered defying Allah's [God's] will. Consequently, they neither practice preventative medicine, nor plan for a death. Middle-Easterners resist seeking psychiatric help because of the stigma associated with mental illness. They use medications heavily, and consider that the more invasive a treatment the more effective it is. Hospitals are considered as places of misfortune where people go to die. A Middle-Eastern patient's family is considered a clearinghouse of information and will block the communication of a grave illness. Consequently, confronting a patient with a grave diagnosis is considered tactless and unforgivable.

However, views of Arabs towards a chronic illness such as congestive heart failure have not been studied. The literature

that exists is mostly anecdotal and experiential, concentrating on the role of the family and the attitudes of Arabs towards hospitalization, terminal illness, and dying. Brajtman and Gassner (2001), for instance, described some of the beliefs and values of the Arab population in Israel towards terminal illness. They reported about the social and cultural obligation of the family to care physically for the patient and to allow him to die at home. The authors also reported that it was unacceptable to discuss a terminal illness with the patient and that decisions regarding treatments were made by the family members.

2.4.3. Culture and social support

Cultural heritage encompasses the ideas, values, and beliefs that individuals have about others and the social relationships in which they participate. McCauley (1995) suggests that a person's cultural heritage can have a direct effect on the perception, provision, acceptance, and effectiveness of social support.

In cultures that are highly socially cohesive and well integrated, it is known that differences in risk between isolated and non-isolated people are not as great, because few people are truly isolated (Berkman & Seeman, 1986). When the culture does not predict such close family ties, a network of

family, friends, and professionals may represent the reality of how social support occurs. If the social network of a patient is strong, referral to social services may not be necessary. Professional services may, however, be necessary for those whose support is not an integral part of their daily life.

The social network of Middle-Eastern immigrants was explored by May (1992) who found that their social networks and help-seeking reflected a sense of ethnic identity and continuity with their roots and a strong affiliation with family, the major source of the provision of support. These findings were confirmed by Hattar-Pollara and Meleis (1995a) who studied the experiences of Jordanian immigrant women in the United States in parenting their adolescents. The researchers found that a driving force behind the parenting was an attempt to avoid loss of honor and bad reputations. The aspects of the maternal role that emerged included promoting cultural identity, disciplining for cultural adherence, and vigilant parenting. In addition, the same women also identified stressors associated with the immigration experience that included feelings of loneliness and social isolation, being apart from the host society, disruption of family stability, inadequacy due to the language barrier, and loss of social status (Hattar-Pollara & Meleis, 1995b).

Equally, lack of social support was identified as a stressor by Iranians immigrating to San Francisco (Lipson, 1992). Other stressors were culture shock, language barriers, perceived loss of status, and finding comparable jobs, which could impact their ability to access support.

2.5 Summary of literature review

In conclusion, the literature review revealed that congestive heart failure is a chronic disease that cannot be cured but can be managed. The social support of patients with heart failure was found to have a direct effect on rate of readmission to the hospital, compliance with the treatment regimens, and psychological and physical wellbeing (Berkman et al., 1992; Evangelista et al., 2001; Freidman & King, 1994; Happ et al., 1997; Hellman & Stewart, 1994; Jaarsma et al., 1996; Stromberg et al., 1999). The sources of support were identified as spouses, children, family members, friends, and health care professionals (Freidman, 1997; Freidman & King, 1994; Hirth & Stewart, 1994).

Culture was found to have an effect on the meaning of health; meaning of, susceptibility to, and reaction to illness; and reported physical and psychological symptoms (Higgins and Learn, 1999; Kulwicki, 1996; Lipson & Meleis, 1983; Rosenbaum, 1991).

In addition, culture could have an effect on the perception, provision, acceptance, and effectiveness of social support. However, more research is needed linking culture, social support, and illness, in particular related to the Arab Canadian population.

CHAPTER 3: METHODOLOGY

3.1 Research objectives

The purpose of this research was to explore the meaning of social support in a sample of Arab Canadians with congestive heart failure. The objectives of the study were:

1. To understand the meaning of social support for the Arab Canadian patient with congestive heart failure.
2. To explore the meaning of heart failure for Arab Canadians.
3. To describe how Arab Canadians with congestive heart failure would define a supportive social network and whom they would include in it.
4. To describe how an Arab Canadian with congestive heart failure describes supportive and non-supportive interactions.

3.2 Research design

A qualitative design was chosen because there is a paucity of literature exploring the social support of Arab Canadians, and in particular those with congestive heart failure. Ethnography is the most appropriate qualitative method to describe and explore the meanings a cultural group

gives to certain phenomena. In this study, the ethnographic approach was used to examine the meaning of social support to the Arab Canadian with heart failure.

Atkinson and Hammersley (1994) described ethnography as a qualitative research having many of the following features: emphasis on exploring particular phenomena, unstructured data, small number of cases, and explicit interpretation of meanings and functions of human action. Ethnographic learning is a result of the bringing together of two perspectives and their interaction. The first perspective, called the "etic" perspective is that of the outsiders studying the culture. The second perspective, or the "emic" perspective, is that of the insiders or natives to the culture (Stewart, 1998). "Rather than studying people, ethnographers learn from people" (Morse & Field, 1995, p. 26). Ethnographers attempt to facilitate our understanding of the health beliefs and practices of a culture by gaining access to the patient's perspective of health and illness behavior.

The overall goal of ethnography is to discover and describe the meaning people give to their experiences (Agar, 1986). Using this methodology, the researcher engages in observations and interviews to identify phenomena under concern from the participants' perspective. This allows the researcher to tell the stories and to define the experiences

of the participants in their own terms.

Historically, ethnography evolved from cultural anthropology and tended to focus on the cultural patterns of ethnic life. Ethnography was incorporated into health care research by nurse-anthropologists such as Leininger (Morse & Field, 1995).

The most appropriate tradition of inquiry that was chosen for this study is what Tesch (1990) has described as Holistic Ethnography. "It has been recognized that groups within cultures form their distinctive subcultures, and that these are sufficiently unique to warrant intensive examination and portrayal" (Tesch, 1990, p.66). Holistic ethnography seeks to describe a culture in terms of the beliefs and practices of its members.

Leininger (1985b) described a narrow area of inquiry for holistic ethnography that she named mini ethnography. This ethnography of small social culture units has also been called micro ethnography (Werner & Schoepfle, 1987), focused ethnography (Morse, 1994) and particularistic ethnography (Boyle, 1994). McFeat (1974) suggested that the ideal size for small group cultural ethnographies be five participants.

"Particularistic ethnographies focused on a social unit or processes within a small group and generally identified and helped us understand the cultural rules, norms, and values and

how they are related to health and illness behavior" (Boyle, 1994). Thus, the unit of a particularistic ethnography in nursing can be a small group of patients representing a specific ethnic group (Arab Canadians) or disease etiology (CHF).

Ethnographic interviewing is aimed at describing the cultural knowledge of the participants. The researcher serves as the instrument through which data are collected (Boyd, 1993). Since the purpose of this study was to explore the cultural meaning of support, discovery was elicited by analysis of data collected through "ethnographic questioning". Sorrell & Redmond (1995) described three major types of ethnographic questions: descriptive, structural, and contrast. Descriptive questions are usually open-ended and informal giving the interviewer a general view of the participants' culture (see Appendix C, Sample Interview Questions). Structural questions are asked concurrently with descriptive questions to clarify data already collected and provide more specific cultural information. For example, the researcher used structural questions in the form of probes to elicit clarification of comments made. Contrast questions can be elicited by asking informants to differentiate between and among two or three terms in order to examine the meanings of the words that informants use to describe their culture. The

researcher used contrast questions to differentiate between the words used most frequently by the participants to describe support: DAAM and SANAD. These terms will be discussed further in Chapter 5.

Strauss and Corbin (1990) described three approaches to qualitative data analysis. The first approach is used when the researcher intends to present the data collected without analysis. The aim of this approach is to let the subjects of the research speak for themselves as much as possible.

The second approach to data analysis is concerned with accurately communicating what the researcher has understood from the participants in the study. This approach is also referred to as "interpretive-descriptive" (Belenky, 1992). The researcher who uses this approach needs to be skilled at weaving all aspects of the data collected into a believable descriptive narrative.

The third approach to data analysis is the theory building approach. This approach requires a high level of analysis and interpretation in order to connect the themes and concepts into a theory that accurately explains the phenomenon of interest (Maykut & Morehouse, 1994).

The aim of this particularistic ethnographic study was to look at the experience and expression of social support as perceived by a specific group of patients. Being Arab Canadian

herself, the researcher used an "emic" approach to engage the participants in the data collection phase of this study. This included the appropriate social etiquette and established phrases of speech. Strauss and Corbin's (1990) interpretive-descriptive approach was used in the data analysis phase.

3.3 Selection of participants

The participants in this study were patients from the Arab Canadian community of Ottawa-Hull who had been admitted to hospital with a diagnosis of heart failure. Due to the limited number of patients that would be eligible, given the inclusion criteria, more than one setting was required. Participants were identified by nurses assigned to their care from the patient registries of medical units located at three campuses of a large tertiary care facility. The inclusion criteria included:

1. Adult,
2. Proficiency in Arabic or English,
3. First generation immigrant to Canada from the Arabic world,
4. Previously diagnosed with congestive heart failure, and
5. Admitted with an exacerbation of their congestive heart failure.

Once potential participants were identified and informed

about the study by the nurses caring for them (See appendix D: Initial Contact Letter for Recruitment), the nurses then contacted the researcher with their names. Potential participants were then approached by the researcher and provided with an Arabic and/or English "Participant Information Sheet / Consent Form" (see Appendix B) and a verbal explanation of the study.

The "Participant Information Sheet / Consent Form", the "Sample Interview Questions" and the "Initial Contact Letter for Recruitment" were originally written in English according to the guidelines of the Research Ethics Board of the institution. The forms were then translated to Arabic by a translation firm and then translated back to English by an independent Arabic reviewer fluent in both languages. The two English versions were then compared and contrasted for validation.

3.4 Protection of human rights

Approval was received from the Ottawa Hospital Research Ethics Board, and the University of Ottawa Heart Institute Research Ethics Board. The University of Ottawa Heart Institute is an affiliate campus of the Ottawa Hospital that requires a separate ethics board approval.

The study was verbally explained to the participants, who were also provided with an information sheet. A consent form was signed before the interview was commenced (see Appendix B, Participant Information Sheet / Consent Form). The participants had the option of withdrawing from the study at any point in time. To insure privacy and confidentiality, pseudonyms and codes were utilized, interview tapes were kept locked up in the researcher's office, and the interview transcripts and codes were kept by the researcher in a separate cabinet. Only the researcher had access to the codes and pseudonyms. The researcher, the thesis advisor, and the thesis committee had access to the field notes and interview transcripts.

3.5 Data collection procedure

3.5.1 Pilot study

A pilot study was conducted to assist the researcher in acquiring initial experience with ethnographic interview techniques and to test the interview questions and format. The participant in the pilot study met the same inclusion criteria as for the main study, but was interviewed after discharge home.

The participant was of Lebanese origin, 50 years old, and

had been in Canada for twenty-eight years. She was married with four children, two girls and two boys, who were still living at home at the time. Her husband worked in a trade while she did not work outside the home. The pilot study was included in the final data analysis as decided by the thesis committee.

After the pilot study, the researcher decided to move the context to the hospital setting and conduct the interview during hospitalization once the patient became stable and within 24 hours prior to discharge. The researcher felt that this provided easier access to the participants due to the private nature of the culture which necessitates the establishment of a relationship prior to interviews being conducted in the private setting of a home. It was also felt that the hospital context would help the researcher observe any family interaction during the interview as well as the interaction with the health care professionals. In addition, the hospitalization experience and the mobilization of the support network would be fresher in the participants' minds, which would greatly enrich the data collected from the interviews.

Following the pilot study, the research questions were modified to include more probes and to allow the participants more freedom in expressing their thoughts and experiences. In

addition, the term "heart failure" was changed to "heart weakness" to reflect a direct translation of the Arabic word for failure [DAAF]. Due to delays in the ethics review process at one institution, the data collection of the participants in the main study took 10 months.

3.5.2. The main study

One-on-one interviews were conducted with six participants during their admission to medical units of three separate campuses of a tertiary care facility in Ottawa. The one-on-one interviews were semi-structured to allow the participants to tell their stories freely and to elaborate with examples. The interviews were held in the hospital at a mutually agreed upon locale to insure privacy and quietness. Despite being given the choice of an interview in the researcher's or another private hospital office, all participants opted to be interviewed in their hospital rooms. Three of the participants insisted on the presence of family members during the interview. Although participants were given the choice of the English or Arabic language for the interviews, all chose to speak in Arabic. The interviews were tape-recorded and then transcribed verbatim.

The questions included demographic data and probes to capture unexpected or additional information and narratives.

During and immediately after the interviews, the researcher took field notes in the form of a "contact summary sheet" (see Appendix E). These notes on impressions and expressions helped the researcher revisit more clearly the interviews when reviewing the transcripts of the tapes.

Attentiveness to context and a previous knowledge of the culture contributed to the richness of data collection and analysis. According to Stewart (1998), observers who are yet unfamiliar with the culture and the emerging themes cannot make sense of their observations and will need longer periods of fieldwork. Those researchers with the unique view of an insider to the culture do not need as much time spent in the field.

Sawyer et al. (1995) posit that it is crucial that the researcher has prior knowledge of the history and social background of the group being studied. They propose the concept of matching of shared identities between the researcher and the participant. Through matching, it is suggested that "the more the researcher and the participants have in common, the greater the potential for an accurate understanding of the health concern or the problem of interest as experienced by the target population" (p. 558). The researcher should also have sensitivity to the facial expressions as well as the body language of the participants

since the way these are manifested is culturally determined.

Data collection concentrated on descriptions of social support. "It is critical that the observer facilitates the expression of meaning but avoids imposing meaning on the situation" (Morse & Field, 1995, p. 107). The investigator focused on maintaining the observer role without venturing into imposing personal values and feelings into the interview setting.

Data collection took place from August, 2000, to April, 2001, at the University of Ottawa Heart Institute; and from January to June, 2001, on the other two campuses of the Ottawa Hospital. Three participants were recruited from the Heart Institute, and the remaining three from the other two campuses.

Those patients who agreed to be seen by the researcher received a copy of the Participant Information Sheet and Consent Form to peruse. The researcher returned after a few hours, thus allowing the participants some time to think about consenting to the study and to discuss it with their families.

During the phase of data collection, the researcher detected a reluctance to participate on the part of the Arabic patients. Lipson & Meleis (1989) have attributed this reluctance in Arabic cultures to distrust of organizations, distrust of research in general, distrust of strangers, and

not understanding the purpose of the research. This resulted in data collection phase taking an extended period of time.

Seventeen potential participants were approached about the study. They were of varied ethnic and religious Arabic background. Of those, two were discharged from the emergency department after their condition drastically improved; three refused; two consented and subsequently refused after discussing it with their families; two were not interviewed due to deteriorating condition; one was confused and, therefore, could not consent; and one was discharged twenty four hours prior to the expected time. Six consented to the study and were successfully interviewed in the hospital. With the decision made by the thesis committee to include the pilot study participant, the total number of participants was seven.

3.5.3 Description of participants

Even though the patients approached for the study were of varied religions and Arabic Nationalities, the participants that consented to the interviews were all Christians of Lebanese origin. The seven participants included three men and four women. The age range was 39 to 92, with the mean age being 68. The average number of years of residence in Canada was 24. Five were married, one was widowed and one was single.

Table 1. represents the demographic data collected on the

participants. The participant codes were chosen as per the campus from which they were recruited (e.g. HI = Heart Institute). For confidentiality reasons and to protect their identity, the participants were also assigned pseudonyms. All the female participants were housewives who did not work outside the house. One of the male participants was employed as a professional, another was retired from a profession, and the third was retired from owning his own business.

Table 1. Participants' Demographic Data.

Code	PI (pilot)	HI-1	HI-2	HI-3	OH-1	OH-2	OH-3
Pseudonym	Vanna	Ghaby	Wilma	Anna	Fred	Ed	Emma
Gender	F	M	F	F	M	M	F
Age	50	40	83	39	68	92	85
Marital Status	M	S	W	M	M	M	M
# of Children	4	0	8	3	7	2	3
Years in Canada	28	14	31	12	44	17	26
Dwelling	House	Condo Appt.	Appt.	Duplex Appt.	House	House	House
Living arrangements	With husband and 4 children	With widowed mother	Alone	With husband and three children	With wife	With wife, daughter, and grandson	With husband

The participants, with the exception of the single gentleman, had children and described being close to them. Four of the participants, two males and two females, spoke of grandchildren.

All the participants had been previously diagnosed with congestive heart failure. They were admitted with an exacerbation of heart failure due to various causes, with the exception of Anna, who was admitted for cardiac surgery.

3.6 Procedure for data analysis

The researcher utilized Strauss and Corbin's (1990) interpretive descriptive approach to data analysis. The researcher was interested in developing "statements of facts" derived from rigorous and systematic data analysis.

The researcher kept a personal journal that included personal reflections on the process of data collection. This was compared to the field notes and interviews during the data analysis phase.

The interviews were tape-recorded then transcribed verbatim in the Arabic language. These transcripts were then translated into English and word-processed along with the field notes and journal entries. Both, the Arabic and the English interviews, were used in the analysis.

All transcript pages were numbered and coded as to the unit from which the participant was recruited. For instance, HI was used as the code for the Heart Institute. Field notes were also coded as per participant. Journal entries were coded by date and page. Then multiple copies were made of all the

data pages.

Once photocopied, the data was examined for chunks of meaning: a process referred to by Lincoln and Guba (1985) as "unitizing the data". The researcher read and reread both the Arabic and English interview transcripts in their entirety.

A two-inch margin was available on the left-hand side of the page to write comments and codes. Colored markers and tags were used to highlight important and recurring elements. These recurrent ideas were then grouped together into categories that were then regrouped into themes.

Each transcript was individually studied for recurring themes. These themes were then examined across cases for emergent patterns. The patterns were compared for repetition and new emerging themes.

Interview transcripts were shared with the thesis committee at intervals throughout the data collection phase. This ensured that the novice researcher was on track. It also allowed the researcher to benefit from the knowledge of the members of the committee related to qualitative research methodologies.

The tapes in Arabic were listened to repeatedly and compared to the transcripts in order to capture some non-verbal communications such as voice intonations and periods of silence. This intense consideration and examination of the

data allowed the researcher to develop insight into the perceptions of the participants related to social support and heart failure. These emergent themes, once approved by the thesis committee, were then shared with three participants, identified at the beginning of the study as key informants.

The follow-up interviews took place at a location chosen by the informants. Two of the informants (Anna and Emma) insisted on the interviews taking place at their homes and the third informant (Ghaby) was met in a public restaurant. The choice of the restaurant was for propriety because the informant was a single male and the researcher was a married female. However, the informant then decided to take the material home and read it at leisure and call the researcher back with the his comments and feedback. The follow-up interview took place by phone ten days later.

The follow-up interviews were also transcribed verbatim and translated into English. Field notes were written as soon as possible after the interviews and used in the data analysis. The same process of analysis occurred with the follow-up interviews.

3.7 Criteria for evaluation

According to Lincoln & Guba (1985) and Leininger (1990, 1994), the rigor of the ethnographic method is to be

maintained by a set of evaluative criteria or epistemic values. These values are: credibility, confirmability, meanings-in-context, and saturation.

Credibility, the truth as it is known to the people, is established by collecting data over a lengthy period of time, verifying the data and emerging themes with the participants, and observing intensely during the interviews. Leininger (1994) described credibility as the believability of findings established by the researcher through observations, engagements, or participation with informants or in situations where knowledge is acquired to reflect the emic view of those studied.

Confirmability is obtaining direct or repeated affirmations of findings and conclusions obtained by the researcher (Leininger, 1994). It is achieved through the evidence of field notes, tape recordings, personal journal, and data analysis records (Rosenbaum, 1991). The researcher satisfied the criterion for *confirmability* by maintaining a record of all field notes, personal journal entries, tape recordings and data analysis records, and by sharing these with the members of the thesis committee. In addition, the findings were shared with the participants in the study.

Meanings-in-context refers to gaining the full meanings of the situation under inquiry within its context. This is

achieved through asking contextually framed questions in the clinical setting (Rosenbaum, 1991) such as "why are you in the hospital now?". The *meanings-in-context* criterion was also satisfied through choosing the clinical setting of a hospital unit to interview the patients. Thus, the meanings of social support were expressed in the context of a hospital admission with an underlying diagnosis of congestive heart failure.

Saturation is reached when, while studying the data extensively, one can no longer find information to add to the understanding of the category being studied (Wolcott, 1994). Themes then start repeating themselves (Creswell, 1998). Saturation was achieved with the sixth interview and data collection was stopped.

The ability to transfer the findings to other settings is facilitated by providing elaborate descriptions of the interview contexts and themes. This will allow other investigators to decide for themselves the appropriateness of transferability (Rosenbaum, 1991). "Because, the goal of qualitative research is not to produce generalization, but rather in-depth understanding and knowledge of particular phenomena, the transferability criterion focuses on general similarity of findings under similar environmental conditions, contexts or circumstances" (Leininger, 1994 pp. 106,107). The researcher describes in detail the context of the interviews

and the themes that emerged from the data analysis in Chapter Four.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter describes the meaning of support as expressed by Arab Canadians with heart failure. The findings are abstracted from the meanings and experiences of support as described by seven Arab Canadian patients admitted to the hospital with a pre-existing diagnosis of congestive heart failure. Table 2. represents the themes that emerged from the initial stages of the data analysis.

Table 2. Initial Themes and Categories.

THEMES	CATEGORIES
Roles	<ul style="list-style-type: none"> • Women • Men • Children • Elderly Parents
Support network	<ul style="list-style-type: none"> • Immediate family • Relatives • Friends • Neighbors • Others
Faith/ religion	<ul style="list-style-type: none"> • Language • Attitudes
Illness	<ul style="list-style-type: none"> • Filtering of information • Disclosure • Perception of and denial of diagnosis
Support	<ul style="list-style-type: none"> • Emotional • Physical/ Concrete/ Material

The researcher set aside the initial themes and then repeated the data analysis of the English and Arabic interview transcripts, field notes, and journal entries. Even though no new themes emerged, the initial categories were re-organized

into new themes and categories that were better reflective of the findings. Table 3. represents the final themes and descriptors shared with and confirmed by the three informants contacted. The three final themes that emerged from the data are discussed in this chapter and supported with quotes from the interviews.

Table 3. The final themes emerging from the data analysis.

THEMES	DESCRIPTORS
"My family will take care of me"	<ul style="list-style-type: none"> • Family obligation to serve and protect • Gender role responsibilities • Respecting parents and the elderly • Daily patterns of support and decision making
"I rely on God"	<ul style="list-style-type: none"> • Faith and reliance on God as support (ITTIKAL) • Expressions embedded in the patterns of speech
Illness is not important	<ul style="list-style-type: none"> • Illness in terms of symptoms • Illness experience as catalyst confirming worth

The themes were very hard to extract from the data due to their interconnectedness. They were interwoven into a lattice of support and thus could not be completely separated from one another. As the findings are presented, this web of themes will become quite apparent.

Other challenges were encountered during the interviews themselves. These challenges will be presented in the

following section prior to the discussion of individual themes.

4.2 Context of the interviews

The interviews took place in the participants' inpatient rooms. Despite the offer of a more private setting for the interviews, the participants all opted for the bedside. This in itself presented a few challenges. These included the presence of family at all times and interruptions from health care providers, clergy, visitors, phone calls, and, in one instance, construction on the floor above.

The situation led the researcher to the realization, that these Arab Canadian participants could not be interviewed in isolation. The interviews took place within the family unit rather than the individual. Family members were constantly qualifying the participant's comments with some of their own, revealing knowledge of the participant's experience and, thus, complementing the data from the participants.

The interviews themselves lasted an average of 25 minutes. However, the average visit was one hour and ten minutes. The constant interruptions were rather challenging since the flow of the interview was repeatedly disrupted and required the researcher to refocus the interviews.

Even though the researcher was part of the culture, she had to take time before and after the interviews to establish a personal relationship with the participants and their families. Instead of being a complete stranger, the researcher was able to establish a trusting relationship with the participants by "socializing" before the interview. This allowed the participants to relax during the interview and forget about the tape recorder.

The researcher also noted that the data was best collected when the participants were allowed the time and space to simply talk rather than answer specific questions. Probes were used to refocus the thrust of the conversation. However the participants were able to speak at length about their families and their illness.

Of interest, questions about social support were met with little or no response. The participants focused more on family relations, obligations, and role responsibilities. These will be discussed at length in the following sections.

The follow-up interviews were quite informative in clarifying the themes. Anna, Ghaby, and Emma were re-interviewed. Anna and Emma were very welcoming into their homes and insisted on serving the researcher coffee, fruits, and cookies. Interactions with the researcher continued after

the formal interview was done. Their feedback was very supportive of the themes.

Ghaby, on the other hand, being single, agreed to meet the researcher in a public restaurant. He took the emerging themes home with him and later called the researcher by phone to give his comments. His feedback was also very positive in confirming all the themes.

4.3 Theme 1: "My family will take care of me"

The participants were asked to speak of what support meant to them and of supportive interactions and relationships. In analyzing their answers, the researcher was able to extract the theme of "my family will take care of me". The theme and its descriptors are further described below.

Participants consistently spoke of their positions within and their relationships to their families. The family members were referred to, deferred to, and consulted about decisions made. Even the decision to participate in the interview was most often made in consultation with the family members.

The family unit extended beyond the nuclear family of husband, wife and children to include sisters, brothers, parents, in-laws, and sometimes even neighbors and friends. When I asked Anna about her family, she automatically told me

about her sisters and brothers. She then referred to her sister-in-law as a family member as well saying,

"My brother's wife, she has no one here. But we wouldn't leave her. We never leave her. Why? Because she is one of us".

Anna then talked about how her next-door neighbor would be coming to bathe her and care for her in the hospital after her surgery. She thanked God for neighbors "that make you forget about being lonesome". The participants described a community that was family and home centered.

4.3.1. Family obligation to serve and protect

One of the study's objectives was to examine the meaning of social support for the Arab Canadian with heart failure. Data from each of the interviews showed evidence that support was considered a family obligation that extended from every day life decisions into crisis situations. The immediate family was obligated by faith, love, and social responsibilities to care for and support the individual during times of illness and crisis. The fulfillment of this obligation was directly connected to maintaining individual and family honor.

The support (SANAD) of the family was a given. The

participants did not worry about their support network but rather focused their energies on getting better and going home. When I asked about how the family supports him, Ed commented,

"They help me by minding me in everything and every request and inquiry. What else, wouldn't they help?!".

The obligation of support transferred as well into the hospital setting. Most of the participants, especially those who did not speak English or French, had a family member with them throughout their waking hours. During their hospitalization, patients were constantly surrounded by family members, relatives, and friends who looked after them. The range of support extended from providing basic care, to acting as a filter of information between the patients and the health care providers, to making decisions for the patient.

Of interest, the participants insisted on having family members present during the interviews even though they were conducted in Arabic. The participants did not feel that they had anything to conceal from their families. The participant was simply a part of the whole that was the family. The same pattern of behavior continued during the follow-up interviews.

The supportive interactions of the family included withholding a grave diagnosis or prognosis from the patient.

Most participants insisted that this practice was good for the patient and his/her family. Anna described how her husband tried to hide from her that the hospital had called and scheduled her valve replacement cardiac surgery. He was waiting for the opportune time to tell her. This same participant insisted she would not want to know if she were diagnosed with terminal cancer.

Revealing a grave diagnosis or poor prognosis was considered non-supportive. Ghaby spoke of how he left instructions for the medical staff on the unit when his father was admitted with cancer, not to allow anyone to go in and talk to his father about his illness. Even though his dad did die of cancer, he was never confronted with his diagnosis.

When I asked Ghaby as to whether he did that because he thought his dad would prefer it. He replied,

"It is not the patient himself who prefers it [being told his diagnosis]. Maybe my condition would be better if they **hadn't** told me about my disease. But because I know and I am able to know, there is the difference..

Theoretically, it is, of course, better if the patient **does not know** about his disease, that he is going to die in two days, for example.."

This was also confirmed by the informants in the follow-

up interview. Emma commented that the patient should not be told his/her diagnosis,

"So he remains comfortable without worrying that he is going to die. He becomes worried too much when he hears bad news. So it is better for him if he does not know these things".

4.3.2. Gender role responsibilities

A major theme that emerged recurrently during data analysis of the interviews referred to the difference in the responsibilities of men and women. The participants all agreed that men and women had different responsibilities in the support of the family. The participants agreed that men and women were equal but had different natures dictating different role responsibilities while being complementary in their focus on the family as most important.

Ghaby simplified it by saying, "the woman is for the house and men are for work outside the house". However, he voiced a disappointment that these roles are starting to blur with the new generation.

The role responsibilities of the woman revolved around caring for and nurturing the husband and children. The woman was viewed as "for the house". None of the women interviewed

were employed outside the home. As Anna stated they simply "did everything at home".

When I asked Vanna about her way of showing her family she cared, she responded,

"Well, let me see... well, for my husband and children, I am there for them all the time. Whenever they need something. I help them. I love them and provide them with all they need. You know, you cook for them, and provide them with all they need. You help them with everything. I remember the things that are important to them... you love them and you look after them".

The women were also expected to bring up the children with the same beliefs and values. The boys were brought up to be husbands and sons who are providers of such things as housing and food and the girls were brought up to be wives and daughters who nurtured and loved. Boys were encouraged to have an education so they were successful in providing for the family. Girls were encouraged to learn home-keeping skills so they were successful wives and mothers.

These gender role responsibilities were revealed in different demonstrations of support. Vanna spoke about the way she was bringing up her daughters and sons. She spoke of the different gender roles of her teenage children saying,

"The children are different. The girls are more affectionate and are closer to me. They remember events and dates as well. They bring flowers and gifts and are always respectful. They are also more helpful around the house. They do a lot of the chores. Especially when I am not feeling well. The boys are also very respectful. But they are more independent. They're men. They are not as affectionate as the girls are. But they are as helpful in that they run a lot of the errands for me. And they are good in that they look after their sisters and protect and defend them".

When I asked Wilma if she had taught her sons to do housework like she taught her daughters, she exclaimed,

"The boy to do?! The boy is a boy. He's proud. He's going to come do dishes!!! I teach him. I only want him to have an education...".

About her daughters she explained,

"...the girls are educated. Their father provided them all with an education. He spent a lot of money on them. And they helped me at home. They would learn in schools outside the home. And help me at home. They all turned out... they are all married. They all know how to cook and know how to do everything".

The woman was also expected to teach her children social etiquettes. There were certain ways of communicating with one's elders and expressing social niceties. Anna spoke about the difference she noticed between Canadian youth behavior and her expectations of her children.

"Socially. Socially with the family. For instance with the children, we are training our children that when someone comes in, you stand up and greet them. I mean, with respect. They ask on the phone can I talk to Salma, with no hello, no Bonjour. No, Bonjour, How are you, "Tante"? How are you, "AAMMY"? May I speak with Salma if she is available, please? Those words. Those words are the least to say. Yes, there is no such thing here. They think that when you say hello, that is your greeting. Now, I always instruct the kids to say "Bonjour. How are you, "Tante"? How are you, "AAMMY"? May I speak with Reem or with any of their friends? Yes, this is life. Now, when someone comes from Lebanon, they stand up, they greet. Maybe these are secondary things here, but, at home, these are essential things".

However, being ill was worrisome in that it could limit the one's ability to carry out role responsibilities. For example, Anna was concerned as to who would teach and instruct her children if something were to happen to her. She viewed

her role as mother and wife as her sole purpose in life. The mother played a most important role in the upbringing of the children in the early years. Consequently, children tended to have a closer relationship to the mother than to the father.

Anna commented on her heart disease by saying she sometimes wished that God would just take her. She stated she would then feel guilty about leaving her children and husband and her role as nurturer and teacher of her children and would pray for God's forgiveness. Her words were:

"... some days I am very nervous and I say if God wills, I hope the surgery is not successful and I will go to my rest. Then I say Lord forgive me because my children are still very young. You feel you are blaspheming from exhaustion... Now some days, while I am walking, I have to walk, I tell myself, if the Lord wills, I hope He does not save me from the operation and then I start praying. Yes, I would usually keep my rosary in my pocket to pray and ask God to forgive me. I keep on saying that my children are still very young and they still need me. I do not need to live for my self or to be happy with my life but I need to live for my children to live to help them and teach them what to do. They are still very young. My eldest daughter is only 13. She is still young".

The relationship of the daughters to the mothers seemed to be close and intimate. The mothers were expected to teach their daughters the traditional beliefs and values of the culture.

The relationship of the boys to the mothers was strong. The eldest son would traditionally provide for and support the mother in her older years. The eldest son was responsible for the economic security of the elderly parents as well. Vanna spoke of how her parents would be taken care of as they got older,

"As they get older, it is the responsibility of the eldest son to look after them and provide for them. They shouldn't need anything. He should look after them and help them. They are his responsibility. He should look after them. When they grow old we should esteem them and provide for all they need. We don't throw them away. We still need them".

The man was expected to provide the economic security of the family. It was considered his responsibility to provide for all the financial needs of the home. He was viewed as "for outside the house". It was a matter of pride for him to provide all these needs without the wife having to work outside the house to help with the finances. Anna responded to

my question about whether she worked outside the home by thanking God for His provisions so that her husband could insist on her not working.

The man was also expected to care for the wife and show her love and consideration. Some participants reported that their husbands did sometimes help around the house, when they felt that the wives needed assistance. They helped with the meals, brought groceries, and even did the dishes. When I visited Emma for the follow-up interview, it was actually her husband who made the coffee and served the cookies. During the initial interview she spoke of how he usually buys all the groceries and helps around the house,

"He helps me, too. He does the dishes sometimes. He doesn't let me do the dishes. He tells me, 'You go rest and don't worry about it'".

Both Emma and Anna seemed comfortable with their husbands' supportive role during their illness. Anna spoke of the unique emotional support that a loving husband can provide during illness. She spoke of how he encouraged her to concentrate on getting better and not worry about being home until after her surgery. She said,

"He told me think of yourself and, if God Wills [INSHALLAH], you come home safely and no one takes your

place. When he says that word, no one is like him. He is very different (special), if truth were told".

Anna put his opinion before any body else's. When I asked her if she took anyone's opinion about decisions for her care, she said,

"My own and that of the people in my house. My husband before anyone else".

4.3.3. Respecting parents and the elderly

Supportive interactions were described by the informants as caring for the elderly, the parents, the children and helping others. It was the obligation of children to support their parents, as they grow older. It was considered that as they grow older, they also grow wiser. It was the obligation of the parents to support the children until they were old enough to care for themselves.

The respect (IHTIRAM) and support (SANAD / DAAM) of the elderly parents was a theme that emerged consistently. The parents gained status and honor with age and earned their families' obligation to support them with the fulfillment of their role responsibilities.

Vanna, in response to the researcher's question about how people in her culture took care of their parents during their

hospitalization, said,

"Well, the whole family serves them as well, of course. Usually it is the daughters who serve the sick parents. Everybody helps, of course. We do not throw them out. Even when they are in the hospital we are all there. We have to respect them and serve them and take care of them. So we are all there for them. We bathe them and feed them and toilet them. We look after them, they are our parents. We don't just take them to the hospital and forget about them. We serve them there and then bring them home and serve them".

During the course of the interview, Vanna described how the obligation of support extends to parents.

"Well, you respect your parents and you defend them. You show them respect always. When they are young or old. You respect your parents and remember things that are important to them. You live respecting them and upholding their honor... When they grow old we should esteem them and provide for all they need. We don't throw them away. We still need them. They took care of us, and now it is our turn to take care of them. We take care of them and honor them. They are wise and we still need them. We ask them about things. Their opinion is most important. We have to

respect them. They are wise. They took care of us. They know a lot of things and they can still help us”.

The participants described a pattern where individuals were almost never alone. Ghaby had his widowed mother living with him. He saw that as an extension of his role as son. Ed and his wife lived with his daughter and her son. Only Wilma lived alone in a senior's apartment. However, it was obvious from the interview that she was rarely alone since she had daily visits from her neighbor and her widowed daughter always visited and stayed with her.

4.3.4. Daily patterns of support and decision making

The researcher was able to witness how family members oversaw the care and made most of the decisions related to it. The family members were more knowledgeable about the illness than the participants and were able to contribute richly to the interviews. With the exception of Ghaby and Fred, the participants all deferred to family members for decisions, explanations, and even history giving.

The exceptions might be due to the fact that Ghaby was a single young man, an only child, and had his widowed mother living with him. This could imply a conflict between his role as caregiver to his parent and care receiver due to his

illness. However, no such role conflict was communicated to the researcher.

The other exception was Fred, who had been in Canada the longest, for 44 years, and whose children had assimilated into the Western culture, and thus may have had a different frame of reference. He did not seem to have the explicit expectation of his children being around him in the hospital. During the interview he responded to my question as to whether his children came and visited with him,

"Well, they drop in once in a while. What do you want, they come and sleep here? They come when they can".

He was also the only participant who referred to professional health care as "looking after". He said,

"Well, when you come to the hospital, the hospital they look after you. And when you go home, your family look after you".

Fred was the only participant who exhibited anxiety about his diagnosis. He repeatedly referred to his illness and voiced disappointment and concern with the diagnosis and professional care. Having knowledge of his diagnosis only increased his anxiety. He was making plans to seek help somewhere else.

The family took decisions collectively since decisions

affecting one member of the family would affect the collective. During a follow-up interview, Emma's husband commented that "they decide together so that they are of one opinion".

Vanna stressed the importance of including friends and relatives in this circle of kin or family and described how the daily decisions to "stay in touch" and "ask after them", extended to times of crises and illness. When asked about how she would show friends support and care, she said,

"Well, friends are very important. You ask after them. You constantly ask after them. You visit them. You are there when they need you. You help them when they need help. You share in their lives. You help them and share with them and ask after them. You help them in funerals and in weddings. They shouldn't be alone then. You share their happiness and their sadness. You should also be jealous for them. Defend them when others talk about them. You should defend them and their honor as if they were family. Always stay in touch with them because sometimes friends are better than your own sisters and brothers".

"Care" was usually provided by and expected from the family members and again was an extension of the daily

patterns of living that were well established prior to the admission.

Many participants included friends and relatives in their support network. However, it was clear that the support was the extension of an ongoing day-to-day relationship that was well established prior to the illness or crises. Wilma spoke of a neighbor who always came and visited with her in her seniors apartment.

"Of course. I have a neighbor; if she doesn't come to visit I call her. She comes and visits with me and keeps me occupied".

In contrast, health care professionals were not viewed as part of this support. The participants consistently used the word "KHIDMEH" (meaning "Service") in describing professional health care. Anna even compared nursing care in the hospital to the service one gets when shopping.

"Their service... Now, I would try to get up and help them by making my bed for instance. She would say to me, no, you are here to rest. No, their service here is very good. Even when you first go shopping, they are very good to you".

The goal of this service was to provide a cure. For example, Fred, who had renal failure and liver failure as well

as heart failure, was quite disenchanted with the medical staff because "they cannot help him". He attributed their inability to "cure" him to the fact that they "were a bunch of student, no one know nothing". He explained that they cannot really help him because "Nobody knows nothing. They can't make no operation", even though they had explained to him that he has renal failure, liver failure, heart failure and peripheral vascular disease that necessitated a left below-knee amputation. If there were no cure for the disease, which is the case with heart failure, then the "cure" of the immediate symptoms was considered adequate.

4.4. Theme 2: "I rely on God"

The meaning of social support for the Arab Canadian with heart failure was also revealed through a fundamental reliance on God. In this section, this theme and its descriptors are discussed at length and supported with quotes from the interview transcripts.

4.4.1. Faith and reliance (ITTIKAL) on God as support

The participants were consistent in their expressions of reliance on God to see them through the illness process and cited this as the reason why they were not afraid in the hospital. This faith in and reliance on God was not dependent

on the outcome of the situation, but was rather constant. They expressed the belief that whatever came from God was Good.

Emma expressed it best by saying,

"I am not afraid. My secret is that I am not afraid. It does not matter to me. To tell you the truth, I do not have that... I rely on God... I am not afraid".

That same participant then said, "If God wills, they will cure me. This is all of God". Anna made sure she had the sacrament of the sick before coming to the hospital for her cardiac surgery. Ghaby said he coped by praying in private to God, because "prayer helps".

Anna, when asked about what would make her feel positive about her situation said,

"Now, Our God... You cross yourself and you say, O Lord, give me the strength, Give me the patience, give me... This is the first thing I ask for. I have my prayer book right here with me. And I pray to God to give me the strength and the patience to be able to get better for my home, my husband, and my children".

Emma confirmed this reliance on God during the follow-up interview with the following quote:

"The word "Allah" should always be on our lips... because we have faith in God and reliance on Him. We always say

thank God [NUSHKUR ALLAH] and reliance is on Him
[ALITTIKAL ALA ALLAH] whatever He wills should happen".

It was also evident from the interviews that the participants did not consistently plan for the future. Emma and her husband said,

"I believe the past is gone, and the present I am very happy in, and the future I don't worry about it. I am today better than tomorrow... Nothing is better than what comes from God, frankly. What else?!"

This present-orientation was attributed to faith in and reliance on God.

4.4.2. Expressions embedded in the patterns of speech

The name of God (ALLAH) was invoked throughout the speech patterns of the participants. Faith seemed to be the foundation upon which understanding and actions were built. The expressions themselves portrayed an utter dependence on God for daily provisions of health and needs as well as the protection from ill.

Because the researcher is of Lebanese origin and was using the Arabic language in the interviews, the recurrence of certain expressions was not noted until the Arabic transcripts were being translated to English. The researcher then noted

the many expressions of faith embedded into the cultural patterns of speech and language.

Here is a list of some of the words and expressions used and their English meaning:

- INSHALLAH (If God Wills)
- ISMALLAH (In God's Name)
- HAMDULLAH (Thanks be to God)
- ALLAH YKHALLIHUN (May the Lord Keep them [well])
- ALLAH YUHFAZIK (God keep you)
- ALLAH YUSTURNA (God protect/shield us)

These expressions were part of the patterns of speech and social etiquette. For instance, when the researcher was asking about the participant's children, she knew she was expected to say "ALLAH YKHALLIHUN" so as to invoke God's blessings upon them.

The expressions "HAMDULLAH" and "INSHALLAH" were also used frequently. They were used to praise God for the present situation, no matter whether good or bad, and to express a reliance on His will. Therefore, even if the patients were not feeling well, they would still thank God.

Of interest, the data analysis revealed that the speech patterns of women had more expressions of faith and references to God than the speech patterns of men. Ghaby commented that

this did not reflect that the individual had less or more faith but that it was a simple reflection of communication patterns.

Vanna, when asked about the meaning of support in her religious beliefs, answered,

"Of course, it all starts with the fear of God. God is merciful and just. And that is what we ought to be. We shouldn't have pride. We should be caring of others and helpful. We should have pity for those who are not as blessed as we are. That is why the church looks after widows and orphans and needy members... [in the] church family. We help each other and look after the needy by providing food or clothes or by serving them. We have to fear God. It might be us one day that need help. It is God who gives and God who takes away. We shouldn't have pride when we have so much".

When I asked Emma about these expressions and how they appeared so often in the speech patterns, she responded "That is all because the word "ALLAH" (God) should remain on our lips". Her husband confirmed by saying that this "is an expression of faith".

4.5 Theme 3: The illness is not important

An objective of the study was to explore the Arabic patients' perception of congestive heart weakness and how they understood the illness. To that end, participants were asked to describe to the researcher the reasons they were admitted to the hospital. In analyzing the descriptions of their experiences within the context of social support, the researcher was able to extract the theme "the illness is not important" that is further expanded upon below.

4.5.1. Illness in terms of symptoms

Because of the present-time orientation of the participants, chronic illnesses such as congestive heart failure were not acknowledged. The patients would take the medications to treat the symptoms rather than manage the disease. Some participants did not adhere to long term therapy once the symptoms disappeared or if the medication was not associated with a specific symptom. Emma consistently "forgot" to take her cholesterol pill because she did not believe she needed it. When asked about their heart weakness, participants consistently denied having anything wrong with their hearts. Their complaints ranged from shortness of breath to swollen

ankles to lungs filling up with water. Yet, they insisted there was nothing wrong with their hearts.

When asked about the reason for their admission, the participants spoke of symptoms, such as "my lungs filled up with water and I couldn't breathe" or "my ankles swelled up". When asked about the cause of their symptoms they never attributed it to heart failure but rather to "an arthritis medication that I should not have been taking", "pneumonia", and "urinary track infection".

Here is Emma's description of what happened to her:

"I first started with this severe pain. Yes, I think about twenty days ago. I do not remember if it were more than twenty days. Yes, more. I started coughing a bit and I said we should go to... I coughed... No first thing, I had diarrhea. Yes, yes, always and for a long time now, I have chills in my back. Not a lot. It comes and goes, comes and goes. My husband (IBN AAMY), after lunch, I tell him "I am cold YA AAMY". He tells me "it is OK, Mama". You know how the Arabs are. "You just had lunch, maybe you are just having a chill after lunch". What a chill! I am talking about every day. Yes. This happened at the very beginning. While I was sitting there, the older boy was at my house, and our neighbors, they are

very "good". We are very good friends with them. I was sitting there. We have that "dish" and we were watching TV. Yes. I felt cold. I didn't say anything. Then I felt cold again. I didn't say anything. Until I felt my hands shaking like this. Just shaking. I started shaking like this, like this, like this. Like I am showing you now. They got up, the poor people, and cared for me, I mean. My son said "get up I will take you to the hospital". I said to him "what am I supposed to go do there, my son". He said "what do you mean what are you supposed to go do there". They brought me to the hospital. To the "emergency". We remained till two, three, after midnight...[she was told she had pneumonia] Four times I came to the hospital before they knew anything. I go home and come back. And they knew nothing. Afterwards they gave me this medication [antibiotics]. We went home."

Some participants insisted they did not know much about their disease and implied that they really did not have to know. When asked about what it meant to him to have heart weakness (failure), Fred replied,

"It means I have heart weakness. What else do you want it to mean?"

Emma said,

"We went to the cardiologist. **How would I know?** They referred me to the Doctor who analyzes the heart. Here they told me that it is not running well... **How would I know?** But I think that they ordered me a new medication. **I wouldn't know.** But they ordered a medication that I think will help the circulation. This is a new medication. **I don't know much about it.** I don't know if it is here already... or not. He was telling me. The boy told me. **How would I know?"**

In contrast, the participants' families seemed to know more about the disease than did the patients. Wilma, Ed, and Emma had their daughters present during the interviews. The daughters were able to better follow and describe the history of the disease than the parents. Emma's daughter explained that her mother had a blocked artery in her heart.

Of interest, there was a difference noted in the way women and men talked about their illness experience. When describing their illness, women tended to talk at length about the progression of their symptoms. The whole history of the illness was discussed and every detail was told within the context of their lives. The women appeared to be justifying why they were in the hospital rather than at home fulfilling their role responsibilities.

Unlike the women, when describing their illness, men tended to use single words and sentences. The illness was never discussed at length. When asked about how the disease affected his life, Ghabby replied, "At work, for instance. Maybe I cannot work properly. The way that I should... I am talking in general". Fred simply stated his diagnosis and refused to elaborate. The illness prevented them from fulfilling their role responsibilities of protectors and providers, and, therefore there was no point in discussing it any further.

4.5.2. Illness experience as catalyst for confirming worth

The illness itself was not given much importance by either gender. Life with all its intricacies went on despite the illness. When a patient was hospitalized, the daily patterns of support and decision making extended from the home into the hospital. However, the hospitalization served to mobilize the family support mechanisms that assured the patients of their status and importance within their family units. The illness was then, simply, the catalyst that confirmed that worth.

Wilma was disappointed when, due to another family crisis, her children were not able to mobilize the mechanisms to support her in the ways she envisioned. She spoke of how she took care of her husband until he died. She spoke of how

she was so exhausted that she felt she was going to die herself and follow him. Now, because of the death of her granddaughter, her children were all occupied elsewhere. The researcher should note here, however, that during the course of the one-and-a-half hour interview, Wilma had two daughters with her and received two visitors and three phone calls. Two of the calls were from her niece and second cousin in France. The third call was from the eldest son, the father of the deceased granddaughter. One of the daughters present was a widow who had actually been staying with her mother prior to her hospitalization. Despite, this obvious show of family network support, Wilma commented that,

"They will support me in everything, of course. But now we've been struck with this disaster [referring to the illness and death of her granddaughter]. This is a disaster. Five months not one child could look at us".

None of the participants interviewed seemed to exhibit any concern about the possibility of lack of support during their illness. Their positions within the collective family established a pattern that did not change with illness or crises. This continuity helped them assess the disease process itself as non-anxiety-provoking.

4.6 Summary of findings

The domain of inquiry for this study was the meaning of social support as perceived by Arab Canadians with CHF within the context of a hospital setting.

The family was found to be the singularly most important unit. The family was obligated by love and social values, to support each individual through daily patterns of living and decision-making. This support extended into the hospital setting and encompassed decision-making and protection of the patient with CHF.

Men and women were found to have separate but complimentary responsibilities in caring for, supporting, and maintaining the family unit. None of the female participants worked outside the home but rather worked at raising and supporting children. The male participants fulfilled their role expectations of providers and protectors and were being supported by their family network. These role responsibilities were enacted as either caregivers for the ill parent or ill participants returning home to resume their responsibilities.

A supportive measure identified was the protection of the patient from a grave diagnosis. This protection extended across generations and included the filtering of all information given to the patient. The participants did not

discuss their diagnosis but rather their symptoms for which they expected a cure.

Language was found to be rich with expressions that invoked the name of God throughout the conversations. These expressions were meshed into the daily patterns of speech and were part of the communication etiquette. However, women seemed to have much more of these expressions in their speech patterns than men.

The spiritual support of utter reliance on God seemed to also explain the present orientation of the participants. The future was God's will.

Women also were more expressive than men in describing their illness experience. They expressed it in terms of their entire bodies, life, and daily activities. The men on the other hand simply mentioned it briefly and did not elaborate on signs and symptoms.

Both genders did not perceive the illness itself as important. Focus was given to the mobilized support mechanisms of family and friends. Older Arab Canadians with CHF, expected their families to fulfill their obligation of caring for and supporting them. This aspect of the illness experience was more important than the illness itself. The heart failure disease was not the part of the experience that was given importance, but rather whether the family network was

fulfilling its obligation. This fulfillment helped confirm to the individual patient his/her worth and importance within the family unit.

4.7 Limitations of the study

The limitations of the study are centered around (1) sample representation, (2) sample size, and (3) the researcher's background. It proved difficult to include an adequate representation of a few Arabic Countries in the participant selection. The Arabic community includes people from many countries and of three major religions: Christianity, Islam, and Druze. However, the sample consisted of seven Christian Lebanese participants. This can limit the transferability of the data. On the other hand, some of the findings, such as the centrality of family, are recognized in the literature as universal commonalities in the Arabic Community. A more in-depth study should include representation from other countries and from the Muslim population.

The common cultural background of the researcher and the participants could be considered a limitation because the researcher might unconsciously attribute meanings and interpretations to the situation. However, the more the researcher and the participants have in common, the greater the potential for an accurate understanding of the

participants' experiences and expressions. "Matching is a term used to recognize shared identities between researchers and study participants" (Sawyer, et al., 1995, p.558).

Additionally, the researcher's Arabic background might have presented a bias during data interpretation. This challenge to objectivity was controlled by the descriptive and extensive field notes as well as by the input of the thesis advisor and committee and key informants into the analysis. The personal journal kept through the course of the study, also helped focus the interpretations.

Despite her Lebanese background, the researcher found it difficult to recruit participants. This difficulty stemmed from the fact that the Arabic culture is very modest and private. A measure of trust needs to be established with the potential participants before they would consent to an interview. This is rather difficult if the researcher is a complete stranger who is approaching them with a request for a taped interview.

The female gender and nursing profession of the researcher might have been an influencing factor in the acquisition of data from the male participants, and may have discouraged potential participants from consenting to the study.

However, the fluency of the researcher in Arabic and the Lebanese dialect added depth to the data analysis. The researcher was able to analyze the data in both English and Arabic, which enriched and confirmed the findings.

In keeping with the qualitative research method of particularistic ethnography, the sample size is small. This would limit the generalizability of the findings.

Finally, the hospital setting of the interviews might have contributed to the perception of the participants that the health care providers were providing a "service". This perception might have been different had the interviews been at home. Also the limited time the researcher had to build a rapport with the participants might have contributed to limiting the quality and quantity of data collected. The formal setting combined with the natural distrust of strangers within this culture might have curtailed information sharing.

CHAPTER 5: DISCUSSION

This study set out to gain a better understanding of the perceptions of social support of a particular ethnic minority in Ottawa-Hull. The objectives of the study were:

1. To understand the meaning of social support for the Arab Canadian patient with congestive heart failure.
2. To explore the meaning of heart failure for Arab Canadians.
3. To describe how Arab Canadians with congestive heart failure would define a supportive social network and whom they would include in it.
4. To describe how an Arab Canadian with congestive heart failure would describe supportive and non-supportive interactions.

The meaning of social support for the Arab Canadian with congestive heart failure revealed three themes: "My family will take care of me", "I rely on God", and The illness is not important. The data analysis revealed that the three themes are interrelated and interwoven into a web-like lattice representing social support for the Arab Canadian with heart failure. Thus, the themes are discussed in relationship to one

another and the objectives of the study rather than in isolation.

5.1 Social support

Stewart et al.'s (1997) definition of social support, with its inclusion of health professionals as one of its components, had been originally chosen for this study. However, the findings revealed that the participants' own perceptions of support did not necessarily include health professionals. Therefore, a decision was made to base the structure of the discussion on the work of Cohen and Wills (1985) and on the social support network described by House and Kahn (1985) because of their congruence with the description by the participants.

As mentioned in the literature review, the defining attributes of social support as outlined by Cohen and Willis (1985) are emotional, instrumental, informational and appraisal support. In addition, House and Kahn's (1985) definition of social support includes the structure or social network which comprises such aspects as the size of the network; the number of contacts, the formal and informal nature of these contacts, such as family or friends versus health care professionals; and the degree of reciprocity and the mix of the relationship including culture and roles within

the network. The findings from the study are compared and contrasted to Cohen and Wills' (1985) four attributes of social support: emotional, instrumental, informational and appraisal support.

5.1.1. Emotional support

Emotional support was expressed by the participants in terms of care, respect and trust and was expected and received from family, friends, and, in some instances, neighbors. Of interest, the word "love" was rarely used but rather one lived for one's family as Anna stated,

"I do not need to live for myself or to be happy with my life, but I need to live for my children... One's life is for her husband and children".

Another interesting finding was emotional support as expressed by faith and reliance on God. This support was noted in the speech patterns of the participants and their spiritual expression of utter reliance on God's will.

For example, the name of Allah was mentioned frequently and invoked throughout the conversations. These references to God were so interwoven into the communication patterns that the researcher did not even notice them until she was translating the verbatim interviews into English. This use of faith as a form of support was referred to by Gibson (1992) as a personal characteristic. In addition, it is confirmed by the

findings of a nursing research literature review done by Baldacchino and Draper (2001) suggesting that the use of spiritual coping strategies helped individuals with their illness by finding a meaning and purpose behind it.

Speech patterns of the participants in the present study were observed to be embedded into the language used by the cultural group. Luna (1989) and Rashidi and Rajaram (2001) also described these expressions of faith in the Arab Muslim population.

Of note, in the current study, the expressions of faith were more evident in the women's speech patterns than the men's. One male informant commented that this does not imply that the women had more faith. It was simply the way they talked. No reference to this variance in speech patterns between Arabic men and women was found in the literature.

In addition, spiritual support was also noted in the expression of faith in and reliance on God, as the reason participants were not afraid. They relied on God to support them through their illness. The participants believed that whatever they were going through was "allowed by God". In other words, if a patient gets better, it is because God willed it, and if a patient gets worse, then it is because God has allowed it.

However, interpretations of this reliance on God must be viewed with caution. For example, Meleis and Jonsen (1983) described a case study of a 28-year-old Arab American patient admitted to the hospital with cellulitis and edema of the neck due to advanced Hodgkin's disease. The researchers reported how the Arab family reacted negatively when the question of termination of life support was introduced. The researchers cautioned that "an Arab's extreme reluctance to speak of death, to anticipate and prepare for it, should not be confused with his acceptance of its inevitability" (p.891).

Of interest, the faith in and reliance [ITTIKAL] on God translated into an orientation into the present for the participants. This present orientation was consistent with what has been reported in the literature, and has been attributed to faith in God and fears of defying His will if plans were made. Haddad and Hoeman (2000), Meleis (1991), and Meleis and Jonsen (1983) all reported that the Arabic patients did not plan for the future.

5.1.2. Instrumental support

During hospitalization with CHF, instrumental support was provided to the participants who were cared for and supported by their family members. The researcher observed that the family members stayed with them in the hospital throughout their waking hours and provided basic physical care, meals,

and translation services when the patient did not speak English or French. Reizian and Meleis (1986) made the same observation about Arab American patients almost never being alone when they visited a medical facility. They were always accompanied by family members who took on a supervisory role.

In the present study, instrumental support from health care providers took on a different meaning for the Arab Canadian with CHF. There was an evident distinction in the participants' perceptions of the support provided by family and friends versus the professional service [KHIDMEH] provided by health care professionals. Hupcey and Morse (1997) maintained this distinction by positing that social support is usually given by someone who has a personal relationship with the patient while professional support is a service governed by policies and standards of practice. Berkman and Seeman (1986) identified that, in cultures that are highly cohesive and well integrated, referral to social services may not be necessary. In this current study, two male participants refused homecare nursing services relying on their families instead. Meleis (1981) also echoed this finding in her study of Arab Americans. She stated, "Arab Americans do not expect personal care from health professionals; they expect effective cure. They expect and receive personal care from their families" (p. 1180). Thus, the offer or provision of personal

care was considered non-supportive, as was the inability of health care providers to "cure" heart failure. On the other hand, the "cure" or successful management of symptoms was considered quite supportive.

Because the participants expected a cure of their symptoms from the health care providers, they became disenchanted with the health care system when confronted with a chronic illness that had no cure. One participant attributed the lack of the cure to his perception that "they are all a bunch of students, no one know nothing".

5.1.3. Informational support

Informational support, in terms of information about the disease, its etiology, trajectory, and management, was not necessarily considered supportive unless expressed in terms of symptom management or a cure. Information sharing with the participants took on unique significance as information was filtered by the family in order to protect the patient from knowing a grave diagnosis.

Interestingly, participants in this study simply did not discuss their diagnosis. Their descriptions of support revealed it was better that families did not discuss it with the patients. The family members acted as a filter of information regarding stressful news. It must be noted, however, that during the interviews, family members were able

to contribute details regarding diagnoses and treatments, to the researcher, in front of the participants. Reizian and Meleis (1986) reported that, "Members of Arab families repeatedly have asked health professionals not to disclose grave diagnoses, level and intensity of pain, and expected or potential consequences to the patients. Some have gone so far as to blatantly ask health care professionals to keep the nature of the diagnosis and prognosis from the patient" (p.36).

Disclosure of diagnosis and poor prognosis has been examined in the Arab culture. For example, a study was done by Hamadeh and Adib (1998) in Beirut with Lebanese physicians to determine the proportion who chose truthful diagnosis disclosure to cancer patients and their families. The survey was completed by 212 physicians and revealed that withholding the truth from patients was accepted practice by Lebanese physicians, whose Code of Medical Ethics did not mandate disclosure of diagnosis. Fifty-three per cent of the physicians did not usually tell cancer patients the truth about their diagnosis or prognosis, and younger physicians and those with less experience were less likely to tell the truth to cancer patients. The belief that patients do not want to know, that confrontation with poor prognosis is detrimental to the patient, and the importance of disclosing to the

supportive family unit rather than to the individual were the reasons given for non-disclosure.

Adib and Hamadeh (1999) conducted a survey with a randomly selected sample of 489 outpatients with cancer, outpatients with other health problems, and visitors in a medical facility in Beirut, Lebanon. The survey covered data about socio-cultural and demographic variables, health status, current health complaints, and a series of statements with a Likert visual scale, eliciting participants' attitudes, beliefs, and expectations regarding disclosure of serious or terminal diagnosis. The results showed that "42% of the respondents generally preferred truth not to be disclosed directly to the patients. Preference for disclosure was associated with younger age, better education, and tendency to rapport-building with physicians" (p. 399). Brajtman and Gassner (2001) confirmed the unacceptability of discussing a terminal illness with an Arabic patient. Reizian and Meleis (1986) suggested that family members be consulted about treatment options and interventions since the patients would not know the diagnosis and would expect decisions to be made by family members.

This current study identified that some discussion did take place in front of the patient regarding the diagnosis.

Whether the patient took heed of the discussion, will never be known.

5.1.4. Appraisal support

Appraisal support is defined as the communication of information that is relevant to self-evaluation (Cohen & Wills, 1985); referring to communication that leads individuals to perceive themselves as loved, esteemed and cared for.

Appraisal support was expressed as respect and esteem for parents and the elderly. Parents gained more respect as they grew older. They served and supported their families throughout their lifetime and thus gained the respect and support of their children and grandchildren in later life. According to Lipson and Meleis (1983), elders gained status and honor with age and successful fulfillment of role responsibilities. Participants in this current study were confirmed their worth by the way they were supported and protected as patients.

5.1.5. Social network

House and Kahn (1985) referred to social networks as including size, nature of contacts, reciprocity, roles and culture within the network. This study offered insight into the social network of the Arab community including size and

role gendered responsibilities. For example, the smallest unit in this cultural group was not the individual but rather the family. This was confirmed by Joseph (1982) who studied the structure of the Lebanese families in Beirut and found that the family was considered the center of all social life in the Arabic world and stated, "The literature on the Arab world is almost unanimous in proclaiming the centrality of the family in the Middle East" (p. 152). Reizian and Meleis (1986) stressed the family as the most important and most prominent social unit.

According to Joseph (1982) and May (1992), the family was the primary source of identity for the individual. Support was for family and from family. The family gave the lives of the individuals meaning. Lipson and Meleis (1985) also found that there was rarely such a thing as individual decision or individual energy with the Arabic patients. The source of energy for the individual was the family.

The social network of the participants also extended beyond the immediate family to encompass extended family, friends, neighbors, and clergy, confirming the findings of Hirth and Stewart (1994) who explored the social network of patients awaiting cardiac transplantation. The participants in the current study consistently insisted that their families and relatives were obligated by love and social responsibility

to help them. "What else?! Wouldn't they help?" There was no anxiety displayed by the participants about the possibility of lack of support by the network in and out of the hospital. The literature on social support indicates that this network with its multiple links to family and friends and the support functions of these links can form a safeguard against ill health, stress, and disease (Callaghan & Morrissey, 1993; Fridlund et al., 1993); and can contribute towards positive mental and physical health outcomes (Hellman & Stewart, 1994).

For example, having heart failure was not found to be the important part of the experience to the participants, and thus was not considered anxiety provoking. The illness itself was viewed as something God allowed to happen, and therefore, the participants did not dwell on it. The family unit rallied its resources around the individual taking care of every day decisions and routines and making the experience as stress-free as possible for the individual. This finding challenged the process of becoming a patient as outlined by Stull et al. (1999) in their study of patients diagnosed with heart failure. The patients described their feelings in that study as "scared", "worried" and "nervous".

The gender role responsibilities of men and women were found to be different and complementary towards achieving the common goal of supporting the family. Women tended to provide

the bulk of emotional and instrumental support in terms of nurturing, basic care, meals, visits, and phone calls.

In addition, role responsibilities of women revolved around the nurturing of the children and the husband. Women managed the home and cared for the children with equal dedication and love. They gained their status and importance in the home and in the community by how well they fulfilled their role. Aswad (1967, 1974) confirmed the current study findings of women being powerful figures in kin and community. Also, women had authority related to the daily care of home and children. Therefore, they had the ability to shape the future and reputation of their families. By fulfilling their role responsibilities as expected, they gained the respect of their children and community (Hattar-Pollara & Meleis, 1995a). This finding challenges the interpretations of sociologists and anthropologists who cast women's role in the Arab culture as a subservient position.

Men, on the other hand, had the role responsibility of financial and material provision for the family. They toiled to provide a secure home for the family. They were viewed as the head of the home and, thus, were deferred to whenever a major decision was to be taken. They gained their status and importance by how well they fulfilled their role responsibilities of protectors and providers. This finding

corroborates Al-Krenawi and Graham's (2000) description of Arab men as heads of the home and disciplinary figures. Men were also expected to provide the emotional and esteem support to their wives when they were ill as demonstrated by the statement of Anna's husband, "No one will take your place".

In addition, men provided the "power" of their presence, as best expressed by Ed,

" The man's support (SANAD) is of a different color... His presence is enough to have a different bend. That is a man... The woman comes after in the second degree... She doesn't have the same power on a person... Of course, she knows everything and does everything at home... She is everything at home".

The women's role was to ensure boys were raised to be providers and protectors, while girls were raised to be caregivers and nurturers. The behaviors of the daughter, including observing the social etiquettes, were viewed as a direct reflection of the mother carrying out her role responsibilities. "Daughters who do not maintain modest behavior and chastity are perceived as destroying the family reputation", and the mother is viewed as though she has failed in her duties (Lipson & Miller, 1994, p 178). If there were a failure in duty, this could be manifested by decreased respect during illness.

The roles of caregiver and provider/protector were complementary representing two separate parts of a whole that appeared to be working together towards a harmonization of the family unit. The complementary role responsibilities implied the reciprocity of support within the network (Stevens, 1992).

However, with successive generations or more recent immigrants, a blurring of men and women roles may be noticed. For example, the researcher witnessed occasional tension between the two generations at the bedside. According to Lipson & Miller (1994), this blurring of the roles may be happening as women from traditional patriarchal societies are assimilating into the North American culture and are holding jobs outside the home.

Gender differences were also noted in the way men and women described their illness experiences. The female participants spoke at length about their symptoms of shortness of breath, the water on the lungs and the leg swelling as though these comprised the illness. Women's descriptions situated the experience within the context of their entire lives. It appeared as if they were trying to explain why they were not at home fulfilling their role responsibilities, but rather in the hospital in need of support from their families.

The male participants, on the other hand, chose not to elaborate much about the illness experience, replying with short terse phrases to questions about their illness.

According to Reizian and Meleis (1986), Arabic patients tend to be specific, precise, and descriptive of their symptoms while describing the experience of being ill, in general, putting it within the context of their lives. While this observation was true of the female Arab Canadian participants with heart failure, the statement does not seem to apply to the male participants.

House and Kahn (1985) include culture in their description of social networks. In this study, the cultural group had a direct effect on the availability and mobilization of support resources to deal with the illness as well as to minimize anxiety related to the hospital experience. To the members of this culture, support was constantly available and a given, through culturally determined role responsibilities of the network, in and out of the hospital setting.

Interestingly, the participants did not differentiate between perceived support and received support as referred to in the literature (Barrera, 1986; Callaghan & Morrissey, 1993; Gibson, 1992; Stewart, 1989). Rather they had expectations as to the constant availability of support in this culture. Leininger (1988) posits that culture and care are inextricably

linked together and that care expressions and practices are influenced by the social network and have a direct effect on health and well being.

5.2 The language of support

In the current study, the meaning of social support had to be indirectly inferred from the data because it was not directly expressed by the participants. In fact, the words most frequently used to describe social support by the participants were SANAD and DAAM. **SANAD** literally means a prop that prevents something or someone from falling. **DAAM**, on the other hand is the prop that helps something or someone stay up. Another word that was also used was **MUSAADEH**. **MUSAADEH** is a word with many meanings that depends on the context of the sentence. It can be translated as help, care, assistance, or support. Interestingly, the context in which it was most frequently used by the participants was care. Family, friends, and neighbors provided **SANAD**, **DAAM**, and **MUSAADEH** to the Arab Canadian with heart failure. These were expressed in the form of providing basic care, visits, phone calls, gifts, respect, protection, material provisions, and faith.

Finally, social support to the Arab Canadians with heart failure was constantly available both in and out of the hospital setting and was a given. This expectation of support

by the participants influenced the perception of health status and reaction to the illness experience.

CHAPTER 6: IMPLICATIONS AND RECOMMENDATIONS

The findings from data analysis can shed light on aspects of the Arab Canadian culture related to family, faith, and perception of illness. The outcomes have the potential to guide health care professionals in providing culturally sensitive care.

Implications for nursing practice, education, and research will be presented as well as recommendations for advanced practice. A re-examination of the paradigm that governs the nursing discipline will also be presented in light of the findings.

6.1 Culturally sensitive care

The findings from this study demonstrated that for Arab Canadians with CHF, support was constantly available. This expectation of support influenced, for example, reactions to the illness. The spiritual support of faith and reliance on God seemed to explain the present orientation of the participants. The findings also demonstrated that participants relied on the family for filtering information and basic care, as well as decision-making.

Culturally sensitive care is fast becoming a critical component of successful outcomes and health services (Rollins, 1997; Setness, 1998). Providing culturally sensitive care requires heightened awareness as well as concrete educational strategies in both clinical and academic settings. Recommendations regarding culturally sensitive care are made for both practice and education.

6.1.1. Nursing practice

The first step in providing competent cultural care is proper assessment for cultural needs. The College of Nurses of Ontario [CNO] (1999) recommended the several questions as part of the cultural assessment tool. For example, the tool included questions such as:

1. What do you think the sickness does to you?
2. What are the major problems the sickness has caused?
3. What kind of treatment do you think you should receive?
4. What do you fear most about your sickness?
5. What do you fear most about the treatment?

However, results of the current study would question the appropriateness of these questions in this culture given their lack of knowledge regarding their illness and its treatment. The nurse is thus encouraged to tailor her assessment

questions to the individual patient in order to understand the patients' perceptions of their situation, their illness and symptoms, and their expectations about treatment. Nurses need to plan care around what the patients already know and want to know, rather than what is expected of them to know. This will minimize cultural conflict, improve the therapeutic relationship, and increase adherence to the treatment plan. "Knowledge, inquiry, and non-judgemental acceptance of folk illness beliefs may enhance the quality of the interaction between the patient and the health care system" (Pachter, 1994, p. 692).

For example, a problem might arise when a patient openly declares or implicitly communicates he/she not be told of a grave diagnosis or a poor prognosis. In this case, health care providers need to tailor their decisions and interventions accordingly. The health care provider can optimize the patient's options by establishing who the decision maker is at the very beginning and involving the family unit in the care and management of the illness. Vandekieft (2001) recommends a simple mnemonic, ABCDE, to help health care professionals prepare for and disclose bad news: **A**dvance preparation of time, privacy, and presence of family; **B**uilding a therapeutic relationship and identifying patient preferences regarding

disclosure; Communicating well; Dealing with patient and family reactions; and Encouraging and validating emotions.

Resources for nurses in the clinical setting could include assessment guidelines, cultural health profiles, access to interpreter services, instructions in the mother tongue of the dominant ethnic groups in the community, and guidelines for cultural care planning. For example, guidelines for care planning could include information related to birth and death rites.

6.1.2. Direct care

The results from the data analysis, as well as conversations before and after the interviews, revealed that the participants expected aspects of personal care to be given by the family members. For example, consulting the patients about what aspects of care they would prefer to receive from their family members is imperative prior to initiating hygiene measures. The nurse can then focus on assessment of the patient, provision of treatments, as well as teaching the family.

This study also revealed the importance of resuming role responsibilities to this cultural group. Nurses need to focus on helping patients to regain functional status for everyday living.

6.1.3. Patient education

Nurses, in the role of educators, need to learn to enter into their clients' experience in order to establish rapport and assess not only the readiness to learn but also whom to involve in the learning. The daily patterns of support and decision making of Arab Canadians were found to revolve around the family rather than the individual. The nurse should expect that this context of family to extend into the hospital setting when a member is a patient.

Therefore, informational support, by the health care professionals, should be provided to the family including the patient. The family members will then encourage and motivate the patient to follow the plan of care, which, with CHF, would include the medication and diet regimen.

Since Arab Canadians come to the hospital mostly for a cure of either the disease or at least the symptoms, it is suggested that nurses concentrate most of their patient and family education on symptom management rather than the process of the disease. Patients would more likely follow a regimen of diet or medications if these were addressed in terms of symptom management within the context of the patients' whole lives. For example, an Arabic woman would more likely decrease her salt intake if the teaching was done to the whole family and stressed as something that will benefit all of them rather

than the patient alone.

Providing teaching to this cultural group should emphasize improvement in functioning so that role responsibilities can be resumed. Aspects of prevention and health promotion might be more useful if linked with the notion of functioning, which is present oriented. To encourage Arab Canadian patients and their families to manage congestive heart failure, it would be advisable to present the interventions in terms of short-term symptom management strategies with periodic follow-ups rather than long term planning (Al-Krenawi & Graham, 2000). Targeting short-term goals is more in congruence with the present-oriented Arab Canadians.

6.1.4. Discharge planning

The findings from this study provide a view of the Arab Canadians' family structure and social resources. Parents and the elderly were highly respected and honored. Their children were directly involved in their care in and out of the clinical setting and should be included in any discharge planning. Health care professionals can collaborate with the patient's support network to provide family-oriented rather than individual-oriented care and discharge planning.

Multidisciplinary discharge rounds for inpatients could incorporate the family in the planning process. Families are the patients' support system and are directly involved in the activities of daily living, by providing emotional, appraisal and instrumental support. By involving the family in the discharge planning, the patient will, most likely, need less resources such as homecare and homemaking services. Having this knowledge would lead to less misuse and waste of health care resources. Although lack of social support was not noted in the participants' descriptions in this study, the literature review revealed challenges associated with the immigration experience and loss of support network. Special attention might be needed if an Arab was without extended family. In this case, health care professionals could make links with Arab community associations for home support.

6.1.5. Clinical education (Staff development)

Cultural care knowledge should be incorporated into the clinical education of primary and tertiary care settings in areas where cultural diversity is an identified issue. The health care facilities in Ottawa-Hull, which is an area of high diversity, would benefit by investing in creating clinical training programs on cultural care for their nursing staff. The programs would target proper cultural assessments,

health profiles and practices of the ethnic and cultural groups in the community, and cultural care planning such as when the diagnosis is not known to the patient. This might help bridge the gap between cultures and increase patient and staff satisfaction with the care delivered.

6.1.6. Academic curricula

Academic Curricula are sets of knowledge that reflect the values and orientations of the nursing profession. This study brought forth aspects of the Arab Canadian culture that focus on the centrality of faith, family, and the meaning of illness when caring for Arab clients.

Aspects of a nursing curriculum need to reinforce the importance of the family in assessing and providing care. As well, the inclusion of faith as a form of support needs further recognition.

Educators are responsible for preparing nursing graduates who are culturally sensitive caregivers, co-workers, and leaders. To that end, Lockhart and Resick (1997) presented an undergraduate three credit elective nursing course on transcultural nursing care. The objectives of the course were to explore the evolution of transcultural nursing, examine the concepts of transcultural nursing, examine health care delivery and acceptance issues, investigate cultural diversity

in nursing, and explore ways to promote knowledge development and the profession's involvement in transcultural nursing.

In addition, the Transcultural Assessment Model [TAM] (Giger & Davidhizar, 1999) used by Lockhart and Resick provides a framework for cultural assessment through the inclusion of assessment for six cultural phenomena that vary yet are evident in all cultural groups. These are,

- Communication: verbal, non-verbal, or a combination of both.
- Personal space, or lack thereof.
- Social organization: the role of the family, gender roles, and life stages.
- Time orientation: past, present or future.
- Environment including perceptions of health and illness, health care providers, and death and dying.
- Biological variation and genetic predisposition.

6.2 Nursing research

This study generated a number of findings that merit further research to explore the cultural care beliefs and attitudes of the ethnic population in order to guide a more culturally sensitive nursing practice. By exploring the meaning of social support to the Arab Canadians with CHF, the

need for further research to better describe concepts such as faith, health, and family, became quite apparent. Recommended lines of research include ethnographic studies to investigate:

1. The meanings of Care to the Arab Canadian in Ottawa within the contexts of home and hospital.
2. The meanings of care and support to second and third generation Arab Canadians.
3. The concepts of faith, health, and family within the Arab Canadian culture.
4. The issues of disclosure of grave diagnosis to Arab Canadian patients.
5. The meaning of other chronic and terminal illnesses like diabetes and cancer in Arab Canadian culture.
6. Caregiver burden for families of Arab Canadian patients with heart failure and other chronic illnesses.
7. The process of becoming a patient within this cultural group.
8. Measures to promote adherence to treatment regimens in this cultural group.

The study underlined the importance of using qualitative research methodologies especially with cultural studies examining values and beliefs. The researcher would not have been able to extract many of the findings from the data had a quantitative methodology been used. Health care professionals

use concepts such as social support and chronic illness in their practice and communication. However, their meanings to clients must be qualified with their own stories and descriptions. In this current study, participants did not speak directly of social support and its meaning but rather implied it with their descriptions of obligation, roles and faith. This gave the meanings depth and richness that would have been lost with a quantitative design.

Meleis (1996) recommends the methodology of choice to be qualitative if the phenomena being studied include cultural patterns, values, beliefs, and lifestyles. If, however, the phenomena of study are driven by concepts of health, transition, marginalization, or self-care, then she recommends a combination of qualitative and quantitative designs to better compare and contrast findings. Meleis also recommends researcher-participant matching where the researcher is an insider to the culture being studied.

6.3 Advanced practice role

Nurses often believe they are not equipped to interpret certain behaviors and thus are unable to help their culturally different patients. This contributes to burnout and a feeling of helplessness in their role (Leininger, 1993).

One of the most significant developments in nursing is

the establishment of the field of transcultural nursing (Leininger, 1993). This was defined by Leininger (1993) as, "a formal area of study and practice focused on the cultural beliefs, values, and lifeways of diverse cultures and on the use of this knowledge to provide cultural specific or cultural universal care to individuals, families, and groups, of particular cultures".

The transcultural care specialist, who is prepared through graduate education (e.g. Masters of Sciences in Nursing), will serve as an expert in cultural care practice, education, research, and consultation. The role is becoming more essential within the health care setting of Ontario that is home to 52.6% of the visible minorities of Canada, and especially in Ottawa-Hull, home to 16.5% of all immigrants to Canada (Statistics Canada, 1998).

The following roles are conceptualized using Leininger's recommendations for the transcultural care specialist.

1. As a clinician, the transcultural care specialist will disseminate cultural research findings into the clinical setting to aid nurses and health care teams in caring for their ethnically diverse population. He or she will initiate clinical protocols of cultural assessment and care planning to increase nurses' cognitive and emotional

comprehension of the cultural groups and avoid cultural conflicts with the clients and their families. For example, the transcultural nurse specialist can alert the staff to focus education on management of symptoms and to include the family in decision making and discharge planning with Arab Canadians with heart failure.

2. Within the consultant role, the transcultural care specialist will be able to communicate her/his knowledge and expertise in cultural care to other disciplines where a diverse population is served. The specialist can assess the clients and create individualized health profiles to assist the multidisciplinary team in planning the care.
3. The transcultural care specialist will also be in a position to generate new knowledge through ongoing research.
4. Lastly, as an educator, the transcultural care specialist will be called upon to initiate new courses and programs in cultural nursing care in academic institutions, hospitals, and clinics. These courses would target the multidisciplinary team members and would include proper cultural assessment skills. One such assessment model that could be used is Giger and Davidhizar's (1999) transcultural assessment model, that was discussed in the section on culturally sensitive care. The programs would

also include modules on interventions and care planning with the culturally diverse clients and general health profiles of the cultural populations most prominent in Ottawa-Hull.

The position of transcultural care specialist has been in existence since the seventies across the United States. With the increased diversity of the patient population of Ottawa-Hull, the need for that role is becoming more critical.

6.4 Nursing discipline

The study also underlined the need for the discipline of nursing to redefine and expand the meta-paradigm that has been the pillar of nursing knowledge for the last three decades. Cultural nursing theorists have stressed the need to polish the nursing meta-paradigm, with its general concepts of person, nursing, health, and environment into more culturally inclusive and relevant concepts. The section below will present some of the work already done in this area:

Person

Our discipline's central vision of the concept of person is well represented in the works of nursing theorists such as Orem (1980) and Neuman (1982) who conceptualized individual clients as dynamically organized systems with specific genetic

and physical makeup. With Giger & Davidhizar (1999), transcultural nursing uses the concept of "culturally unique client" in informing its theoretical foundation. While celebrating cultural diversities of people, the concept also acknowledges the importance of individual variation.

The findings give credit to our discipline's representation of the family as the patient and command the expansion of knowledge on the family as well as a reconsideration of concepts such as autonomy. In this current study, the smallest unit in the Arab Canadian culture was recognized to be the family rather than the individual, moving the emphasis to family-centered care. In addition, concepts such as autonomy might not be as valued in a culture that emphasizes family decision-making during times of illness. Whether future generations of Arab Canadians would follow in the footsteps of their parents is yet to be seen. However, with the present sample, the need to know should not be confused with the right to know as was the case with Anna and Ghaby who appreciated the need to shelter the patient from a grave diagnosis and filter through only what is perceived necessary for the patient to know.

We must emphasize the utility of qualitative inquiry to gather relevant information on patency. Looking at the language of the individual and of the family allows us to

learn about the cultural context, language being an essential medium of communication. We must also elaborate further on our knowledge so that gender particularities are distinguished from sexist constructions.

Health

Leininger (2001) conceptualized health as a state of well being that is culturally defined and which reflects the ability of individuals to perform their daily roles in a culturally patterned lifeway. This definition expands on, for example, Neuman's (1982) and Orem's (1980) conceptualization of health as a process or a continuum of health and illness that develops over time. Leininger's definition stresses the view that it is culture not nature that defines disease. The participants in this current study viewed their symptoms within the context of their entire lives and their abilities to perform their role responsibilities. What was considered important was being able to function in order to resume role responsibilities, rather than the etiology of the illness. This focus confirms Leininger's conceptualization of health and signals the need for a sounder theoretical linkage of the concept of health with the more pragmatic concept of human functioning.

Nursing

Knowledge on nursing process is more involved than that described by Neuman (1982) as assessment, planning, interventions and evaluation as a mode of practice. Andrews and Boyle (1995, 1999) expanded the conceptualization of nursing to include the nurse (with her culture), the process, and the interaction between the nurse and the culturally unique client. The cornerstone of this conceptualization of nursing is the transcultural concept of care (Leininger, 2001). The Arab Canadian participants in this current study concentrated on the usefulness of the interaction between them and the health care professionals in helping them resume their lifeways rather than on understanding the etiology and process of their illness. Nursing should further develop its practice foundations to include cultural particularities and its knowledge on human interactions within nurse-patient situations.

Environment

Leininger (2001) saw the environment as encompassing the physical (climate, geography, sanitation, etc.), ecological (flora, fauna, etc.), sociopolitical (family, group, community, politics, religion, etc.), and cultural (art, music, history, language, etc.) settings. This definition is an expansion of,

for example, Neuman's (1982) view of the environment as comprised of stress factors. The participants in this current study, through cultural and religious beliefs, were found to have a present orientation to time. This time orientation is in direct conflict with the future orientation of nurses in Western cultures that emphasizes preventative treatments and planning for long term therapies. The need to broaden the description of the concept of environment is one of this study's strong conclusions.

The findings also support the belief that there are no rigid separations between the personal environment and the external environment. Here, the personal, social, and macro-social environments are intimately connected, which puts the focus on the need to develop theories that discuss the circularity of the environment's components.

6.5 Conclusion

This study provided additional insight for nursing into the meaning of social support for Arab Canadians with congestive heart failure within the context of a clinical setting. The method used was particularistic ethnography.

Seven Arab Canadian participants, who were specifically Christian Lebanese, were interviewed in the hospital during their admission with congestive heart failure. The data

collected was then analyzed to reveal three dominant themes that were interwoven together. These themes were: "My family will take care of me", "I rely on God", and The illness is not important. Each of these themes were expanded on and compared to existing literature.

Some of the findings of this study are consistent with what is already documented in the literature with respect to the kinship worldview of family by the Arab population. The family was found to be the singularly most important unit in the community. The family is obligated by love and social values, to support each individual through daily patterns of living and decision-making. This support extends into the hospital setting and encompasses decision-making and protection of the patient with CHF.

The gender role responsibilities of support and care were consistent with the findings in the literature. Men and women have separate but complimentary responsibilities in caring for, supporting, and maintaining the family unit.

The study emphasized the driving force of faith in the language and lives of the participants. The language was rich with expressions that invoke the name of God throughout the conversations.

Of interest, the participants did not seem to dwell on the chronic nature of the illness but rather on its symptoms.

This study has contributed new knowledge in terms of the gender differences of expression with women more expressive than men in describing their illness experience. Both genders, however, did not perceive the illness itself as important. The heart failure disease is not the part of the experience that is given importance, but rather whether the family network is fulfilling its obligation. This fulfillment helps confirm to the individual's worth and importance within the family unit.

In conclusion, the meaning of social support for the Arab Canadian with heart failure has stressed the importance of promoting culturally sensitive education, practice, and research. The need to create cultural care programs within the health care context has been made apparent.

ENDING

The level of personal growth and rich insight gained by the researcher into the Lebanese community of Ottawa-Hull were invaluable, as was the research mentorship. The experience was life altering and most rewarding.

As this time of discovery comes to an end, I must share with you a passage from a book I read in Arabic as a child. This book has been translated into more than thirty languages and read by millions of people worldwide. The author still influences people through his words decades after his death. I pray it will be as meaningful for you.

And a man said, Speak to us of Self-Knowledge.

And he answered, saying:

Your hearts know in silence the secrets of the days and the nights.

But your ears thirst for the sound of your heart's knowledge.

You would know in words that which you have always known in thought.

You would touch with your fingers the naked body of your dreams.

And it is well you should.

The hidden well-spring of your soul must needs rise and run murmuring to the sea;

And the treasure of your infinite depths would be revealed to your eyes.

But let there be no scales to weigh your unknown treasure;

And seek not the depth of your knowledge with staff or sounding line.

For self is a sea boundless and measureless.

Say not "I have found the truth", but rather, "I have found a truth".

Say not "I have found the path of the soul", but rather, "I have met the soul walking upon my path".

For the soul walks upon all paths.

The soul walks not upon a line; neither does it grow like a reed.

The soul unfolds itself, like a lotus of countless petals.

The Prophet

(Kahlil Gibran, 1923/1995)

REFERENCES

AbuGharbieh, P. (1998). Arab-Americans. In L.D. Purnell and B.J. Paulanka (Eds.), Transcultural Health care: a culturally competent approach (pp. 137-162). Philadelphia, F. A. Davis.

Adib, S. & Hamadeh, G. (1999). Attitudes of the Lebanese public regarding disclosure of serious illness. Journal of Medical Ethics, 25, 399-403.

Advisory Council To Improve Outcomes Nationwide in Heart Failure [ACTION HF]. (1999). Consensus recommendations for heart failure. The American Journal of Cardiology, 83 (2A), 1A-38A.

Agar, M. (1986). Speaking of Ethnography. Newbury Park, California: Sage Publications.

Agency for Health Care Policy and Research [AHCPR] (1998). Guidelines on heart failure. U.S. Department of Health and Human Services, Public Health Service. Retrieved April 1999 from the World Wide Web:

<http://www.text.nlm.nih.gov/ftrs/gateway>

Al-Krenawi, A. & Graham, J.R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. Health and Social Work, 25(1), 9-22.

Andrews, M.M. & Boyle, J.S. (1995). Transcultural concepts in Nursing Care, 2nd Ed. Philadelphia, PA: Lippincott Williams & Wilkins.

Andrews, M.M. & Boyle, J.S. (1999). Transcultural concepts in Nursing Care, 3rd Ed. Philadelphia, PA: Lippincott Williams & Wilkins.

Antonucci, T.C. (1985). Social support: Theoretical advances, recent findings and pressing issues. In I.G. Sarason and B.R. Sarason (Eds.) Social Support: Theory, research, and applications, (pp. 21-49). Boston, Massachusetts: Martinus Nyhoff Publishers.

Aswad, B. (1967). Key and peripheral roles of noble women in a Middle Eastern plains village. Anthropological Quarterly, 40, 139-152.

Aswad, B. (1974). Visiting patterns among women of the elite in a small Turkish city. Anthropological Quarterly, 47, 9-27.

Atkinson, P. & Hammersley, M. (1994). Ethnography and participant observation. In N.K. Denzin and Y.S. Lincoln (Eds.) Handbook of qualitative research, (pp. 248-261). Thousand Oaks, California: Sage Publications.

Backeland, F. & Lundwall, L. (1975). Dropping out of treatment: A critical review. Psychological Bulletin, 82, 738-783.

Baldacchino, D. & Draper, P. (2001). Spiritual coping strategies: a review of the nursing research literature. Journal of Advanced Nursing, 34 (6), 833-841.

Barrera, M. (1986). Distinctions between social support concepts, measures, and models. American Journal of Community Psychology, 14(4), 413-445.

Belenky, M.F. (1992). "Bringing Balance to the Classroom or Workplace" paper presented at the Wisconsin Women's Studies conference, Pre-conference workshop, Green Bay, Wisconsin.

Bennett, S.J., Baker, S.L., & Huster, G.A. (1998). Quality of life in women with heart failure. Health Care for Women International, 19, 217-229.

Berkman, L.F., Leo-Summers, L., & Horwitz, R.I. (1992). Emotional support and survival after myocardial infarction: a prospective, population-based study of the elderly. Annals of Internal Medicine, 117, 1003-1009.

Berkman, L.F. & Seeman, T. (1986). The influences of social relationships on aging and the development of cardiovascular disease - a review. Postgraduate Medical Journal, 62, 805-807.

Boone, M.S. (1985). Social and cultural factors in the etiology of low birth-weight among disadvantaged blacks. Social Sciences & Medicine, 20(10), 1001-1011.

Boyd, C.O. (1993). Toward a nursing practice research

method. Advances in Nursing Science, 16(2), 9-25.

Boyle, J. S. (1994). Styles of ethnography. In J.M. Morse (Ed.), Critical issues in qualitative research methods (pp. 159-185). California, Newbury: Sage Publications.

Brajtman, S. & Gassner, R. (2001). Israel. In B.R. Ferrell & N. Coyle (Eds.) Textbook of Palliative Nursing, (pp. 781-787). Oxford: University Press.

Brostrom, A., Stromberg, A., Dahlstrom, U., & Fridlund, B. (2001). Patients with congestive heart failure and their conceptions of their sleep situation. Journal of Advanced Nursing, 34 (4), 520-529.

Callaghan, P. & Morrissey J. (1993). Social support and health: a review. Journal of Advanced Nursing, 18, 203-210.

Chin, M.H., Goldman, L. (1997). Correlates of early hospital readmission or death in patients with congestive heart failure. American Journal of Cardiology, 79, 1640-1644.

Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38 (5), 300-314.

Cohen, S. & Wills, T.A. (1985). Stress, social support, and the buffering hypothesis. Psychological Bulletin, 98 (2), 310-357.

College of Nurses of Ontario (1999). A guide to nurses for providing culturally sensitive care. Toronto, Ontario: Author.

Creswell, J.W. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage Publications.

Daddy, J. & Clegg, A. (2001). Cultural sensitivity: a practical approach to improving services. Nursing Standard, 15 (33), 39-40.

Dimond, M. & Jones, S. (1983). Social support: A review and theoretical integration. In P.L. Chinn (Ed.), Advances in nursing theory development (pp. 235-249). Maryland: Aspen Systems Corp.

Evangelista, L.S., Berg, J., & Dracup, K. (2001). Relationship between psychosocial variables and compliance in patients with heart failure. Heart & Lung, 30(4), 294-301.

Fridlund, B., Stener-Bengtsson, A. & Wannman, A. (1993). Social support and social network after acute myocardial infarction; the critically ill male patient's needs, choices and motives. Intensive Care and Critical Nursing, 9, 88-94.

Friedman, M.M. (1997). Social support sources among older women with heart failure: Continuity versus loss over time. Research in Nursing & Health, 20, 319-327.

Friedman, M.M. & King, K.B. (1994). The relationship of emotional and tangible support to psychological well-being among older women with heart failure. Research in Nursing & Health, 17, 433-440.

Gibran, K. (1995). The Prophet. New York: Alfred A. Knopf. (Original work published in 1923)

Gibson, C.H. (1992). A revised conceptualization of social support. Journal of Clinical Nursing, 1, 147-152.

Giger, J.N. & Davidhizar, R.E. (1999). Transcultural nursing: assessment and intervention (3rd ed.). St. Louis, Missouri: Mosby, Inc.

Haddad, L.G. & Hoeman, S.P. (2000). Home health care and the Arab-American client. Home Healthcare Nurse, 18(3), 189-197.

Hamadeh, G.N. & Adib, S.M. (1998). Cancer truth disclosure by Lebanese Doctors. Social Sciences and Medicine, 47(9), 1289-1294.

Happ, M.B., Naylor, M.D., & Roe-Prior, P. (1997). Factors contributing to rehospitalization of elderly patients with heart failure. Journal of Cardiovascular Nursing, 11(4), 75-84.

Hattar-Pollara, M. & Meleis, A.I. (1995a). Parenting their adolescents: the experiences of Jordanian immigrant women in California. Health Care for Women International, 16, 195-211.

Hattar-Pollara, M. & Meleis, A.I. (1995b). The stress of immigration and the daily living experiences of Jordanian immigrant women in the United States. Western Journal of

Nursing Research, 17(5), 521-539.

Health Canada. (1997, October 16). Heart Disease and Stroke in Canada. Ottawa: Health Protection Branch - Laboratory Center for Disease Control. Retrieved September 3, 1999 from the World Wide Web:

<http://www.hc-sc.gc.ca/hpb/lcdc/bcrdd/hdsc/>

Hellman, A.E. & Stewart, C. (1994). Social support and the elderly client. Home Healthcare Nurse, 12(5), 51-60.

Higgins, P.G. & Learn, C.D. (1999). Health practices of adult Hispanic women. Journal of Advanced Nursing, 29(5), 1105-1112.

Hirth, A.M. & Stewart, M.J. (1994). Hope and social support as coping resources for adults waiting for cardiac transplantation. Canadian Journal of Nursing Research, 26(3), 31-47.

Hourani, A. (1991). A History of the Arab Peoples. Cambridge, Mass.: Belknap Press of Harvard University Press.

House, J.S. & Kahn, R.L. (1985). Measures and concepts of social support. In S. Cohen and S.L. Syme (Eds.), Social support and health (pp.83-106). Toronto, ONT: Academic Press.

Hupcey, J.E. & Morse, J.M. (1997). Can a professional relationship be considered social support? Nursing Outlook, 45(16), 270-276.

Jaarsma, T., Halfens, R., & Huijjer-Abu Saad, H. (1996).

Readmission of older heart failure patients. Progress in Cardiovascular Nursing, 11 (1), 15-20, 48.

Joseph, S. (1982). Family as security and bondage: A political strategy of the Lebanese urban working class. In H. Safa (Ed.), Towards a political economy of urbanization in third world countries (pp. 151-171). Delhi: Oxford University Press.

Kahn, R.L. & Antonucci, T.C. (1980). Convoys over the life course: Attachments, roles, and social support. In P.B. Baltes and O. Brim (Eds.), Life-span Development and Behavior (vol.3). New York: Academic Press.

Kulwicki, A. (1996). An ethnographic study of illness perceptions and practices of Yemeni Arabs in Michigan. Journal of Cultural Diversity, 3(3), 80-89.

Laffrey, S.C., Meleis, A.I., Lipson, J.G., Solomon, M., Omidian, P.A. (1989). Assessing Arab-American health care needs. Social Sciences and Medicine, 29(7), 977-883.

Langford, P.H., Bowsher, J., Maloney, J.P. & Lillis, P.P. (1997). Social support: a conceptual analysis. Journal of Advanced Nursing, 25 (1), 95-100.

Lazarus, R.S. & Folkman, S. (1984). Appraisal, coping, and adaptational outcomes. In R.S. Lazarus and S. Folkman (Eds.), Stress, appraisal and coping (pp. 181-225). New York: Springer Publishing Company.

Leininger, M. (1985a). Transcultural care diversity and universality: A theory of nursing. Nursing and Health Care, 6 (4), 209-212.

Leininger, M. (1985b). Ethnography and Ethnonursing: models and modes of qualitative data analysis. In M. Leininger (Ed.), Qualitative methods in nursing (pp. 33-71). New York: Grune and Stratton.

Leininger, M. (1988). Leininger's theory of nursing: Cultural care diversity and universality. Nursing Science Quarterly, 1(4), 152-160.

Leininger, M. (1990). Ethnomethods: the philosophic and epistemic bases to explicate transcultural nursing knowledge. Journal of Transcultural Nursing, 1(2), 40-51.

Leininger, M. (1991). Cultural care diversity and universality: A theory for nursing. New York: National League for Nursing.

Leininger, M. (1993). The transcultural nurse specialist: imperative in today's world. Nursing and Health Care 10(5), 151-156.

Leininger, M. (1994). Evaluation Criteria and Critique of Qualitative Research Studies. In J.M. Morse (Ed.), Critical issues in qualitative research methods (pp. 95-115). California, Newbury: Sage Publications.

Leininger, M. (Ed.). (1995). Transcultural nursing:

Concepts, theories, research, and practice. New York: McGraw-Hill, Inc.

Leininger, M. (1998). Special research report: Dominant culture care (emic) meanings and practice findings from Leininger's Theory. Journal of Transcultural Nursing, 9(2), 45-48.

Leininger, M (2001). Cultural Care Diversity and Universality: A Theory of Nursing. Sudbury, Massachusetts: Jones and Bartlett Publishers and National League for Nursing.

Lincoln, Y. & Guba, E. (1985). Naturalistic inquiry. Beverly Hills, CA: Sage publications.

Lipson, J.G. (1992). The health and adjustment of Iranian immigrants to the United States. Western Journal of Nursing Research, 14(1), 10-29.

Lipson, J.G., Meleis, A.I. (1983) Issues in health care of Middle-Eastern patients. The Western Journal of Medicine, 139(6) 854-861.

Lipson, J.G. & Meleis, A.I. (1985). Culturally appropriate care: the case of immigrants. Topics in Clinical Nursing, 7(3), 48-56.

Lipson, J.G. & Meleis, A.I. (1989). Methodological issues in research with immigrants. Medical Anthropology, 12, 103-115.

Lipson, J.G. & Miller, S. (1994). Changing roles of

Afghan refugee women in the United States. Health Care for Women International, 15, 171-180.

Lockhart, J. & Resick, L. (1997). Teaching cultural competence: the value of experiential learning and community resources. Nurse Educator, 22 (3), 27-31.

Luna, L.J. (1989). Care and cultural context of Lebanese Muslims in an urban U.S. community: an ethnographic and ethnonursing study conceptualized within Leininger's Theory. An Unpublished doctoral dissertation. Detroit, Michigan: Wayne State University.

Luna, L.J. (1995). Arab Muslims and Cultural Care. In M. Leininger (Ed.), Transcultural nursing: Concepts, theories, research, and practice (pp. 317 - 333), New York: McGraw-Hill, Inc.

May, M.K. (1992). Middle-Eastern immigrant parents' social networks and help-seeking for child health care. Journal of Advanced Nursing, 17, 905-912.

Maykut, P. & Morehouse, R. (1994). Beginning Qualitative Research: A Philosophic and Practical Guide. Washington, D.C.: The Falmer Press.

McCauley, K. (1995). Assessing social support in patients with cardiac disease. Journal of Cardiovascular Nursing, 10 (1), 73-80.

McDonald, D. (1994). Gender and ethnic stereotyping and

narcotic analgesic administration. Research in Nursing and Health, 17 (1), 45-49.

McFeat, T. (1974). Small group cultures. New York: Pergamon.

Meleis, A.I. (1981). The Arab American in the health care system. American Journal of Nursing, 81(6), 1180-1183.

Meleis, A.I. (1991). Between two cultures: identity, roles and health. Health Care for Women International, 12(4), 365-377.

Meleis, A.I. (1996). Culturally competent scholarship: substance and rigor. Advances in Nursing Science, 19 (2), 1-16.

Meleis, A.I. & Jonsen, A.R. (1983). Ethical Crises and cultural differences. The Western Journal of Medicine, 138(6), 889-893.

Morse, J.M. (1994). Handbook of qualitative research. Thousand Oaks, CA: Sage Publications.

Morse, J.M. & Field, P.A. (1995). Qualitative research methods for health professionals. Thousand Oaks, CA: Sage Publications.

Naff, A. (1980). Arabs. In S. Therstrom (Ed.), Harvard encyclopedia of American ethnic groups (pp. 128-136). Cambridge, MA: Harvard University Press.

Naff, A. (1983). Arabs in America: A historical overview.

In S.Y. Abraham & N. Abraham (Eds.), Arabs in the New World (pp. 9-29). Detroit, Michigan: Wayne State University.

Neuman, B. (1982). The Neuman Systems Model. Norwalk, CT: Appleton-Century-crofts.

Oka, R.K., Gortner, S.R., Stotts, N.A., & Haskell, W.L. (1996). Predictors of physical activity in patients with chronic heart failure secondary to either ischemic or idiopathic dilated cardiomyopathy. American Journal of Cardiology, 77, 159-163.

Orem, D.E. (1980). Nursing: concepts of practice (2nd Edition). New York: McGraw-Hill.

Oxman, T. & Berkman, L. (1990). Assessment of social relationships in elderly patients. International Journal of Psychiatry and Medicine, 20(1), 65-84.

Pachter, L.M. (1994). Culture and clinical care. Journal of the American Medical Association, 271(9), 690-694.

Rashidi, A. & Rajaram, S.S. (2001). Culture care conflicts among Asian-Islamic immigrant women in U.S. hospitals. Holistic Nursing Practice, 16 (1), 55-64.

Reizian, A. & Meleis, A.I. (1986) Arab-American's Perceptions of and responses to pain. Critical Care Nurse, 6(6) 30-37.

Reizian, A., & Meleis, A.I. (1987) Symptoms reported by Arab-American patients on the Cornell Medical Index (CMI).

Western Journal of Nursing Research, 9(3) 368-384.

Reynolds, C.L. & Leininger, M. (1993). Madeleine Leininger: Cultural Care Diversity and Universality Theory. Newbury Park, CA: Sage Publications Inc.

Rockwell, J.M. & Riegel, B. (2001). Predictors of self-care in persons with heart failure. Heart & Lung, 30 (1), 18-25.

Rollins, R. (1997). Managed care: an opportunity to improve the cultural competency of providers. Through the eyes of others: envisioning culturally competent health care. Conference held at the Brooklyn Center, Minnesota: September 19-20, 1997.

Rosenbaum, J.N. (1991). The health meanings and practices of older Greek-Canadian widows. Journal of Advanced Nursing, 16 (11), 1320-1327.

Sawyer, L., Regev, H., Proctor, S., Nelson, M., Messias, D., Barnes, D., & Meleis, A.I. (1995). Matching versus cultural competence in research: Methodological considerations. Research in Nursing and Health, 18 (6), 557-567.

Schaefer, C., Coyne, J.C., & Lazarus, R.S. (1981). The health related functions of social support. Journal of Behavioral Medicine, 4, 430-435.

Setness, P.A. (1998). Culturally competent health care

[editorial]. Postgraduate Medicine, 103(2), 4.

Shapiro, S. & Brundage, B. (1994). Cardiac problems in critical care. In F.S. Bonegard & D.Y. Sue (Eds.), Current Critical Care: Diagnosis & Treatment (pp. 427-453). East Norwalk, Connecticut: Appleton & Lange.

Sorrell, J.M. & Redmond, G.M. (1995). Interviews in qualitative nursing research: differing approaches for ethnographic and phenomenological studies. Journal of Advanced Nursing, 21, 1117-1122.

Statistics Canada (1998, February 17). The Daily: 1996 Census: ethnic origin, visible minorities [Release]. Ottawa: Statistics Canada. Retrieved February 27, 1998 from the World Wide Web:

<http://www.statcan.ca/Daily/English/980217/d980217.htm>

Stevens, E.S. (1992). Reciprocity in social support: an advantage for the aging family. The Journal of Contemporary Human Services, 533-541.

Stewart, A. (1998). Qualitative research methods series (Volume 46): The ethnographer's method. Thousand Oaks, CA: Sage Publications.

Stewart, M. (1989). Social support instruments created by nurse investigators. Nursing Research, 38(5), 268-275.

Stewart, M. (1993). Integrating Social Support in Nursing. Thousand Oaks, CA : SAGE Publications.

Stewart, M., Ellerton, M., Hart, G., Hirth, A., Mann, K., Meager-Stewart, D., Ritchie, J., & Tomblin-Murphy, G. (1997). Insights from a nursing research program on social support. Canadian Journal of Nursing Research, 29 (3), 93-110.

Strauss, A. & Corbin, J. (1990). Basics of Qualitative Research: Grounded Theory Procedure and Techniques. Newbury Park, California: Sage Publications.

Stromberg, A., Brostrom, A., Dahlstrom, U. & Fridlund, B. (1999). Factors influencing patient compliance with therapeutic regimens in chronic heart failure: A critical incidence technique analysis. Heart & Lung, 28(5), 334-341.

Stull, D.E., Starling, R., Haas, G., & Young, J.B. (1999). Becoming a patient with heart failure. Heart & Lung, 28(4), 284-292.

Swann, W.B. & Brown, J.D. (1990). From self to health: self-verification and identity disruption. In B.R. Saranson, I.G. Saranson, & G.R. Pierce (Eds.) Social support: an interactional view (pp. 150-172), New York : John Wiley and Sons.

Tesch, R. (1990). Qualitative research: Analysis types and software tools. New York: Falmer Press.

Tsuchihashi, M., Tsutsui, H., Kodama, K., Kasagi, F., Setoguchi, S., Mohr, M., Kubota, T., & Takeshita, A. (2001). Medical and socioenvironmental predictors of hospital

readmission in patients with congestive heart failure.

American Heart Journal, 142 (4), e7.

Vaccarino, V., Chen, Y.T., Wang, Y., Radford, M.J., & Krumholz, H.M. (1999). Sex differences in the clinical care and outcomes of congestive heart failure in the elderly.

American Heart Journal, 138 (5), 835-842.

Vandekieft, G.K. (2001). Breaking bad news. American Family Physician, 64 (12), 1975-1978.

Vinson, J.M., Rich, M.W., Sperry, J.C., Shah, A.S., & McNamara, T. (1990). Early readmission of elderly patients with congestive heart failure. Journal of the American Geriatric Society, 38, 1290-1295.

Walker, L.O. & Avant, K.C. (1995). Strategies for Theory Construction in Nursing. Norfolk: Appleton & Lange.

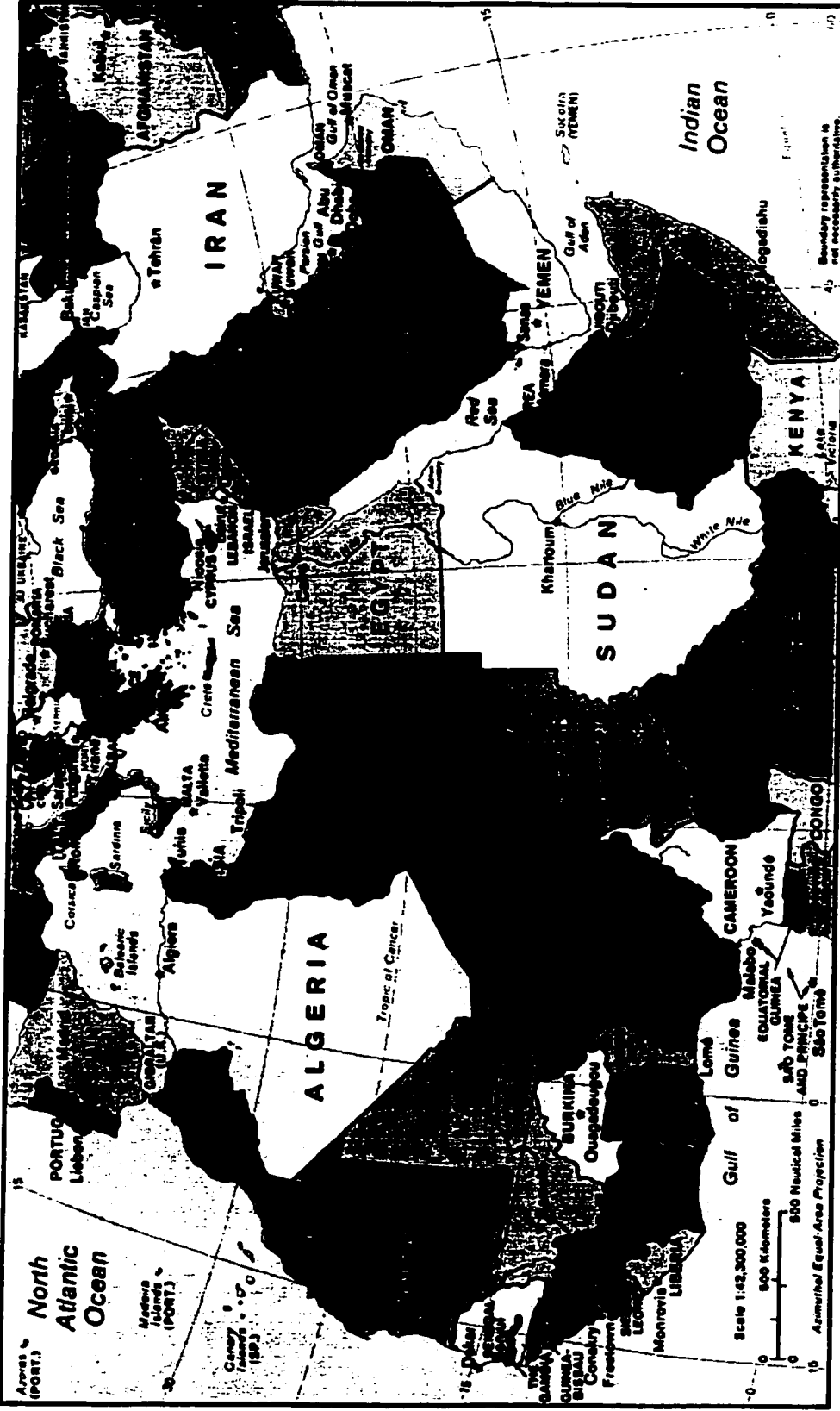
Werner, O., & Schoepfle, G.M. (1987). Systemic fieldwork: Foundations of ethnography and interviewing (Vol.1). Newbury Park, CA: Sage Publications.

White, N.E., Richter, J.M., & Fry, C. (1992). Coping, social support, and adaptation to chronic illness. Western Journal of Nursing Research, 14(2), 211-224.

Wolcott, H.F. (1994). Transforming qualitative data: Description, analysis, and interpretation. Thousand Oaks, CA: Sage Publications.

APPENDIX A: MAP OF NORTH AFRICA AND THE MIDDLE EAST

Northern Africa and the Middle East



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APPENDIX B: PARTICIPANT INFORMATION SHEET / CONSENT FORM

TITLE OF PROTOCOL: "The meaning of social support: the perspective of Arab Canadians with congestive heart weakness."

INVESTIGATOR: Salma Debs-Ivall, Tel.#: (613) 737-8020 (Ottawa)

SUPERVISOR: Dr. Frances Fothergill-Bourbonnais, School of Nursing/Faculty of Health Sciences, University of Ottawa, Tel.#: (613) 562-5800, Ext: 8423.

Please read this Participant Information Sheet and Consent Form carefully and ask as many questions as you like before deciding whether or not to participate.

INTRODUCTION

You are being invited to participate in a research project that will study the perception of support by Arab Canadian immigrants diagnosed with congestive heart weakness. The study is conducted by a Masters of Nursing student under the supervision of Dr. Frances Fothergill-Bourbonnais of the School of Nursing/Faculty of Health Sciences, University of Ottawa.

As a nurse, the investigator believes that she can learn a lot from patients such as you who live with heart weakness. For this reason, you are being asked to share your perceptions of support and the meanings you attach to it.

The investigator will be interviewing participants from the Ottawa Hospital, and would like to conduct this interview during your hospitalization at a mutually convenient time.

PROCEDURE

The study involves an interview, on the day of discharge, of approximately 30-40 minutes with the investigator. The interview will be held in a quiet place as per your preference and recorded on an audiotape. The interviewer will ask you questions about your understanding of support. The questions will also concentrate on your interactions with your family, friends, and the health professionals after being diagnosed with congestive heart weakness. Data collected will then be analyzed to determine your perception of support and the meanings you attach to it.

You may be asked to participate in a follow-up interview of approximately 20 minutes to see if you agree with the investigator's interpretation of the first interview.

RISKS

There are no risks of participating in this study. However, if you begin to feel distressed or anxious during the interview, please tell the investigator and the interview will be stopped. Also, if there are specific questions that you do not wish to answer, just ask the investigator to skip to the next question.

BENEFITS

While you may not benefit directly from the study, the information you share will help to plan care for Arab Canadian patients in hospital, as well as for discharge planning. It will also be used in the development of education programs and information that are translated into the Arabic language.

CONTACT

This protocol has been approved by the Ottawa Hospital Research Ethics Board. The Board considers the ethical aspects of all hospital research projects using human subjects. If you wish, you may talk to the Chair of the Ottawa Hospital Research Ethics Board through the Secretariat at (613) 761-4902.

RIGHT TO WITHDRAW

Your participation in this study is voluntary. You may withdraw at any time without it affecting your present or future care at the hospital. If you choose not to participate in the study, your care will not be compromised in any way. You may also choose not to answer any specific questions.

CONFIDENTIALITY

As indicated the interview will be tape-recorded. Only the investigator and the thesis committee have access to the data. Tapes and transcripts will be stored in a locked cabinet in the investigator's office at the General Campus. Any identifying information, such as your name will be deleted to maintain confidentiality. False names will be used on the interview transcripts and on the field notes. The identity of the participants will not be disclosed in any published findings of the study. The list of participants' initials and numbers will only be kept by the investigator in a separate locked file. This identifying information and the tapes will be destroyed once the final report is complete.

Your files may be reviewed by the Ottawa Hospital Research Ethics Board for audit purposes.

CONSENT TO VOLUNTARY PARTICIPATION

I understand that I am being asked to participate in a research study about the perception of support by Arab Canadians with heart weakness. This study has been explained to me by Mrs. Salma Debs-Ivall.

I have read and understood this Patient Information Sheet and Consent Form. All my questions at this time have been answered to my satisfaction. If I, or any of my family members, have any further questions about this study, we may contact Mrs. Salma Debs-Ivall at (613) 737-8020.

I will receive a signed copy of this Consent Form and the attached Participant Information Sheet.

I voluntarily agree to participate in this study.

Participant's Name _____

Participant's Signature _____

Date _____

The information within this consent has been explained to the participant and to the best of my knowledge the subject understands the nature of the study and the risks and benefits involved in the study.

Investigator's/Co-investigator's
Signature _____

Date _____

APPENDIX C: SAMPLE INTERVIEW QUESTIONS

Years in Canada: _____ Age: _____

Marital Status: _____ Gender: _____

Number of children: _____ Decision maker: _____

How long ago has a diagnosis of heart weakness been made? _____

As a nurse, I am interested in learning about meanings and expressions of support in your culture.

1. Why were you admitted to the hospital?
2. What does congestive heart weakness mean to you?
3. How are you being helped in the hospital in terms of managing your disease?
4. Can you tell me what the term "support" means to you? Are there special words for support in your language? Can you give me examples of what they mean?
5. How do others show you their support?
6. In your family how do you perceive support from different members? Men? Women? Children?
7. In your family, are there people who will support you in planning for your discharge?
8. Who will help you when you go home? How will they help?
9. What are the ways by which support has been demonstrated to you since you were hospitalized?

APPENDIX D: INITIAL CONTACT LETTER FOR RECRUITMENT

Dear Prospective Participant,

Salma Debs-Ivall, School of Nursing, University of Ottawa, is a nurse who is conducting a study of Arab Canadians with congestive heart weakness. The focus of the study concerns support as perceived by Arab Canadian immigrants who have been diagnosed with congestive heart weakness. She has asked me to introduce her to people such as yourself who would be interested in participating in such a study. All interviews will take place in the hospital during your stay and at a time convenient to you.

If you are interested in the study, please indicate below your interest and write your name. The researcher will contact you to arrange for a convenient time to explain the study in detail.

Your agreement to participate in this study and all information provided in this letter will be treated in strict confidence. Thank you for your consideration.

Yours Sincerely,

INTERESTED YES _____ NO _____

IF INTERESTED Name _____

Room # _____

APPENDIX E: CONTACT SUMMARY SHEET

Participant Code # _____ Interview Date: _____
Starting Time: _____ Ending Time: _____

Pre-interview goals for the interview:

Location of Interview: _____

People Present: _____

Description of Environment:

Nonverbal Behaviour:

Content of the interview (key words, topics, focus, exact words):

Researcher's Impressions (discomfort of participant re certain topics, emotional response):

Technological problems:
