

**A Descriptive Metasynthesis of Doctoral Dissertations**  
**Guided by the Culture Care Theory and Using the Ethnonursing Method**

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2010

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Thesis

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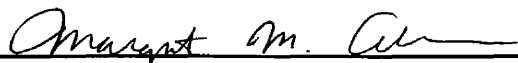
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## **Dedication**

This study is dedicated to all the diverse cultural groups presented within the pages of the doctoral dissertations we examined. Their daily lives, struggles, culture care beliefs, and diverse worldviews inspired us, and collectively, made us better people.

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We wish to extend our deepest appreciation to:

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## CHAPTER 1

### *Introduction*

Throughout the annals of time, nursing scholars, researchers, and theorists have been keenly interested in the concept of care: how to define it, how to implement it, and how to improve upon it. The concept of care within the context of the nursing profession is clearly foundational, but it can be elusive and often difficult to articulate. Florence Nightingale, revered as the founder of modern nursing, wrote eloquently at the turn of the century about the concept of care in *Notes on Nursing* (1969): “Care should be taken in all these operations of sponging, washing, and cleansing the skin, not to expose too great a surface at once, so as to check the perspiration, which would renew the evil in another form” (p.94). Jean Watson, an influential modern-day nurse theorist, developed the *Philosophy of Science and Caring* theory in 1979, studying and developing the basic premise that care can only be demonstrated and practiced interpersonally, that care is a moral ideal rather than a task-oriented behavior, and that care is intrinsically related to healing (Nelson & Gordon, 2006).

Likewise, another basic concept that has sparked considerable interest and study within the nursing profession is that of culture. Different cultural groups have inhabited this planet for thousands of years, and each of these cultures brings with it a unique worldview, social structure, environmental context and cultural values, which make them distinct. Madeleine Leininger is emblematic of and synonymous with groundbreaking work that has been done on the subject of culture and care within nursing. Leininger (1970) stated, “Culture is the blueprint for man’s way of living, and only by understanding culture can we hope to gain the fullest understanding of man as a social and cultural being” (p.vii) She has challenged nurses and other healthcare professionals to view the world from a global perspective and to appreciate the

complexities as well as commonalities and differences in cultures, with their concerns, beliefs, values, and lifeways. As Leininger so aptly states, “If human beings are to survive and live in a healthy, peaceful, and meaningful world, then nurses and other healthcare providers need to understand the cultural care beliefs, values and lifeways of people in order to provide culturally congruent and beneficial healthcare” (Leininger, 1978, p.3).

The concept of culture has its ancestral roots in the discipline of anthropology, while the concept of care is rooted in the nursing profession. It is this intimate blending and intertwining of culture and care, examined within a collection of doctoral dissertations that provided the thematic foundation for this study. This metasynthesis was designed within the qualitative research paradigm, used the ethnonursing research method, and was guided by Leininger’s theory of culture care diversity and universality.

### ***Domain of Inquiry***

The domain of inquiry (DOI) for this study was the synthesis of culture care expressions, beliefs, and practices of diverse and similar cultures. This DOI is central to the discipline of nursing and is of major importance to the profession because it may result in theory building and theory development, as well as a higher level of abstraction of findings beyond that of the individual studies examined. The researchers predict that by contributing to the existing body of knowledge already created using the culture care theory and the ethnonursing method, healthcare policy, evidence-based best practices, nursing education and future research may be potentially benefited.

### ***Purpose and Goal of Study***

The purpose of this descriptive metasynthesis was to discover, describe, and systematically synthesize the culture care expressions, beliefs, and practices of diverse and similar cultures. The

goal of this study was to synthesize generic (also referred to as folk) and professional culture care actions and decisions that promote health, well-being, and beneficial lifeways for people of similar and diverse cultures. This study served as an exploration of both generic and professional care documented within the doctoral dissertations examined, with the objective being an improved understanding and appreciation of how both types of care influence the culture care within and between cultural groups.

### ***Rationale for the Study***

The United States of America has historically been revered as a place where people from all over the world have migrated, seeking a better life for themselves and their families. However, when one considers the issue of healthcare delivery in this country, this phenomenon of cultural diversity, while making the country unique, has brought with it distinct and significant challenges. On a daily basis, nurses care for patients from diverse cultural backgrounds, and the obvious goal for the nurse and the nursing profession as a whole is to provide these diverse groups with culturally congruent care.

The question then becomes, how does the nursing profession achieve cultural competence in the modern-day healthcare workplace? Cultural competence in healthcare can be defined as “having the knowledge, abilities, and skills to deliver care congruent with the client’s cultural beliefs and practices” (Purnell & Paulanka, 2008, p. 6). Another question that comes to the collective mind of the researchers is if the nursing profession becomes more culturally competent; will this improve the profession’s ability to deliver better healthcare, improve outcomes, and influence healthcare policy and evidence-based best practices? Purnell & Paulanka (2008), further comment, “Increasing one’s consciousness of cultural diversity improves the possibilities for healthcare practitioners to provide culturally competent care” (p.6).

Leininger's culture care theory encompasses both similarities and diversities of cultural groups. This is a strength of the culture care theory using the ethnonursing research method, bringing the theory into action for culturally congruent nursing care.

The latest United States population census data from the year 2006 shows the total population numbers at over 300 million, an increase of 16 million people since the 2000 census was conducted, with an overall increase in numbers of ethnic group representation (see Table A).

**Table A (U.S Population Census Data):**

<p><b>*U.S. POPULATION STATISTICS</b></p> <p><b>(2006)</b></p> <p>WHITE 74.7%</p> <p>HISPANIC/LATINO 14.5%</p> <p>BLACK/AFRICAN-AMERICAN 12.1%</p> <p>ASIAN 4.3%</p> <p>AMERICAN INDIAN/ALASKAN NATIVE 0.8%</p> <p>NATIVE HAWAIIAN/PACIFIC ISLANDER 0.1%</p> <p>SOME OTHER RACE 6%</p> <p>TWO OR MORE RACES 1.9%</p> <p><a href="http://www.census.gov">www.census.gov</a></p> <p><small>*Please note: Figures total more than 100% because federal government considers race and Hispanic origin to be two separate and distinct categories.</small></p>
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Table A clearly shows that as we move forward as a country, we are collectively becoming more culturally diverse. For example, the Hispanic/Latino and Asian populations continue to increase in numbers and in percentage of the overall U.S. population. Immigration to the United States is no longer as prevalent from European countries as it was in the past. Rather, most modern-day immigrants hail from Mexico, China, India, Pakistan, Japan, Egypt and Thailand, thereby adding to the cultural mosaic that has defined the United States of America (Purnell & Paulanka, 2008). These groups of people bring with them their own cultural identities, values,

language and customs. The importance of delivering culturally congruent care in order to achieve positive health outcomes has never been as important a topic as it is now.

Leininger's transcultural nursing research and her own documented experiences through the years have emphasized the basic premise that professional nursing care and generic (folk) care delivered in a culturally congruent manner have led to positive health outcomes within the healthcare environment. Andrews and Boyle (2008), both disciples of the transcultural nursing movement stated, "Recognizing that nursing is an art and a science, transcultural nursing enables us to view our profession from a cultural perspective...Everyone has a cultural heritage, including nurses, patients, and other members of the healthcare team" (p.4). Leininger (2006) succinctly stated, "From the beginning, the goal of the Culture Care Theory has been to use culture care research findings to provide specific and-or general care that would be culturally congruent, safe, and beneficial to people of diverse or similar cultures for their health, well-being, and healing, and to help people face disabilities and death" (p.5). This profound statement provides the ethos with which the researchers conducted this study.

### ***Research Questions***

The researchers were keenly interested in looking at the commonalities and differences of culture care, and wanted to examine how worldview, social structure factors, and environmental context influenced culture care. The researchers also wanted to discover the ways in which Leininger's three nursing care action modes could be used to facilitate the provision of culturally congruent care. The following questions were posed by the researchers so as to provide a solid foundation upon which to fully explore the domain of inquiry. The research questions were:

1. What are the commonalities and differences of culture care expressions, beliefs, and practices among people of diverse and similar cultures?

2. In what ways do worldview, social structure factors, and environmental context influence culture care expressions, beliefs, and practices of people of diverse and similar cultures?
3. In what ways can Leininger's three nursing care action modes facilitate the provision of culturally congruent care for people of diverse and similar cultures?

### ***Theoretical Framework***

The theory of culture care diversity and universality was selected as the framework for this descriptive metasynthesis of doctoral dissertations using the ethnonursing research method. The researchers realized the importance of this theory to the nursing profession in that it provides nurses with a better understanding of culture as it relates to professional care and generic (folk) care. The ability of a nurse to provide culturally congruent care in the workplace setting promotes the preservation of the health and well-being of the cultural groups being served. The culture care theory has been developed and refined by Leininger over five decades of study and research. Even before the culture care theory was presented in publications and recognized for its significant contribution to the nursing profession and nursing theory, Leininger (1970) wrote in her first publication *Nursing and Anthropology: Two Worlds to Blend*:

The field of nursing is growing rapidly and is extending its traditional boundaries of health practice and education. Nurses today are working with people in a variety of communities and world settings and they need to have an understanding of the particular needs of people of different cultures and subcultural backgrounds" (p.1).

Care as defined by Leininger (2006) is "an interrelated phenomenon crucial to identify and advance nursing and healthcare" (p.3). The concept of caring, at its most basic and fundamental level, is without question the cornerstone of the nursing profession. The expression of caring through a nurse manifests itself as respect, trust, advocacy, empathy and compassion. The

concept of culture plays an integral role in the nurse's understanding and ability to provide quality culturally congruent care. Nursing care steeped in cultural competence leads to more positive outcomes for individual clients and diverse cultural groups.

### ***Orientational Definitions***

Because the researchers worked within the qualitative research paradigm, orientational definitions (rather than operational) were used as a means of clarifying certain basic constructs and tenets specific to transcultural nursing, the ethn nursing research method, and the culture care theory. This terminology was used and referred to throughout this study, and the orientational definitions provided the researchers with discovery from an emic (insider's) perspective, as well as an understanding of the phenomenon of culture care.

1. **Health/well-being:** A state of being to maintain and the ability to help individuals or groups to perform their daily role activities in culturally expressed beneficial care and patterned lifeways (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.10).
2. **Culture Care:** Refers to the synthesized and culturally constituted assistive, supportive, and facilitative caring acts toward self or others focused on evident or anticipated needs for the client's health or well-being or to face disabilities, death, or other human conditions (Derived from Leininger, 2002, 3<sup>rd</sup> ed., p.83).
3. **Professional (Etic/Outsider) Care:** Refers to formal and explicit cognitively learned professional care knowledge and practices obtained generally through educational institutions (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.14).
4. **Generic (Emic/Folk/Insider) Care:** Refers to the learned and transmitted lay, indigenous, traditional, or local folk (emic) knowledge and practices to provide assistive, supportive, enabling, and facilitative acts for or towards others with evident or anticipated

health needs in order to improve well-being or to help with dying or other human conditions (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.14).

5. **Emic:** Refers to the local, indigenous, or insider's views and values about a phenomenon (Derived from Leininger, 2002, 3<sup>rd</sup> ed., p.84).
6. **Etic:** Refers to the outsider's or more universal views and values about a phenomenon (Derived from Leininger, 2002, 3<sup>rd</sup> ed., p.84).
7. **Worldview:** Refers to the way an individual or group looks out on and understands their world about them as a value, stance, picture, or perspective about life in the world (Derived from Leininger, 2002, 3<sup>rd</sup> ed., p.83).
8. **Lifeways (Cultural Values):** Refers to the powerful internal and external directive forces that give meaning and order to the thinking, decisions, and actions of an individual or group (Derived from Leininger, 2002, 3<sup>rd</sup> ed., p.49).
9. **Culturally Congruent Care:** Refers to the explicit use of culturally based care and health knowledge in sensitive, creative, and meaningful ways to fit the general lifeways and needs of individuals or groups for beneficial and meaningful health and well-being or to face illness, disabilities, or death (Derived from Leininger, 2002, 3<sup>rd</sup> ed., p.84).
10. **Culture Care Preservation and/or Maintenance:** Refers to those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve, or maintain beneficial care beliefs and values or to face handicaps and death (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.8).
11. **Culture Care Accommodation and/or Negotiation:** Refers to those assistive, accommodating, facilitative, or enabling creative provider care actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe, and effective



care for their health, well-being, or to deal with illness or dying (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.8).

12. **Culture Care Repatterning and/or Restructuring:** Refers to those assistive, supportive, facilitative, or enabling professional actions and mutual decisions that would help people to reorder, change, modify, or restructure their lifeways and institutions for better (or beneficial) health care patterns, practices, or outcomes (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.8).
13. **Ethnonursing:** Refers to method developed by Leininger within the qualitative paradigm to fit the purposes of the culture care theory, allowing for discovery of vague, complex, largely covert cultural care and phenomena, with the generation of fresh data based in culturally congruent care (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).
14. **Meta-ethnography:** Sequential process which seeks to merge and combine the findings from individual studies by using metaphors to capture the relationships within and between accounts (Derived from Dixon & Finlayson, 2008, p.62)

**New orientational definitions developed/discovered by researchers during the process of this study:**

1. **Meta-ethnonursing:** Refers to a synthesis of multiple studies guided by the culture care theory using the ethnonursing method, allowing for expansion of ideas, higher level abstraction and ultimately theory building.
2. **Meta-theme:** Refers to a higher level of abstraction, drawing on the themes and patterns discovered within individual studies guided by the culture care theory and synthesized across studies with development of new and expanded theoretical formulations.

3. **Meta-pattern:** Refers to a higher level of abstraction, drawing on universal and diverse patterns discovered within individual studies guided by the culture care theory and synthesized across studies with development of new and expanded theoretical formulations.
4. **Meta-mode:** Refers to the synthesis of cultural action and decision modes discovered from study findings of diverse and similar cultures from multiple studies guided by the culture care theory using the ethnonursing research method, resulting in expansion of ideas and ultimately, significant contributions to nursing practice.

### *Assumptive Premises of the Research*

Leininger's theory of culture care can be condensed into several of the following basic assumptions and theoretical tenets specifically related to this study. The researchers were guided by the selected theoretical assumptions (hunches) described below that supported the general purposes of this study:

1. Diverse and similar cultures have generic (folk, naturalistic, emic) and some professional (etic) care practices to be discovered and used for providing culturally congruent care practices (Derived from Leininger, 2006 2<sup>nd</sup> ed., p.19).
2. Culture care expressions, beliefs, meanings, patterns, practices and structural forms are diverse but some commonalities exist amongst cultures (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.18).
3. Culture care beliefs, values, and practices are influenced by and are embedded in the worldview, social structure, religion, kinship, economics, and cultural values within environmental contexts (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).

4. Leininger's three theoretical modes of care offer creative new nursing care decision and action modes that are therapeutic ways to help people of diverse cultures across the continuum of nursing care (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).

The researchers determined that Leininger's theoretical assumptions would guide this study. They predicted that care is central to providing culturally congruent care using generic care practices (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p. 19). The first premise of Leininger's assumptions related to this study takes the position that diverse and similar cultures have generic (lay, folk, naturalistic, emic) and some professional (etic) care practices that are to be discovered and used for providing culturally congruent care practices. The researchers predict the metasynthesis of dissertations guided by the culture care theory will discover many cultural groups that use generic and professional care that influence health, well-being, and illness outcomes.

Additionally, the second premise of Leininger's assumptions related to this study takes the position that culture care expressions, beliefs, meanings, patterns, practices and structural forms are diverse but some commonalities amongst cultures exist. The researchers predict these findings will be discovered within the metasynthesis of the dissertations (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p. 19). More specifically, the researchers predict that social structure factors including family and kinship, religion and spirituality, economics and cultural values and lifeways are influencers on culture care to predict health, well-being and illness outcomes.

Furthermore, the third premise of Leininger's assumptions related to this study takes the position that the three theoretical modes of care offer creative, new nursing care decision and action modes that are therapeutic ways to help people of diverse cultures across the continuum of nursing care (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p. 19). Leininger's transcultural nursing

practice is known as a discipline within a body of knowledge and practice that will assist in maintaining the goal of providing culturally congruent care for the health and well-being of diverse cultural groups. The researchers predicted these findings will be discovered within the metasynthesis of the dissertations studied. Assumptions #1 and #4 have far-reaching implications for the future of nursing care for diverse and similar cultures, and are predicted to influence the health, well-being and illness outcomes for cultural groups. The researchers also predicted that culture care decision and action modes are imperative for providing culturally congruent nursing care that will be essential and will ultimately contribute to the health and well-being of similar and diverse cultures.

Culture care beliefs, values, and practices are influenced by and are embedded in the worldview and cultural values within environmental contexts. The researchers were confident that environmental contexts influence health and well-being within diverse cultural groups in all the dissertations studied (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p. 19). The researchers also predicted that care patterns, expressions, beliefs and practices would be discovered and viewed within urban and rural environmental contexts as a continuing life experience, with differences between urban and rural settings, with documented supporting themes and patterns within the dissertations studied. Leininger's assumptions supported the theoretical framework for this meta-ethnonursing study and guided the researchers in the discovery process.

Within the context of the four premises, it is a goal to add to the existing body of knowledge for nursing research and evidence-based best practice. The third assumptive premise of the three theoretical modes of care which offer creative nursing care decision and action modes will provide a therapeutic modality for helping people of diverse cultures, providing culturally congruent nursing care (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p. 19). Leininger's transcultural

nursing practice and this research study will add to the existing body of knowledge and clinical practice, assisting and maintaining the goal of providing culturally congruent care for the health and well-being of diverse cultural groups.

Leininger's culture care theory explicitly focuses on the concepts of culture and care within the nursing profession in a way that has been sorely neglected through the years. Care and culture have been revered by the theorist as being at the very core of the nursing profession. This theory is unique in that it uses culture care action modes as a means of providing creative approaches for nurses to meet the culture care needs of clients. These three culture care action modes are outlined below (Leininger, 2006, p.8):

1. Culture care preservation and/or maintenance referred to those assistive, supportive, facilitative, or enabling professional acts or decisions that help cultures to retain, preserve, or maintain beneficial care beliefs and values or to face handicaps and death.
2. Culture care accommodation and/or negotiation referred to those assistive, accommodating, facilitative, or enabling creative provider care actions or decisions that help cultures adapt to or negotiate with others for culturally congruent, safe, and effective care for their health, well-being, or to deal with illness or dying.
3. Culture care repatterning and/or restructuring referred to those assistive, supportive, facilitative, or enabling professional actions and mutual decisions that would help people to reorder, change, modify, or restructure their lifeways and institutions for better (or beneficial) healthcare patterns, practices, or outcomes.

In an earlier publication (1988), Leininger powerfully sums up the purpose of the theory, which is to "describe, account for, interpret, and predict cultural congruent care in order to attain the ultimate goal of the theory, namely, to provide quality care to clients of diverse cultures that

is congruent, satisfying, and beneficial to them” (p. 155). The true beauty of the theory lies in its ability to be specific and non-specific, all at the same time. The theory is non-specific in that it incorporates nursing care ideas in a broad fashion, while being specific enough to allow for culturally-specific nursing care worldwide.

### ***The Ethnonursing Research Method***

The ethnonursing research method, created by Leininger in the late 1950s, was designed within the qualitative research paradigm to facilitate naturalistic, open discovery and interpretation of data using the culture care theory. Ethnonursing is the study of human cultures, more specifically focusing on a particular group’s belief system and practices related to nursing care and related health behaviors (Polit & Beck, 2008). The notion of universality in ethnonursing is a reference to the commonly shared “threads” that flow through culture care; the features of human beings and groups of human beings, including patterns, values and lifeways for diverse and similar cultural groups. These features serve as signposts for the nursing profession, improving health outcomes and resulting in evidence-based best practice, providing culturally congruent care for diverse cultural groups.

The culture care theory and the ethnonursing method were created to go hand-in-hand, and ethnonursing remains the first as well as the only nursing research method designed within the discipline of nursing (Leininger, 1997). According to Leininger (2006), “Ethnonursing is a rigorous, systematic, and indepth method for studying multiple cultures and care factors within familiar environments of people and to focus on the interrelationships of care and culture and to arrive at the goal of culturally congruent care services” (p.20). Prior to Leininger’s creation of the ethnonursing method, the nursing profession drew heavily on other disciplines for research methods, scales, and statistical formulas to study phenomena that were unique to nursing. Most

studies were also conducted within the quantitative paradigm. This was of great concern to Leininger, especially where studies of cultural groups were concerned.

According to Leininger's tenets (Leininger, 2006, 2<sup>nd</sup> ed., p. 18-19), qualitative research methods offer important means to discover and describe largely embedded, covert, epistemic and ontologic culture care knowledge and practices. In addition, culture care beliefs, values, and practices are influenced by and are embedded in the worldview, social structure factors, religion, kinship, politics, economics, education, technology, and cultural values within ethnohistorical and environmental contexts, and have supported the discovery of the "meta-ethnonursing method." Within this study, a major discovery was unearthed within this metasynthesis of multiple studies using the ethnonursing method. This has allowed for the expansion of ideas, higher level abstraction and ultimately, theory building and the development of the meta-ethnonursing research method.

### ***Significance to the Nursing Profession***

Historically speaking, nursing as an academic profession has strived to build a body of knowledge to guide nursing practice. According to Cross (1981), "The systematic accumulation of knowledge is essential to progress in any profession...however, theory and practice must be constantly interactive. Theory without practice is empty and practice without theory is blind" (p.110). The researchers were convinced that this descriptive metasynthesis of doctoral dissertations using the ethnonursing method and guided by the culture care theory would result in theory building, theory development, and a higher level of abstraction of findings beyond the themes discovered in the individual studies. In building upon Leininger's body of work, the researchers were attempting to move the research forward that had been done based on the culture care theory and the ethnonursing method. Through this descriptive metasynthesis, the

researchers hoped to contribute to the continued development and enhancement of the culture care theory and through the findings in this study, add to and embellish the existing body of knowledge for evidence-based best practices in education, consultation, research, administration and healthcare policy. According to Leininger (1998), “A continued in-depth analysis and systematic documentary study of the care phenomenon will lead to a full explication of the essences and epistemological roots of nursing care knowledge to guide nursing decisions and practices” (p. 155).



## CHAPTER 2

### *Introduction / Review of the Literature*

Prior to starting the actual metasynthesis project, it was necessary to do a review of the literature (ROL) in order to determine and establish the existing body of knowledge. Some basic questions surfaced: What would be the best methodology to use for the metasynthesis? How much information was out there that could be explored? Once a best methodology for the study was established, which method would be the “best fit” for integration with the purpose and goal of the study, as well as for the synthesis of the collection of doctoral dissertations using the ethnonursing method and guided by the culture care theory?

The review of the literature for this study was not done in the traditional sense, and therefore has been divided into two separate and distinct segments; that of a best methodology focus, and secondly, a focus on the studies that have used different methods within the metasynthesis paradigm. The main thrust of this rather unorthodox literature review was to discover and define the metasynthesis method variation that would be most applicable to a metasynthesis of doctoral dissertations using the ethnonursing method and guided by the culture care theory. Finding and selecting a metasynthesis methodology provided direction for streamlining and interpreting the qualitative data contained within the doctoral dissertations. The ROL provided the researchers with an overview of metasynthesis methodologies available for use for this project.

### *Metasynthesis Methodology/ Metasynthesis Studies*

In an effort to locate metasynthesis literature, three literature searches were done using the University of Michigan-Flint databases (ProQuest nursing journals) in March of 2008, which discovered 34 metasynthesis articles in total, four of which were nursing publications describing various metasynthesis methodologies, and 30 nursing research articles that utilized various

metasynthesis methodologies. The keywords used were *metasynthesis methodology*, *qualitative metasynthesis*, and *qualitative metasynthesis methodology*. It should be noted that within the three literature searches, some of the same articles surfaced more than one time. Both types of articles were beneficial to the researchers during the review of literature, and several of these articles are referred to in the following sections on the discussion of metasynthesis.

### ***Historical Background of Metasynthesis***

As the researchers embraced and familiarized themselves with the term *metasynthesis*, the group soon realized that it is an emerging methodology, rapidly evolving, and with little in the way of firm guidelines. Since 1994, metasynthesis studies have been published on a variety of topics germane to the health sciences. These studies have contributed to theory building and explication, as well as substantive description of phenomena (Finfgeld, 2003). However, results from qualitative projects have been sparse and fragmented, and qualitative researchers have been pushing for synthesis, or *metasynthesis*, of study findings for years. Metasynthesis is not without its share of controversy, as qualitative researchers walk a fine line between analyzing the data to a degree so as to maintain the integrity of the individual studies, while resisting the temptation to become too immersed in details so that the final outcome is not usable (Tatano-Beck, 2001).

Prior to the popularity and subsequent proliferation of metasynthesis studies, the quantitative approach of *meta-analysis* was center-stage as the preferred method of synthesizing material across studies and traditions. However, a profound difference exists between meta-analysis and metasynthesis; where meta-analysis *integrates* and *condenses*, metasynthesis *expands* and *enlarges*. As described by McCormick, Rodney & Varcoe (2003), “Practitioners need a synthesis of the vast array of individual qualitative research studies to make sense of the findings and to serve as a basis for evidence-based practice” (p.943). There is definitely agreement within the

qualitative research community that involvement of seasoned researchers facilitates the achievement of high-level metasynthesis integration. The inherent beauty and allure of this particular metasynthesis is that not only were seasoned researchers involved in mentoring and overseeing the study, but the fresh, almost naïve perspective of graduate nursing students gave the project a “new pair of eyes.” Leininger (1992) expounded on the importance of seasoned mentors when she wrote, “Novices usually need research mentors experienced with the method to guide them effectively. Qualified qualitative mentors know how the method is used appropriately; how to explicate often embedded phenomena, and how to become immersed with the findings in a conscious and systematic way” (p.404).

### ***Defining Metasynthesis***

In the true nursing tradition of Florence Nightingale, oftentimes when attempting to define a concept such as *metasynthesis*, it is easier for one to articulate what a metasynthesis is *not*. “Metasynthesis is not a literature review-that is, not the collating or aggregation of research findings-nor is it a concept analysis” (Polit & Beck, 2008, p. 679). Rather, “It is the bringing together and breaking down of findings, examining them, discovering the essential features, and in some way, combining phenomena into a transformed whole (Schreiber, et al. 1997, p.314). A metasynthesis can also be defined as a complete study that involves rigorously examining and interpreting the findings (versus the raw data) of a number of qualitative research studies using qualitative methods (Jensen & Allen, 1996). Perhaps the most eloquent description of metasynthesis was contained in Tatano-Beck’s 2001 publication *Caring Within Nursing Education: Metasynthesis*, where Sandelowski et al. (1997), stated that synthesizing qualitative studies involve, “peeling away the surface layers of studies to find their hearts and souls in a way that does the least damage to them” (p.370).

### ***Why Metasynthesis?***

The researchers concurred that the use of metasynthesis for the analysis of doctoral dissertations using the ethnonursing method and guided by the culture care theory was a reasonable and logical “fit.” Comparing and synthesizing across studies that have used the same theory and methodology (culture care theory and ethnonursing), is advantageous and, “Although informative, isolated studies in and of themselves, like the pieces of a jigsaw puzzle, do not contribute significantly to our full understanding of the phenomenon of interest. In order to advance knowledge and influence practice, a synthesis of representations is essential” (Jensen & Allen, 1996, p.553). Metasynthesis is used to produce a new and integrative interpretation of findings (in this case, culture care findings) that is more substantive than those findings resulting from individual studies (Adapted from Finfgeld, 2003). The metasynthesis model also allows for clarification of culture care patterns and themes, as well as refinement of the existing state of transcultural nursing knowledge and theories, such as the culture care theory (Adapted from Sherwood, 1999). Additionally, the researchers predicted that this metasynthesis process will result in the discovery of culture care findings that will improve care, enhance research and shape healthcare policy in the future (Adapted from Finfgeld, 2003). As so aptly described by Tatano-Beck (2001), “The aim of a qualitative metasynthesis is to enlarge the interpretation and understanding of findings, and not to average results into an effect size as is done in meta-analysis” (p.101).

### ***Types of Metasynthesis Methods***

The researchers quickly came to the realization that metasynthesis was an umbrella term, and within its confines were three major methods; theory building (which included grounded formal theory and meta-study), theory explication, and descriptive metasynthesis. While

discussion of these three methods will be done separately, it is important to note that they are complementary and overlap in style and substance.

Theory building, including grounded formal theory and meta-study (considered variations), is metasynthesis that goes beyond what can normally be achieved through the examination and explication of individual studies. Through this type of metasynthesis, qualitative researchers “flesh out” and reconceptualize abstract concepts (Polit & Beck, 2008).

Theory explication, the second method considered, involves “fleshing out” abstract concepts, allowing for fresh perspective on an original idea. This method also uses deconstruction, reconstruction, and synthesis of report findings across studies in an effort to better explicate a particular concept (Finfgeld, 2003). What becomes evident to the reader is that the first two methods, theory building and theory explication, are very similar in approach and format, allowing for reconceptualization of an original idea from single studies, and elevating the concept to a higher level of abstraction across multiple studies.

The third method, descriptive metasynthesis, involves a comprehensive investigation and analysis of a phenomenon based on synthesizing qualitative findings across multiple studies. In this particular method, concepts are not deconstructed or reconstructed, as in theory-related inquiries (Polit & Beck, 2008). This method also tends to be broader and more inclusive, examining phenomena rather than a single concept. The unaltered text of research reports provides data for translation across multiple studies (Sandelowski et al., 1997). As one can clearly see, there is overlap and redundancy among the metasynthesis methods discussed in this section. It is important to note during this discussion of descriptive metasynthesis, that after multiple literature searches, the researchers were unable to find a single metasynthesis study using the descriptive metasynthesis technique.

After careful consideration of the different types of qualitative metasyntheses, and after careful discussion among the researchers and expert mentors of the phenomenon under study (culture care), it was decided that descriptive metasynthesis was clearly the “best fit,” accommodating both the assumptions and premises of the culture care theory, as well as being congruent with the purpose and goal of the study.

To the novice researchers, the high-level abstraction that is the hallmark of metasynthesis methodology seemed overwhelming and daunting, but intriguing at the same time. As described by Thorne, Jensen, Kearney, Noblit & Sandelowski, (2004), “The appeal of metasynthesis to the qualitative health research community seems akin to the allure of Mt. Everest to those who love climbing: We feel drawn to it because it is “there” (p.1362). Before embarking on the thesis project, the researchers felt that a metaphorical understanding of the underlying concept of metasynthesis was in order. In the search and review of literature, an ancient Buddhist parable emerged within an article that provided the researchers with some much-needed conceptual clarity and understanding:

An ancient Buddhist parable details the attempts of several blind men to describe an elephant. On feeling the trunk, one proclaims it to be rather like a snake; while another, on feeling the ear, explains it to be more like a fan; yet another, upon touching the legs, describes the beast as tree-like, and so on. Each makes valid and relevant claims in relation to the elephant, but only when the findings of all contributors are combined, does a clear image of the animal emerge (Dixon & Finlayson, 2008, p.59).

This parable has served as a beacon for the researchers throughout the thesis process, aiding in the basic understanding of the nature of qualitative metasynthesis, as well as allowing differentiation among a qualitative metasynthesis, a systematic literature review and a basic

literature review. The true beauty of metasynthesis methodology is that it allows for collective creativity and higher-level thinking with abstraction. It is the perfect blend of art and science. In the study of qualitative metasynthesis, the emphasis is placed on interpretation, specifically the interpretation of findings from a carefully selected collection of research studies (primary studies) in a chosen area of interest (Jensen et al., 2004). Thorne et al. (2004) concur:

We therefore advocate for qualitative metasynthesis strategies and standards in which our knowledge claims remain grounded in a genuine mantle of humility, the inherent complexity of that which we study remains intact, and the measure of our product is determined by criteria derived from both art and science (p.1362).

### ***Sample Size (in a metasynthesis)***

Sample size in a metasynthesis is an important consideration, as the primary objective of a descriptive metasynthesis is to discover meaning and to uncover multiple realities through the interpretation of studies across disciplines and demographic elements (i.e., gender, ethnicity), in an effort to promote transferability of findings. A greater number of studies are necessary if the scope of the study is broad and the topic is obscure and difficult to define. Additionally, the number of reports used can depend on the quality and amount of data available in each dissertation. Finally, when seasoned qualitative researchers are involved, often fewer documents are required, as inferences and links can be more easily extracted from the data (Finfgeld, 2003).

Sample size in a metasynthesis can be highly variable, ranging from a very small number, in the case of Varcoe and colleagues (2003), who used only three primary studies in a metaethnography, to a metasynthesis done by Paterson (2001) on chronic illness that used nearly 300 reports. Polit & Beck (2008) state, "Sample size is largely a function of the purpose of the inquiry, the quality of the informants, and the type of sampling strategy used" (p.357). The

feature of an adequate sample size is the concept of data saturation, that is, the point at which the collection of raw data yields a sense of closure or repetitiveness (redundancy) in the findings.

When making the decision about proper sample size for this qualitative metasynthesis, the fundamental question entertained by the researchers was: When each dissertation is pulled apart and coded according to the ethnoscript created for the study, will the coding categories be saturated? Will redundancy and repetitiveness occur?

The review of the literature for this research study was unique and involved a two-part process: First, it was a review of the different types of methods available to the researchers that would coincide and correlate with the purpose and goal of the study, the ethnonursing research method and the culture care theory. Secondly, it served as a search and review of studies previously conducted using methods under consideration within the qualitative paradigm. The ROL proved interesting, as it became evident to the researchers that metasynthesis was a new and expanding concept, with little in the way of established criteria and guidelines. Furthermore, when the search was conducted for studies utilizing the various methods, it was blatantly obvious to the researchers that the body of available knowledge was sparse and fragmented.

After careful consideration and consultation with the seasoned qualitative researchers involved in this study, the decision was made to conduct this metasynthesis as a descriptive metasynthesis. The novice researchers were convinced that the descriptive metasynthesis method would provide the comprehensiveness needed to synthesize across multiple studies, avoiding deconstruction and reconstruction. The researchers were interested in expanding ideas, not “boiling them down” or reducing them. While overlap and redundancy were sure to emerge across the dissertations that were to be examined, the ultimate goal was higher-level abstraction



and ultimately, new theoretical formulations. Descriptive metasynthesis allowed the researchers to accomplish this goal.

## CHAPTER 3

### *Research Design / Method*

The quantitative approach to cultural studies, by its very definition, often left groups of people generalized and marginalized, without full and accurate description of a people's worldview, social structure factors, values, cultural beliefs and lifeways. Because the inherent nature of the quantitative research paradigm is based on obtaining precise measurements and establishing specific causal relationships between variables, Leininger firmly believed that this method was counterintuitive when studying human caring, health and cultures in nursing and healthcare situations. Rather, the ethnonursing research method, in tandem with the culture care theory, allowed for a "focus on emic and etic knowledge and practices related to care, health, well-being, illness, lifecycle experiences, dying, disabilities, prevention modes, and other actual or potential areas of interest to nurses and transcultural nursing phenomena" (Leininger, 2002, p.85). The philosophy and intent of the ethnonursing research method was to allow for *expansion* rather than *reduction* of data, to discover in-depth knowledge about human care, health, ethnohistory, and the values and lifeways of various cultures. Leininger's ethnonursing method is of importance to the nursing profession in that it allows for emic (insider-folk) as well as etic (outsider-professional) discoveries in an open and user-friendly way.

### *Human Subject Considerations (IRB Process)*

The Institutional Review Board (IRB) approval process is an integral part of establishing and maintaining participants' rights when conducting a research project. While the subject matter at hand, a metasynthesis of doctoral dissertations, did not involve a risk/benefit ratio or a potential violation of human rights issues, the researchers were mandated to go through the IRB process. Polit & Beck (2008) further explained, "Federal regulations also allow certain types of research

to be totally exempt from IRB review. These are studies in which there are no apparent risks to human participants” (p.185).

After multiple attempts at completing the IRB application on-line, the researchers were notified that the metasynthesis study fell within a quality assurance and quality improvement category, and therefore, did not require IRB review. The contents of the expedited review process and the corresponding, confirmatory documentation are included in Appendix E. In the final analysis the researchers concluded, with assistance from the University of Michigan-Ann Arbor eResearch office, that the descriptive metasynthesis of published doctoral dissertations (part of the public domain) did not require IRB approval.

### ***Major Features / Enablers of the Ethnonursing Research Method***

The researchers determined that the purposes of the ethnonursing research method (described below) accurately reflected the purpose and goal of this study (Leininger & McFarland, 2002):

1. To discover largely unknown or vaguely known complex nursing phenomena impacting care, well-being, health, and related cultural knowledge.
2. To facilitate the researcher to get inside the people’s emic (insider) cultural world and learn from them first-hand of their beliefs, values, experiences, and lifeways regarding human care and health.
3. To gain in-depth knowledge about the care meanings, expressions, symbols, metaphors and daily night-and-day factors influencing health and well-being as depicted in the Sunrise Enabler (Appendix A).
4. To utilize existing as well as new Enablers to tease out covert or embedded care and nursing knowledge relevant to the culture care theory with both an emic and etic perspective.

5. To use a rigorous, detailed, and systematic method of qualitative data analysis that would preserve naturalistic cultural and contextual data related to the theory of culture care.
6. To use qualitative criteria (not quantitative) for accurate, meaningful, and credible analysis of findings.
7. To identify the strengths and shortcomings of the ethnonursing method in advancing transcultural nursing science knowledge and outcomes.

It should be noted that use of the ethnonursing method in conjunction with the culture care theory requires a certain “openness” for discovery of different influencers on care and caring on the part of the researchers applying it. Leininger (2006) wrote that the ethnonursing method was “designed so the researcher could discover both macro and micro phenomena depending on the researcher’s stated domain of inquiry within the tenets of the Culture Care Theory....Both rich descriptive subjective and objective culture care phenomena are the informants’ authentic *truths* to explain care and culture phenomena within their world” (p.20).

The term *enabler* was created for use within the ethnonursing research method to explore a cultures’ innermost world of knowing, and to allow for extraction of rich data bearing on culture care related to the specific domain of study. These various enablers were developed to fully explicate the rich data related to the theory tenets, and allowed for further investigatory probing into largely unknown, covert, and ambiguous nursing phenomena. In stark contrast with the traditional tools and scales used in quantitative research studies, Leininger’s enablers help “tease out” important cultural information without frightening or isolating an informant, which could potentially lead to inaccurate or fragmented data (Leininger, 1997). Additionally, the enablers give depth and breadth to the research knowledge about human care phenomena (Leininger & McFarland, 2006).

Perhaps the most classic enabler is the Sunrise Enabler (Appendix A), which has been widely used and serves as a cognitive visual map to guide the discovery of embedded factors related to the basic tenets and assumptive premises of the culture care theory. This depiction resembling a sunrise in its configuration has served as a visual conceptualization for the researchers to always search in broad terms when investigating cultures, their commonalities and their differences, and to approach cultural phenomena from an emic (insider's) as well as an etic (outsider's) perspective. Care constructs from the Sunrise Enabler were used by the researchers for interpretation of raw data. The traditional Sunrise Enabler was referred to and utilized as the foundational underpinning in all 24 doctoral dissertations examined by the researchers.

Some of the other more popular enablers developed by Leininger and used in the doctoral dissertations examined were: (1) *Stranger to Trusted Friend Enabler* (Appendix B), (2) *Observation – Participation – Reflection (O-P-R) Enabler* (Appendix C), and (3) *Leininger-Templin-Thompson Ethnoscript Qualitative Enabler* (Appendix D). The Leininger-Templin-Thompson Ethnoscript Enabler was created from the Leininger-Templin-Thompson qualitative software that was developed around 1985 (Leininger, 2006, 2<sup>nd</sup> ed., p.64). The ethnoscript was extremely helpful to the researchers throughout the coding process, allowing for the processing of large amounts of ethnonursing data for use with the culture care theory and specific to this study. The qualitative data focused on cultural values, beliefs, social structure, folk and professional healthcare systems, environmental context, care action and decision modes, and worldview, and was coded, processed and entered into the NVivo 8 qualitative software program. In addition, the researchers added significant custom codes for data that included major themes, patterns, action and decision modes that were discovered within all doctoral

dissertations, and added to the Leininger-Templin-Thompson Ethnoscript Qualitative Enabler (Appendix D) in order to fit this study.

Through the reading and subsequent coding of data in the 24 doctoral dissertations examined, it was obvious to the researchers that the enablers allowed for interviews and observations of key and general informants within cultural groups in a natural and open inquiry way. Informants of all kinds, both key and general, were invited to share their ideas, tell stories about their life experiences, and talk about ideas important to them and to the domain of inquiry. In each instance, the researcher assumed the role of active observer, listener, participant, and reflector of what transpired in each situation, allowing for the unfolding of events that occurred naturally in a particular environment, without bias or outsider (etic) “attitude” from the researcher (Leininger, 1997).

For example, in Ehrmin’s (1998) doctoral dissertation on African-American substance abusers in an inner city transitional home, the O-P-R enabler, “facilitated the researcher’s entrance into the transitional home and guided the researcher in observation, active listening, and reflecting on what the women said and did, before actively participating in the lifeways of the women and activities of the transitional home” (p. 71). The participatory feature of all the enablers developed by Leininger allowed for open discovery and entry into the various groups’ lifeways, human care meanings, expressions, patterns and general care experiences.

Another example of the importance of enablers was in the study done by Wehbe-Alamah (2008) on Syrian Muslims living in the Midwestern United States, in which she writes, “This four phase enabler [O-P-R] was designed to help researchers get close to the people, study the total context, and obtain accurate data from the people” (p.33). McFarland (1995) in her study of Anglo and African-American residents within a long-term care institution writes, “The enabler

[Acculturation Health Care Assessment Enabler] provided a general qualitative profile or assessment of the traditional or nontraditional orientation (acculturation) of each informant to the institutional culture (p. 70). These examples clearly demonstrate the fundamental nature and importance of enablers in facilitating the “teasing out” of important and often hidden data that might otherwise go unnoticed and undetected in a study.

### ***Thesis Timeline***

A qualitative research activity timeline serves as a visual tool, assisting researchers in outlining the data collection and data management process, ultimately culminating in an organized analytical procedural flowsheet. The timeline is designed to highlight time sequences and fine-tune major decision-making events and factors that may be sensitive to the relationships of the collected data (Polit & Beck, 2008). The timeline serves as a linear process that allows all of the qualitative data to mesh in an organized manner, thereby illuminating the research project as a whole, visually displaying tasks that have been completed as well as depicting tasks that still lie ahead. The researchers' timeline included selection of the phenomena of interest, purpose of the study, DOI, research questions, ROL, methodology, etc. Interestingly enough, Leininger's O-P-R Enabler, with its four phases of observation, observation with limited participation, primary participation with continued observation, and reflection/reconfirmation gave the researchers the enabler needed to construct a meaningful concrete timeline. This timeline appears as Appendix F.

### ***Sample Size (for this study)***

The sample size for this descriptive metasynthesis was 24 doctoral dissertations using the ethnonursing method and conceptualized within the culture care theory. These dissertations were acquired through UMI's (Universal Microfilms International) Dissertations Abstracts database, which is a central source for almost every doctoral dissertation in North America since 1861,

from October of 2007 through March of 2008. These dissertations were reviewed by graduate student researchers in collaboration with the seasoned qualitative researchers McFarland, Wehbe-Alamah and Andrews.

### ***Inclusion / Exclusion Criteria***

While 24 doctoral dissertations represented the final number used for this particular study, it is noteworthy to mention at this time that the original search for doctoral dissertations using the keywords *culture care theory* and *ethnonursing* produced 33 documents. The 33 studies were reviewed by the novice researchers and their seasoned qualitative research counterparts, in an effort to determine if the studies would fit the criteria for the descriptive metasynthesis. It was important to the researchers that all studies considered be doctoral dissertations, and they needed to have Leininger's ethnonursing as the research method and the culture care theory as the theoretical framework.

Out of the original 33 studies generated from the searches, five were excluded because they were masters' theses, not doctoral dissertations. One dissertation authored by Finn was excluded because while it used Leininger's culture care theory, Colaizzi's phenomenology served as the methodological framework. Another dissertation authored by Vlassess was excluded from the pool of studies because it represented an analysis of nurses and the "invisible" work they do. It did not deal with the diversity of cultures, which represented the basic thrust of the study being conducted. Two dissertations, one authored by Chase-Ziolek and a second by Curtis, represented outliers. According to Polit & Beck (2008), outliers are defined as, "values that lie outside the normal range of values" (p.645). This was considered to be the case with these two aforementioned studies, as Chase-Ziolek dealt with the health ministry of a parish nurse, and Curtis dealt with advanced practice registered nurses working in a community context. After



sifting through the 33 original studies, it was determined collaboratively with both seasoned and novice researchers, that 24 doctoral dissertations would be used to complete the study. The entire 33 study collection is listed for reference in Appendix G, with the outliers mentioned above having two asterisks (\*\*) beside them for ease in differentiation from the 24 dissertations included in the study. The sample size was considered broad and sufficient enough to achieve data saturation and address the phenomenon of interest, while being focused enough to allow for links and inferences that would prove meaningful to researchers, policymakers and healthcare providers.

### ***Dissertation Attributes / Discussion of Ethnography Within Study***

Prior to the start of the coding and analysis, a table was developed by the researchers which included a variety of demographics contained within each individual doctoral dissertation (Appendix H). This table proved to be an invaluable tool throughout the thesis process when studying the commonalities and differences related to the demographics included within the doctoral dissertations. For example, the rural and urban contexts of this study revealed a vast array of educational levels, languages spoken within cultural groups, and lifeways that led to diverse and similar care patterns, expressions, beliefs and practices within their respective environments. Urban informants' educational levels ranged from eighth grade to college degrees, while the majority of rural informants' educational levels were described by the authors from illiterate (Schumacher, 2006) to one rural study which included master's degree informants (Farrell, 2001). The ages of the informants ranged from 6 years (Wenger, 1998) to 89 years old (McFarland, 1995), both male and female genders. Twelve studies included both male and female genders, ten studies were exclusively focused on women, and two studies included men only.

The majority of the informants spoke English; however, there were a few cultural groups where the elders spoke in their native languages, which were able to be interpreted by family members during the interviews. Many of the doctoral dissertations described specific emic (insider's) language that was clearly diverse. For example, the rural Amish spoke German (Wenger, 1998), while the urban African-American adolescent gang members developed a slang indigenous to them (Morris, 2004). The language of informants was documented in the respective studies.

According to the research findings within the doctoral dissertations, there were 17 urban sites, six rural sites and one *mixed* site (Morgan, 1994), *mixed* being defined by the researchers as a study including both urban and rural settings. As one can clearly delineate, the urban environments had the largest concentration of studies. This is in large part due to the fact that nurse researchers conducted their studies at major universities with access to surrounding urban areas. The majority of the study sites were located within the United States of America, while other sites where studies were conducted included Mexico (Berry, 1996), Africa (MacNeil, 1994), Canada (Rosenbaum, 1990) and the Dominican Republic (Schumacher, 2006). More specifically, actual locations within studies included urban clinics, hospitals, nursing homes, rural medical clinics, long-term institutions, partial day treatment programs, a charter school, parishes, churches, entire communities, village centers and individual informants' homes. The locations proved to be as diverse as the cultural groups studied.

### ***Data Collection / Analysis Using NVivo 8***

The process of data analysis within Leininger's ethnonursing research method involves a specific framework which includes four specific phases. Phase one is the collection and documentation of raw data, which is represented by the 24 doctoral dissertations that comprised

this study. Phase two included the recording, processing and coding of raw data contained within the 24 doctoral dissertations examined. Phase two was facilitated by the NVivo 8 software program, which will be described in detail in the next section. Phase three was characterized by data saturation, with the emergence of recurrent themes and patterns, with meaning in-context, further credibility and confirmation of findings related to the DOI. Phase four is considered to be the highest phase of data analysis; it involved higher-level critical thinking with synthesis and in-depth analysis of data from the previous three phases. It is at this level that creativity was linked with the raw data, resulting in new theoretical formulations, future recommendations and new evidence-based best practices for nursing.

As qualitative researchers, it was understood that accurate analysis of large amounts of qualitative data, which was the case in the 24 doctoral dissertations, can be very tedious, cumbersome, and time-consuming. Unlike the analysis of quantitative research, words are very different than numbers and can be ambiguous, with important information embedded in contextual verbiage, challenging the meaningful and systematic interpretation of the data. As part of the qualitative data analysis process, NVivo 8 software was used to process large volumes of data within the 24 dissertations studied. The raw data was linked to the Leininger-Templin and Thompson Field Research Ethnoscrypt (Appendix D), which facilitated a higher level of data analysis with discovered themes and patterns related to the DOI.

The NVivo 8 software application has distinct terminology specific to its use. In an effort to provide clarity for future discussions, a few of these basic terms will be defined below (www.qsrinternational.com):

1. **Node:** Ideas extracted from text. For this study, the nodes are the codes within the *Leininger, Templin, and Thompson Field Research Ethnoscrypt*.
2. **Attribute:** A property assigned to describe features of a case. For this study, attributes are the demographics, such as gender, study locale, ethnicity, setting, and education.

3. **Case:** A unit of analysis in a research study, a special type of node that can take on attributes, such as gender, study locale or age. Case nodes can be organized in a hierarchal fashion.
4. **Source:** Data physically stored inside the NVivo project file. For this study, the sources are the 24 doctoral dissertations.
5. **Coding:** The process by which nodes are linked to certain segments of documents.
6. **Query:** A method within NVivo that allows the asking of questions and linking of nodes to attributes, and cases to patterns and themes.

Dr. Elaine Welsh (2002), in her published article, *Dealing With Data: Using NVivo in the Qualitative Data Analysis Process*, wrote:

At this point it is useful to think of the qualitative research project as a rich tapestry. The software [NVivo] is the loom that facilitates the knitting together of the tapestry, but the loom cannot determine the final picture on the tapestry. It can though, through its advanced technology, speed up the process of producing the tapestry and it may also limit the weaver's errors, but for the weaver to succeed in making the tapestry, he or she needs to have an overview of what he or she is trying to produce (p.4).

The 24 doctoral dissertations selected for this study were received by the researchers in Adobe PDF (.pdf) format. While NVivo 8 does allow users to directly import PDF files, the files are usually scanned into text, and oftentimes the quality of the scanning and the subsequent image on paper is substandard. Therefore, to preserve the quality and legibility of the text in the doctoral dissertations and to have the files in a usable format for coding purposes, the Office of Research at the University of Michigan-Flint used another specialized conversion software program, Adobe Acrobat 8.0 Professional, to convert the PDF files into Microsoft Word files. This method worked in most cases and produced a legible usable document that could be imported into NVivo 8. However, some of the dissertations still did not convert properly using this method. In several instances, the researchers had to pull the dissertations up in Microsoft Word format, and go through the *Results* and *Findings* chapters line-by-line, making sure that

words were separated and that sentences read properly; ensuring that raw data, ideas and concepts were accurate.

The coding scheme, known as the *Coding Data System for the Leininger, Templin, and Thompson Field Research Ethnoscrypt* (previously mentioned in the *Major Features/Enabler* section as Appendix D), was used by the researchers, with some additional codes developed specifically for this study. The following represents the process used by the researchers to code and analyze the 24 doctoral dissertations:

The *Results* and *Findings* chapters of each of the 24 doctoral dissertations were read and re-read, carefully examined for content, and coded according to how the text matched the corresponding codes developed within the ethnoscrypt. Through the process of organizing raw data, patterns were discovered, which then (in a hierarchal fashion) led to the emergence of themes; with additional synthesis metathemes and metapatterns were discovered at a higher level of abstraction, which then allowed the researchers to answer with clarity the fundamental research questions posed in chapter one of this study.

At the time that the 24 doctoral dissertations (sources) were being coded, the dissertation attributes table (Appendix H) was also being developed by the researchers which included a variety of ethnodemographics (attributes) contained within each individual dissertation. Once this attributes table was developed, multiple advanced coding queries could then be done within NVivo 8 including node-to-node, node-to-attribute, and node-to-text search. The node-to-text sorts yielded the largest amount of data for analysis. More specifically, four metathemes were discovered as a result of stemmed word searches for themes, patterns and descriptors (nodes), including:

Metatheme I: Generic and professional care in health and well-being

Metatheme II: Social structure in health and well-being

Metatheme III: Modes in health and well-being and/or culturally congruent care

Metatheme IV: Environmental context

For example with metatheme 4, *Environmental context*, a text search was done using a Boolean search with words such as environment or environmental or context or setting or rural or urban or physical or ecological or cultural or social, placing the Boolean operator or between each word, in an effort to maximize the number of hits produced when the text search was run against nodes #75 (themes), #76 (patterns) and #77 (descriptors) from the ethnoscript. According to Zhang (2008), “This type of query can serve many purposes. People in the text analysis field are interested in knowing the occurrence of the words. Even frequency alone could reveal interesting stories....If people are studying the relationship between words, text search query could be the starting point of a collocation analysis” (p.75).

### ***Substantiating the Research***

For many years, qualitative researchers have tried to use quantitative criteria for evaluation of qualitative studies. Concepts such as rigor, validity and reliability, which are traditionally used within the quantitative paradigm blurred the lines between qualitative and quantitative research studies creating confusion, inaccurate interpretations, and questionable outcomes. For this reason, Leininger developed and refined six specific qualitative criteria to be used with the ethn nursing research method and the culture care theory. These criteria are credibility, confirmability, meaning in-context, recurrent patterning, saturation and transferability; they have brought increasing clarity to the evaluation of qualitative data and have established trustworthiness of data within studies using the culture care theory.

Credibility refers to the emic (insider's) perspective that is embedded in each of the doctoral dissertations examined. It is the "truth", accuracy, or believability of findings that have been mutually established between the researcher and the informants established as accurate, believable, and credible about their personal experiences and knowledge of their own cultural phenomena (Leininger & McFarland, 2006). For example, in McFarland's dissertation (1995), the researcher spent one year observing, participating, and collecting data from the two cultural groups studied (Anglo and African-American elders in a long-term care setting), lending credibility to the discovery of basic beliefs and lifeways held by both key and general informants studied. In a broader context, the metasynthesis study conducted by the researchers met the criterion of credibility as all 24 doctoral dissertations examined were prepared, defended and published by culture care experts.

Confirmability is the repeated affirmation contained within the doctoral dissertations regarding direct and documented evidence from both observed and primary informational sources. Confirmability involves repetition of ideas and lived experiences that have occurred within cultural groups when they are encountered in familiar and natural environmental contexts (Leininger & McFarland, 2006). Contained within Wehbe-Alamah's dissertation (2008), the researcher commented, "Throughout interviews, the researcher frequently stopped and repeated or paraphrased the informants' answers to make sure that she understood exactly what she was being told" (p.38). On a broader scale, this study conducted by the researchers met the criterion of confirmability, as all four members of the research team sat down and agreed upon the coding scheme contained within the ethnoscript. Additionally, the 24 doctoral dissertations were read, re-read, and reviewed in great detail multiple times throughout the progression of the study.

Meaning in-context is the third criterion that focuses on “data that has become understandable with relevant referents or meanings to the informants or people studied in different or similar environments” (Leininger, 2006, p.77). To support this criterion, Schumacher (2006), whose dissertation focused on Dominicans living in a rural village wrote, “The researcher met and interviewed people in different environments and situations, and aimed at getting wide knowledge of the community” (p.44). In a broader context, the third criterion of meaning in-context was achieved in that the researchers studied in-depth and then selected ethnonursing as the research method which goes hand-in-hand with the culture care theory.

The fourth criterion, recurrent patterning, involves evidence of documented repetition of themes, patterns and behaviors within a specific cultural group being studied over time, resulting in consistency with regard to lifeways and cultural beliefs (Leininger & McFarland, 2006). George (1998), in her dissertation on the mentally ill in a day treatment center supported this criterion when she wrote, “Field notes clearly show consistency in the structured time frame and activities of Passages and the lifeways of many informants” (p.70). On a broader scale, recurrent patterning was achieved by the researchers in this study as redundancy emerged across all 24 studies, with recurrent patterns, themes and related descriptors, as evidenced through NVivo text searches.

Saturation is the fifth criterion which is a reference to the processing of information from key and general informants in such a full, in-depth, and comprehensive manner so as to reach a point of redundancy and repetitiveness that the researcher perceives the informants have no new information to offer. Lamp (1998) in her dissertation on Finnish women and the experience of childbirth commented, “When the researcher found all that could be discovered and understood, the care meanings and practices for Finnish women in birth were established and saturation was



achieved” (p.92). In a broader context, saturation was accomplished in the metasynthesis study in that certain coding categories in the ethnoscript became exhaustive with information gleaned from all 24 studies; new information no longer emerged from across all cultural groups studied regarding worldview, cultural beliefs, generic care, professional care, social structure and environment.

The final and sixth criterion, transferability, is a higher level criterion and deals with the ability of a particular study to transcend its “singleness” and be applicable to or appropriately used in another similar culture within their contexts. The responsibility of transferability lies with the researcher intending to do the transfer. However, it is the responsibility of the researchers involved with this particular study to provide as clear a “road map” for potential transfer as possible (Lincoln & Guba, 1985). Then and only then can nurse and other healthcare providers decide just how closely the situation resembles the circumstances he or she is in, and whether or not they can safely and logically invoke a transfer. The researchers believe that this criterion was achieved and will be elaborated upon in chapter four.

Collectively, the 24 doctoral dissertations examined by the researchers represented considerable diversity among the cultural groups, but ultimately cultural care within and among all groups represented had distinct commonalities in regard to themes and patterns. Furthermore, there was consistency throughout the dissertations with the enablers used for data collection (Leininger’s Stranger to Trusted Friend Enabler, O-P-R Enabler). Within the 24 doctoral dissertations, differences did exist; differences in study locales, interview questions, cultural groups, gender, age, and level of education, to highlight a few. However, in spite of the differences, the recurrent thread that ran through all 24 studies was the importance of culture within the context of care. According to Lincoln & Guba (1985), an important mechanism for

promoting transferability is the amount of information and the “thick description” of the information qualitative nurse researchers provide about the context of the studies.

The goal of qualitative research is not to generalize or “pare down”, but rather to enhance and embellish existing meanings, attributes, patterns, symbols, metaphors, and other features related to qualitative paradigmatic findings (Leininger, 1992, Lincoln & Guba, 1985). The six criteria for the substantiation of qualitative research, developed by Leininger, served as a guide for the systematic evaluation of the 24 doctoral dissertations using the ethn nursing research method and guided by the culture care theory.

## CHAPTER 4

### *Results and Findings*

The results section of any study is arguably the “heart and soul” of the work. In the results section of this metasynthesis, the researchers summarized themes and/or theories that have been discovered within the context of the individual studies. According to Polit & Beck (2008), “Key themes, metaphors, or domains are often used as subheadings, organized in order of salience to participants or to a theory” (p.700). The descriptive metasynthesis conducted by the researchers of 24 doctoral dissertations using the ethn nursing research method and guided by the culture care theory was laden with themes and metaphors, scattered throughout the rich descriptors embedded in each of the studies scrutinized, examined and coded. The challenge for the researchers has been the extraction of the rich descriptors contained within the pages of the individual studies, which ultimately allowed the researchers to “flesh out” commonalities and differences existing within diverse cultures, resulting in culture care findings that are both interpretive and explanatory. The ultimate goal was to discover new theoretical formulations over and above what the individual studies each offered, resulting in a significant contribution to the discipline and practice of nursing within the context of culture care.

#### *Cultural Groups Studied*

The 24 doctoral dissertations that were used by the researchers for this study addressed many different groups of people. There was considerable diversity within cultural groups; different age ranges, gender, and a variety of life stages represented; including pregnancy, end-of-life, and mental illness, to name a few. Table B provided a visual depiction of the cultural groups studied with their respective authors:

**Table B**

<b>Authors</b>	<b>Cultural Groups Studied</b>	<b>Dates</b>
Berry, Anita	Pregnant Mexican-American women	1996
Ehrmin, Joann	African-American women residing in an inner city transitional home for substance abuse	1998
Farrell, Linda	Potawatomi who have experienced family violence	2001
Fox-Hill, Emily	Persons with AIDS living-dying in a nursing home	1999
Gelazis, Rauda	Humor, care and well-being of Lithuanian Americans	1994
Gates, Marie F.	Persons dying in a hospice facility and oncology unit	1988
George, Tamara	Chronically mentally ill in a day treatment center	1998
Herp, Cheryl	Guatemalan Mayans in southeast Florida	1996
Higgins, Barbara	Puerto-Rican cultural beliefs and influences on infant feeding practices in western New York	1995
Johnson, Catherine	Rural immigrant Mexican women	2005
Kelsey, Beth Marie	Mexican-American migrant farm workers related to health promoting behaviors	2005
Lamp, Judith	Finnish women in childbirth	1998
Luna, Linda	Lebanese Muslims in an urban U.S. community	1989
MacNeil, Joan	Baganda women as AIDS caregivers	1994
McFarland, Marilyn	Anglo and African-American elderly residents within the environmental context of a long-term care institution	1995
Miller, June	Politics and care of Czech Americans	1997
Morgan, Marjorie	Prenatal care of African-American women in selected U.S.A. urban and rural cultural contexts	1994
Morris, Edith	Selected urban African-American adolescent gang members	2004
Prince, Lola	Minority women residing in a transitional home recovering from prostitution	2005
Rosenbaum, Janet	Older Greek Canadian widows	1990
Schumacher, Gretchen	Rural Dominicans in a rural village of the Dominican Republic	2006
Wehbe-Alamah, Hiba	Syrian Muslims living in the Midwestern United States	2005
Wekselman, Kathryn	Natural childbirth	1999
Wenger, Anna	Old Order Amish	1998

### ***Findings***

The data analysis process of this study began with reading and re-reading the doctoral dissertations, and then coding the *Results* and *Findings* section of each individual dissertation using the ethnoscript (Appendix D). The process of coding was always done by two researchers

in an effort to achieve confirmability, a qualitative evaluative research criterion of the ethn nursing research method. The text was read, discussed and coded (with consensus and confirmation) in correspondence with the categories within the ethnoscript (Appendix D). As each dissertation was analyzed, coded and then uploaded into NVivo 8, the researchers began to note recurrent patterning and eventually data saturation, two other important evaluative criteria. From the rich descriptors, patterns emerged, which then led to themes, which were synthesized to metapatterns and metathemes, defined as over-arching themes and patterns at a higher level of abstraction. For the purposes of this discussion, the four over-arching metathemes discovered will be presented, followed by three (of the many) supporting themes extracted from individual dissertations, followed by a metapattern, followed by supporting care patterns, which will then be followed by supportive and corresponding raw data descriptors.

#### Metatheme One: Generic and Professional Care

Culturally congruent professional and generic care for diverse and similar cultures influence health, well-being, and illness outcomes.

This universal metatheme was derived from the 24 dissertation research authors reporting generic and professional care experiences by diverse and similar cultures which influenced health, well-being and illness outcomes.

#### Examples of Supporting Themes for Metatheme One: Generic and Professional Care

1. Theme one supporting metatheme one: Old Order Amish informants considered and selected from an array of healthcare options which included folk, professional, and alternative care (Wenger, 1998) [generic and professional care].
2. Theme two supporting metatheme one: Syrian Muslims have reported care as professional and generic care beliefs, values and practices in Syrian and US hospital

contexts (Wehbe-Alamah, 2005). For example, generic care was reported as care given by an informant's husband, children or community friends. Syrian Muslim men and women provide physical and emotional support to their families, relatives and friends. Professional care was reported from nurses in hospitals.

3. Theme three supporting metatheme one: Professional care meanings and practices were reported as ritualized care that was built by respect, trust, anticipatory care with education and advocacy, and generic care was reported as protective care. For example, Finnish women giving birth reported generic care was in the context of comfort from family members by touch and presence. (Lamp, 1998).

#### Metapattern One for Metatheme One: Generic and Professional Care

The context of generic and professional care patterns was reported as generic/family care patterns, professional care patterns, alternative care patterns, resident-to-resident/reciprocity care patterns, reciprocal care patterns, and protective care patterns which influenced the health and well-being of diverse and similar cultures and could be predictors of health, well-being or illness.

This universal metapattern was derived from the 24 dissertation research authors reporting generic and professional care experience care patterns by diverse and similar cultures which influenced health, well-being and illness outcomes. Generic care patterns included health and illness beliefs, values and practices, human care and caring, emic or indigenous beliefs, human folk care/curing patterns, reciprocal care patterns, and protective care patterns. Professional care patterns included emic and etic beliefs, practices, professional staff and nursing care patterns, alternative care patterns and emergency care/cure patterns.

Examples of Supporting Care Patterns for Metapattern One: Generic and Professional Care

1. Care pattern one supporting metapattern one: The Old Order Amish informants reported family and their lifeways, values and beliefs influenced their decision on and when to use folk or professional care services, generic role expectations, and reported care is first given directly through family presence (folk care), then the use of professional care (Wenger, 1988).

Supporting descriptor: "...100% of the informants made use of brauche [warm hands as a gift from God] and other folk care modalities, chiropractic and reflexology in addition to the services of professional physicians and nurses" (Stated by Old Order Amish, Wenger, 1998).

2. Care pattern two supporting metapattern one: Syrian Muslims reported husbands tend to care for their wives by taking them to the doctor or hospital, purchasing and/or administering medicine, cooking healthy meals, helping with the kids, cleaning around the house and/or asking their wives to rest and not worry about housework (Wehbe-Alamah, 2005) [Generic care].

Supporting descriptor: One male Syrian informant shared that a caring nurse is unselfish and lives for others; whereas noncaring nurses look at their patients as a task that they cannot wait to be done with" (Stated by Syrian Muslims living in the Midwestern US, Wehbe-Alamah, 2005).

3. Care pattern three supporting metapattern one: Finnish women reported ritualized care patterns by the nurse meant continuous presence during childbirth (Lamp, 1998) [Professional care].

Supporting descriptor: “She [nurse] was there with me like family” (Stated by a Finnish woman in labor, Lamp, 1998).

### Metatheme Two: Social Structure

Social structure factors including family and kinship, religion and spirituality, economics, and cultural values and lifeways are influencers on culture care to predict health and well-being.

This universal metatheme was derived from the 24 dissertation research authors reporting social structure factors such as family, kinship, religion and spirituality, economics, and cultural values and lifeways which influenced health, well-being and illness outcomes.

#### Examples of Supporting Themes for Metatheme Two: Social Structure

1. Theme one supporting metatheme two: For Baganda women [Rural Uganda, Africa] as AIDS caregivers, culture care means responsibility, love, and comfort derived from their kinship, religious, cultural beliefs and values, as well as their generic health beliefs, and those of professionals (MacNeil, 1994).
2. Theme two supporting metatheme two: Social structural factors of spirituality, kinship, and economics, had great influence on the health and well-being of African-American women receiving prenatal care in rural and urban United States (Morgan, 1994).
3. Theme three supporting metatheme two: The chronically mentally ill in the community [Urban Midwestern United States] are a subculture with shared social structure factors and specific cultural norms, values, and lifeways which differ in some respects from those of the dominant culture (George, 1998).



### Metapattern One for Metatheme Two: Social Structure

Within the context of social structure factors family, kinship, religion, spirituality, economics, cultural values and lifeways are influencers on culture care and can be predictors of health and well-being.

This universal metapattern was derived from the 24 dissertation research authors reporting social structure factors such as family, kinship, religion and spirituality, economics, and cultural values and lifeways influenced health, well-being and illness outcomes, with a few diverse care patterns also described. The dissertations examined discovered protective care, respectful care, comfort care from religion/spiritual beliefs, and folk and professional care patterns which influenced health and well-being.

#### Examples of Supporting Care Patterns for Metapattern Two: Social Structure

1. Care pattern one supporting metapattern one: Traditional Baganda customs of children belonging to the paternal clan were weakened due to the numerous deaths from AIDS, often resulting from violence and family conflict, although the Baganda women sought care as comfort from God and within the Roman Catholic or Protestant religions, and prayed and bore suffering (MacNeil, 1994). [Family and religious factors]

Supporting descriptor: “This is hard to describe, but I care for my daughter, and I love her. She is all I have left” (Stated by a Ugandan grandmother whose daughter was dying of AIDS, MacNeil, 1994).

2. Care pattern two supporting metapattern one: Spirituality enabled African-American women receiving prenatal care to experience life with equanimity (Morgan, 1994) [Spiritual and religious factors].

Supporting descriptor: “I just started talking to God about it...I try to trust in the Lord and everything will be all right” (Stated by an African-American woman in a prenatal care clinic, Morgan, 1994).

3. Care pattern three supporting metapattern one: The mentally ill strove to move towards independence in achieving and maintaining stability in living arrangements, personal relationships, kinship, social factors and treatment of their mental illness, and searching for a place to belong in society (George, 1995). [Kinship and social factors]

Supporting descriptor: “I think that sometimes people with mental health problems just sort of drift away or aren’t part of the larger society” (Stated by a mental health consumer, George, 1998).

4. Care pattern four supporting metapattern one: Financial disadvantage and bureaucracy made it difficult to obtain healthcare (Prince, 2005). [Economics]

Supporting descriptor: “Health means money. Most times to maintain your health you have to have money, insurance” (Stated by an African-American female prostitute living within the urban city, Prince, 2005).

5. Care pattern five supporting metapattern one: Generosity and sharing was viewed as a care pattern influence by kinship, cultural values of family and lifeways (Farrell, 2001) [Cultural values and lifeways].

Supporting descriptor: “We always make sure family has what they need. We honor our children even if we don’t like the things they do. We honor our elders. I experience that every day. It is nice to be an elder. I know that my people will take care of me if I need anything” (Stated by a Potawatomi female elder living in a rural setting, Farrell, 2001).

### Metatheme Three: Action and Decision Meta-Modes

Culture care action and decision modes for providing culturally congruent nursing care are essential and contribute to the health and well-being of similar and diverse cultures.

This universal metatheme was derived from all 24 dissertation research authors reporting culture care action and decision modes were essential for providing culturally congruent nursing care and contributed to the health and well-being for similar and diverse cultures.

#### Examples of Supporting Themes for Metatheme Three: Action and Decision Meta-Modes

1. Theme one supporting metatheme three: Culture care preservation/maintenance and nursing actions/decisions are essential for health and well-being within similar and diverse cultures. Culture care maintenance/preservation refers to assistive, supportive, facilitative, or enabling creative professional actions and decisions that help Baganda women as AIDS caregivers to preserve or maintain a state of help, or to face handicap or death (MacNeil, 1994).
2. Theme two supporting metatheme three: Culture care negotiation/accommodation of culture-specific nursing care actions/decisions is essential for health and well-being within similar and diverse cultures. For example, culture care accommodation and/or negotiation was reported to be a goal to alleviate barriers for African-American working class women for prenatal care. Free transportation was available to accommodate women (Morgan, 1993).
3. Theme three supporting metatheme three: Culture care repatterning/restructuring of unhealthy folk and alternative care practices did promote safe culturally congruent care for Finnish women. For example, pregnant Finnish women restructured a shorter length

of time and cooler temperatures in the sauna for promoting safer cultural care practice (Lamp, 1998).

### Metapattern One for Metatheme Three: Action and Decision Meta-Modes

The context of preservation/maintenance patterns, negotiation/accommodation patterns, re-patterning and /or re-structuring patterns, influence family, kinship, professional and generic care patterns, practices, beliefs and cultural values which contribute and provide for culturally congruent nursing care that support the health and well-being of diverse and similar cultures.

This universal metapattern was derived from all 24 dissertation research authors reporting culture care action and decision modes were essential for providing culturally congruent nursing care and contributed to the health and well-being for similar and diverse cultures.

### Examples of Supporting Care Patterns for Metapattern One: Action and Decision Meta-Modes

1. Care pattern one supporting metapattern one: During a period of serious illness such as AIDS, the nurse should be prepared to accommodate immediate family, relatives and generic folk healer care patterns within the home as well as in the healthcare setting (MacNeil study in Uganda, 1994).

Supporting descriptor: “My husband was polygamous. He had several other children with other women and brought these children home for me to look after. I did not like it, but I had no choice. I had to look after the family” (Stated by a Uganda mother living in Africa, MacNeil, 1994) [Preservation/maintenance].

2. Care pattern two supporting metapattern one: Morgan reported culture care negotiation involves alternative, generic, or folk healer care patterns in the prenatal care of African-American women to enhance or shorten labor (Morgan study in Detroit, Michigan and the rural South, 1994).

Supporting descriptor: “I prefer that they [babies] in the hospital-they know what they are doing, so babies are safe, better safe than sorry....You need doctors and nurses to keep them safe, you need to protect your body” (Stated by an African-American woman in the hospital, Morgan, 1994) [Negotiation/accommodation].

3. Care pattern three supporting metapattern one: Lamp reported pregnant Finnish women restructured care patterns shortened the length of time and facilitated cooler temperature in the sauna for the safety of their unborn child (Lamp, 1998).

Supporting descriptor: “She was the only nurse and knows what happened, beginning to end” (Stated by a laboring Finnish woman in a hospital, Lamp, 1998)

[Repatterning/restructuring].

#### Metatheme Four: Environmental Context

Care patterns, expressions, beliefs and practices were viewed within urban and rural environmental contexts as a continuing life experience with both similar and diverse findings within urban and rural settings.

This universal metatheme was derived from all 24 dissertation research authors reporting environmental context was viewed and influenced care patterns, expressions, beliefs and practices within urban and rural settings and contributed to the health and well-being for similar and diverse cultures.

#### Environmental Contexts for Metatheme Four

##### Urban Environments

Examples of urban environments described within the studies included inner city neighborhoods (Ehrmin, 1998), suburban/urban neighborhoods (Miller, 1997), city hospitals

(Gates, 1988), city churches (Gelazis, 1993), retirement homes (McFarland, 1995), apartments, urban centers (George, 1995) and transition centers (Prince, 2005).

### Rural Environments

Examples of rural environments were rural American Midwest (Wenger, 1998), Dominican village center (Schumacher, 2006), rural Ohio homes (Johnson, 2005), and rural medical clinics (Farrell, 2001).

#### Examples of Supporting Themes for Metatheme Four: Environmental Context

1. Theme one supporting metatheme four: Anglo and African-American residents viewed, expressed, and lived generic care to maintain their pre-admission generic lifeways and to maintain beneficial and healthy lifeways in the [urban] retirement home (McFarland, 1995).
2. Theme two supporting metatheme four: Culture care for [urban] African-American adolescent gang members reported nurses have knowledge, understanding of emotional, cultural, physical and environmental pain and genuine compassion to assist the gang members in ameliorating their pain influenced by family, spiritual-religious factors, and the social and lifeways of the culture (Morris, 2002).
3. Theme three supporting metatheme four: Old Order Amish worldview, social structure, anticipatory care, active participation in their care situations were expected to maintain high context relationships within their [rural] community (Wenger, 1998).

#### Metapattern One for Metatheme Four: Environmental Context

Within the context of urban and rural environments, family, kinship, care patterns, practices, beliefs, expressions and cultural values influenced health and well-being.

Urban and rural environments influenced universal community care patterns, maternal and paternal protective care patterns, organizational care patterns, institutional care patterns, apartment living care patterns, retirement home care patterns, nursing home care patterns, and professional care institution patterns.

Urban environments influenced diverse inner city care patterns, poverty care patterns and destructive life care patterns. Adult females developed recovery care networks within their neighborhoods which left the culture in need of compassion, love and understanding (Ehrmin, 1998). Rural environments influenced diverse community care patterns, generic and professional care patterns and family and kinship care patterns.

#### Examples of Supporting Care Patterns for Metapattern One: Environmental Context

1. Care pattern one supporting metapattern one: Anglo and African-American retired male and female elders living in an urban nursing home and apartments were found to have retirement home care patterns, viewing day and night within their environmental context as continuing life experiences, although were found to have major differences between living in the apartment section and nursing home setting. Protective care, watchfulness, and a sense of extending family relationships were developed within these environments (McFarland, 1995).

Supporting descriptor: “I help her here on and off the elevators...You can’t live here and just be concerned with individuality...and I have arranged for others to come and live here because I knew they needed care” (Stated by a retired female elder living in an apartment setting, McFarland, 1995).

2. Care pattern two supporting metapattern one: African-American adolescent urban gang members used destructive lifeways to survive in their urban environment and need to learn healthier ways of coping with stress within their urban environment (Morris, 2004).  
Supporting descriptor: “These young kids are going to jail for the older gang leaders and even beyond...high stakes drug dealers” (Stated by a family member within the urban community of African-American adolescent gang members, Morris, 2004).
3. Care pattern three supporting metapattern one: The rural Amish participants discovered care patterns of community care including bonding of family members intergenerationally, and this was expressed through helping and participating in functions that brought people together (Wenger, 1998).  
Supporting descriptor: “Our people belong together. Caring for each other is what keeps the community together. Helping others is a time for bringing relatives together. It is a time for visiting. It is good for people to get together. It is how we care for each other and know about each other” (Stated by an Amish person in a rural community, Wenger, 1998).

In summary, the ultimate goal of this metasynthesis was to unearth new theoretical formulations above and beyond what each individual study had to offer, resulting in a profound contribution to the discipline of nursing within the context of culture and care. It is noteworthy to mention at this time that there were more metapatterns for each of the four metathemes, but in the interest of time and page limitation, only one metapattern per metatheme was presented. The synthesis of themes and patterns into metathemes and metapatterns with a universal perspective provided the basis for the discovery of important data that could ultimately result in improved culturally congruent care within the nursing profession.



## CHAPTER 5

### *Discussion of the Findings*

The domain of inquiry (DOI) for this research study was a metasynthesis of 24 doctoral dissertation research studies of culture care expressions, beliefs, practices and values of diverse and similar cultures. This DOI is central to the discipline of nursing and is of major importance to the profession because it will result in theory building and development; improve nursing care actions and decisions for diverse and similar cultures by adding to a higher level of abstraction of findings. The goal of this study was to discover and synthesize generic (folk) and professional culture care actions and decision modes that promoted health, well-being, and beneficial lifeways for people of diverse and similar cultures.

This descriptive metasynthesis was conceptualized within the qualitative research paradigm, guided by Leininger's culture care theory and utilized the ethnonursing research method. The foundational concepts of "culture" and "care" are essential features of the nursing profession, and it is the blending and intertwining of these two concepts that provided a prospective congruent transcultural nursing approach for this study. This study has contributed to and will potentially impact the existing body of knowledge using the culture care theory and the ethnonursing method for improving future culturally congruent healthcare policy, evidence-based best practices, nursing education, nursing actions and decisions and future research.

The ethnonursing research method created by Leininger guided open discovery and interpretation for the metasynthesis of findings of the 24 cultural groups studied. The researchers focused on all of the cultural group's particular emic (insider) views, expressions, beliefs, practices and values, of diverse and similar cultures and how they related to healthcare practices. Etic (outsider) views from key informants were included within the dissertations

studied. The researchers focused on emic (insider) and etic (outsider) knowledge and practices related to care, health, well-being, illness, social structure, environment, generic and professional care, along with other transcultural nursing phenomena. This knowledge serves as a beacon for the nursing profession to improve health outcomes and may even potentially result in future evidence-based best practice for providing culturally congruent care. The researchers spent two years studying and “dwelling with the data” of the dissertations (McFarland, 2009), to substantiate evidence related to qualitative criteria of credibility, confirmability, meaning-in-context, recurrent patterning, and data saturation.

The discussion of the findings will focus on qualitative synthesized themes, patterns, action and decision modes that were abstracted from the 24 dissertations and categorized with the assistance of NVivo 8 and the ethnoscript, using Leininger’s Sunrise Enabler along with Leininger’s four phases of ethnonursing analysis. The findings are grounded in extensive research within the context of generic and professional care, social structure, care action and decision modes and environmental context for diverse and similar cultures. The findings discovered include supporting care patterns along with corresponding raw data descriptors. The discovered themes, patterns, and modes were exponential and with the Leininger Sunrise Enabler and with the synthesis of tenets, provided metathemes, metapatterns and metamodes which led the researchers to the concept of meta-ethnonursing. This evolved after in-depth discussion with seasoned transcultural nurse researchers.

Leininger’s four phases of ethnonursing data analysis were used to tease out raw data from the 24 dissertations for NVivo 8 coding, categorizing the raw descriptors guided by Leininger’s theory and the Sunrise Enabler, then identifying diverse and similar care patterns and themes, which supported major metathemes and metapatterns. During the first phase, the researchers

collected, described, and began to analyze data related to the purposes, domain of inquiry, and research questions. During the second phase, the data was coded and classified as related to the ethnoscript along with emic and etic descriptors, which were then studied within context for similarities and differences. Recurrent themes and patterns were studied for their meanings. The third phase included the discovery of saturation of recurrent themes and patterns of similar or diverse meanings, expressions, structural forms, interpretations, or explanations of the data related to the domain of inquiry. Data was also examined to show patterning with respect to meanings-in-context, along with further credibility and confirmation of the findings amongst the researchers. The fourth phase was the highest phase of data analysis, that of synthesis and interpretation. It required higher level synthesis of abstraction, interpretation of findings, and creative mind-mapping and formulation of the data from the previous phases. The researchers were then able to abstract and document major themes, care patterns, research findings, recommendations and theoretical formulations that emerged from the 24 cultural groups studied (Appendix H).

The assumptive premises of Leininger's theory that guided this study were:

- Generic and professional care practices have been discovered for providing culturally congruent care, culture care and influenced health, well-being and illness outcomes (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).
- Social structure factors including family and kinship, religion and spirituality, economic and cultural values and lifeways, are influencers on health, well-being and illness outcomes (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).

- Leininger's three theoretical modes of action and decision have been discovered to help people of diverse cultures across the continuum of nursing care (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).
- Culture care beliefs, values and practices are embedded in worldview and cultural values within environmental contexts of urban and rural settings and influence health and well-being or illness outcomes (Derived from Leininger, 2006, 2<sup>nd</sup> ed., p.19).

In summary, Leininger's assumptive premises guided this study to discover and unearth universal themes and care patterns as well as diverse universal themes and care patterns. Generic and professional care practices are embedded in all 24 dissertations that influenced health and well-being. For example, Farrell (2001) described listening and storytelling by oral history from elders influenced cultural values, kinship and generic care patterns and practices within families. McFarland (1995) reported elders in a long-term care setting discovered supportive care patterns that included protective care, care as doing for others, such as activities and physical tasks, care as presence, care as watchfulness or surveillance, and care as spiritual or religious helping. In Wehbe-Alamah's study (2005), one male Syrian informant shared that a caring nurse is unselfish and lives for others; whereas as a noncaring nurse looks at their patients as a task that they cannot wait to be done with. This was experienced in Syrian and United States hospital contexts which influenced health, well-being and illness outcomes. In Lamp's study (1998), Finnish women in labor reported professional care meanings and practices were experienced as ritualized care that built respect and trust. For example, the Finnish informant stated, "she [the nurse] was there with me like family." All of the other doctoral dissertations in this research metasynthesis supported this finding and data saturation was achieved, as the researchers abstracted accurate interpretations which were viewed as credible findings.

Diverse themes and culture care patterns discovered were embedded in Morris' (2004), Prince's (2005), Miller's (1997) and MacNeil's (1994) dissertations. The diverse culture care patterns reported were desperation (Morris, 2004), political care/non-care (Miller, 1997), and remorse (Prince, 2005). For example, in Morris' (2004) dissertation with African-American adolescent gang members, she described the culture care patterns of experiencing desperation and remorse over using illegal economic means to help others and to relieve the pain of living in their urban neighborhoods. Morris added that adolescent gang members used these strategies to promote healthy emotional and social maturation. In Prince's (2005) dissertation, remorse and desperation care patterns were experienced within the cultural milieu of street prostitution, described as an orientation toward a unique social context, influencing street-prostituted women's participation in the culture of prostitution. In MacNeil's (1994) dissertation, remorse and desperation care patterns were experienced as well for Baganda women as caregivers for family and rural community members suffering and dying from AIDS. One informant, a Ugandan grandmother whose daughter was dying of AIDS reported, "This is hard to describe but I care for my daughter, I love her. She is all I have left" (MacNeil, 1994).

Unique diverse political care patterns were abstracted from Miller's (1997) study, in which political care patterns were described with Czech Americans who reported making a choice in how they made a living, how hard they worked toward goals, and what education they chose to pursue. These were considered political freedoms and influenced health and well-being. One Czech American informant reported, "Here you have a chance...you have the choice...In my country because my father escaped (Czechoslovakia) when I was young, I couldn't even go to the University....I never had a chance" (Miller, 1997). Miller reported political care patterns influenced health and well-being.

Leininger's assumptive premises grounded the abstraction of social structure factor universal themes and care patterns which included family and kinship, religion and spirituality, economic and cultural values and lifeways which influenced health, well-being and illness outcomes and were embedded in all 24 dissertations. For example, community care patterns and themes, (Wenger, 1998 & Wehbe-Alamah, 2005) and protective care patterns and themes (McFarland, 1995) which included family and kinship, cultural values and lifeways influenced health and well-being. Additionally, Wenger's (1998) dissertation, which studied the Old Order Amish, reported that giving is both an obligation and a privilege, and that community care patterns are expressed through helping and bringing people together. In Wehbe-Alamah's (1995) dissertation, Syrian Muslims reported community care patterns were expressed through helping and bringing people together, and was also perceived as an obligation and a privilege. McFarland (1995) reported Anglo and African American residents viewed, expressed, and lived generic care patterns to maintain their preadmission generic lifeways and to maintain beneficial and healthy lifeways in the retirement home. An Anglo American elder living in a nursing home reported, "I have my daughter Mary, to bring things down to me...My son calls me every week...[And] My daughter came and got me for Thanksgiving" (McFarland, 1995). Protective care patterns were also expressed by Anglo and African American elder nursing home residents as watchfulness and surveillance and were described as kinship, cultural values and lifeways which influenced health, well-being and illness outcomes (McFarland, 1995).

Leininger's three theoretical modes of action and decision care patterns and themes were embedded in all 24 dissertations that influenced health and well-being and illness outcomes. Preservation/maintenance action and decision care themes and patterns were discovered in McFarland's (1995), Rosenbaum's (1990), and Ehrmin's, (1998) dissertations, although they

were embedded in all 24 dissertations. One example is in McFarland's (1995) study, as culture care preservation/maintenance action and decision care patterns discovered and described by Anglo and African American nursing home elders who continued to receive care from their families, even though they were residing in a long-term nursing facility receiving professional nursing care. Another example was discovered in Rosenbaum's (1990) study where Greek Canadian widows reported preservation/maintenance themes and care patterns as nurses encouraging strong family, church, and community resources for providing culturally congruent care for Greek Canadian widows. Ehrmin's (1998) study discovered African American family and kinship preservation/maintenance action and decision themes and care patterns were maintained within the context of a treatment facility for substance abuse and provided for culturally congruent care with positive care experiences, values, beliefs, and practices associated with the African American informant's families and their kinship systems (Ehrmin, 1998).

Repatterning/restructuring care patterns and themes were discovered in George's (1998), Wehbe-Alamah's, (1995) and Lamp's (1998) dissertations although they were embedded throughout all 24 dissertations. For example, culture care repatterning/restructuring was used to guide nurses to provide culturally congruent nursing care for individuals and groups within the subculture of the chronically mentally ill (George, 1998). Such culturally congruent care was predicted to promote and support more positive mental health among the chronically mentally ill in the community (George, 1998). Culture care repatterning/restructuring discovered within Wehbe-Alamah's (1995) study of Syrian Americans reported the generic practice of sharing medication and of taking medication without receiving consultation from a healthcare provider (Wehbe-Alamah, 2005). Repatterning/restructuring care action and decision care patterns were used to guide nurses to provide safe culturally congruent care to promote health and well-being.

Accommodation/negotiation care patterns and themes were discovered in Schumacher's (2006), George's (1998), and MacNeil's (1994) dissertations although they were embedded throughout all 24 dissertations. Schumacher (2006) reported family [accommodation/negotiation care patterns] involvement is necessary to promote health and well-being in hospitals and clinics for the rural Dominicans. Because the family also includes the extended family, the presence of many individuals with a sick person is a universal experience. Schumacher remarked that to achieve culturally congruent care outcomes, a pattern of accommodation and negotiation was required. An instance of this was nurses and caregivers needed to find ways to accommodate the family so they could spend time with an ill loved one (Schumacher, 2006). According to George (1998), culture care accommodation/negotiation patterns were used to provide for flexible medication regimens and rules which were culturally congruent with the mentally ill client's lifeways. Accommodation/negotiation nursing care action and decision care patterns for Uganda women during periods of serious illness such as AIDS guided nurses to accommodate immediate family, relatives, and generic folk healers in the home as well as in the healthcare setting (MacNeil, 1994). Culturally congruent nursing care action and decision modes and care patterns are paramount in preserving, maintaining, restructuring, repatterning, accommodating and negotiating to alter unhealthy folk and alternative practices to promote health and well-being for diverse and similar cultural groups. Leininger's three modes of action and decision culture care theoretical framework are essential for nurses to provide culturally congruent care to promote health and well-being within similar and diverse cultures.

Leininger's assumptive premise of environmental context of urban and rural settings discovered within this study influenced cultural care beliefs, values and practices and were embedded within worldviews and cultural values which influenced health, well-being and illness



outcomes. Environmental context care patterns and themes within urban and rural settings were discovered within all 24 dissertations. Some examples of urban environments included city hospitals (Gates, 1988), city churches (Gelazis, 1993), retirement homes (McFarland, 1995), and apartments and urban centers (George, 1995). Some examples of rural environments included Midwestern America (Wenger, 1998), rural medical clinics (Farrell, 2001) and village centers (Schumacher, 2006). A comprehensive list of urban and rural environments and cultural groups are listed in appendix H. Generic and professional culture care, social structure factors, culture care action and decision modes and environmental contexts all influence similar and diverse cultural groups.

### ***Reflections on the Study***

Through the process of Leininger's four phases of analysis and coding using the NVivo 8 qualitative software program, followed by re-examining data from multiple queries within the 24 doctoral dissertations guided by the culture care theory and using the ethnonursing method, four major metathemes were discovered and supported by themes, patterns and qualitative descriptors from general and key informants from all 24 dissertations:

Metatheme One-Generic and professional care: Culturally congruent professional and generic care for diverse and similar cultures influence health, well-being, and illness outcomes.

Metatheme Two-Social structure: Social structure factors for diverse and similar cultures including family and kinship, religion and spirituality, economics, and cultural values and lifeways are influencers on culture care to predict health and well-being.

Metatheme Three-Action and decision meta-modes: Culture care action and decision modes for providing culturally congruent nursing care contribute to health and well-being for diverse and similar cultures.

Metatheme Four-Environmental context: Care patterns, expressions, beliefs and practices were viewed within urban and rural environmental contexts as a continuing life experience, but with differences between urban and rural settings.

The process of reflecting on metatheme one revealed that generic and professional care did influence health, well-being and illness outcomes. When discussing generic and professional care, Wenger (1998) reported Old Order Amish participants reflected on generic care as the expression of feeling privilege of giving care, obligation to care for each other, the expectation of receiving care throughout one's lifetime, receiving care with humility and gratitude, and encouraging intergenerational caring relationships. Wenger (1998) reported the importance of family and generic care for health and well-being. Additionally, McFarland (1995) reported Anglo-American and African-American retirement home residents reported generic care as doing for others and care as presence. Lamp (1998) reported Finnish women considered professional care practices by nurses as ritualized care by building respect and trust during childbirth.

When discussing professional care, Wehbe-Alamah (2005) reported Syrian Muslims in a hospital received professional care, and perceived and expressed the important caring attributes of nurses as smiling and responding quickly to the needs of their sick patients. In addition, professional care was perceived as empathy, sensitivity, kindness, understanding, respecting the patient's culture, and going beyond the call of duty, and was held by Syrian Muslims as an important quality of a caring nurse. Wehbe-Alamah also reported Syrian Muslim key informants expressed beliefs and values of professional care with the inclusion of generic care as culturally

congruent care. Miller (1997), McFarland (1995) and Morris (2004) reported diverse and similar cultures expressed beliefs and values of professional and generic care practices as family care and protective care and is desirable for culturally congruent care.

The process of reflecting on metatheme two assisted in abstracting social structure factors for diverse and similar cultures including family and kinship, religion and spirituality, economics, and cultural values and lifeways which were influencers on health, well-being and illness outcomes. For example, embedded within the findings related to social structure Berry (1996) reported that care for Mexican-American women was greatly influenced by religion, family practices and beliefs. The care finding, “sharing of self and being with family” was very important within the kinship dimension of the social structure of the Mexican-American culture. Additionally, Farrell (2001) reported that the Potawatomi Native Indians had as an integral part of their social structure the belief that all were equal “as in a circle” and were influenced by their spirituality, cultural lifeways and kinship systems. These were universal themes discovered across multiple dissertations, including Lamp (1998), McFarland (1995) and several other researchers, reporting that cultures expressed similar beliefs of family presence, touch and generic (folk) care, and these beliefs were beneficial in culturally congruent care for health, well-being and satisfying lifeways.

On the other hand, diverse thematic social structure findings were reported by Miller (1997) regarding the expressed political care and acculturation influenced by economics. Miller (1997) reported political care for the Czech American immigrants in the United States meant learning to care for oneself in a context of feeling respected and supported in a new environment and a new learned economic environmental structure that influenced daily lifeways and care. Other diverse thematic findings were discovered in the Potawatomi Native Indians, where Farrell (2001)

reported that family violence led to destruction within the social structure and there was a perceived loss of community within their spiritual realm, cultural values, lifeways and kinship system. The Potawatomi Native Indians lived experience included the destruction of their culture associated with the use of alcohol and drugs, physical, mental and sexual violence which contributed to weakening of the social structure within their community that affected their spirituality, cultural values and lifeways and kinship.

Reflecting on metatheme three, culture care action and decision modes provide the nursing profession with culturally based knowledge, nursing interventions (actions), and decisions to provide sensitive, appropriate and meaningful culturally congruent care that benefit their clients. This was a universal finding within all of the 24 dissertations and was described as contributing to the knowledge of the profession of nursing as a basis for providing culturally congruent care for diverse and similar cultural groups. For example, culture care repatterning has been used to guide nurses to provide culturally congruent nursing care to individuals and groups of the subculture of the chronically mentally ill receiving nursing care in psychiatric partial day treatment center (George, 1998). Such culturally congruent nursing care was predicted to promote and support mental health clients in the community (George, 1998). Schumacher (2006) reported family [accommodation] involvement is necessary to promote health and well-being in hospitals and clinics for the rural Dominicans. Because the family included the extended family, the presence of many individuals with a sick person was a common experience. Schumacher reported that to achieve culturally congruent care outcomes, a pattern of accommodation and negotiation was required. For instance, nurses and caregivers needed to find ways to accommodate the family so they may spend time with an ill loved one (Schumacher, 2006). According to George (1998), culture care accommodation was needed to provide for flexible

medication regimens and rules which were culturally congruent with the mentally ill client's lifeways.

Reflecting on metatheme 4 environmental context, care patterns, expressions, beliefs and practices were discovered within urban and rural environmental contexts as a continuing life experience, but discovered differences between urban and rural settings did influence the health and well-being for diverse and similar cultures within all 24 dissertations. Ehrmin (1998) reported urban African-American women living in a transition home within the inner city viewed culture care as guidance and direction through suggestions of professional care providers that fit their values, lifeways, and anticipated rhythm and process of their lifeworld. Additionally, these urban African-American women reflected concern regarding the resolution of past cultural pain experiences in an effort to ameliorate their feelings of guilt, shame, fear of rejection, fear of abandonment, and fear of not belonging which were associated with meanings and expressions of family, social, philosophical and cultural lifeways within their urban environmental context. In Farrell's (2001) dissertation, the rural Potawatomi native Indian informants described their environmental context as Mother Earth. Furthermore, culture care to them meant respect for all things living and non-living within their environment which influenced their spirituality, cultural values, lifeways and kinship.

All 24 dissertations described the cultural groups' universality and diversity that adds to the strength of the study and the future of the nursing profession as it relates to the delivery of culturally congruent care. The universal and diverse themes, patterns and supporting raw descriptors have contributed to the theory of culture care diversity and universality. Culture care universality is a commonly shared phenomenon among similar cultural groups. Universality refers to cultural groups with recurrent meanings, patterns, lifeways and beliefs that serve as a

guide for caregivers to provide culturally congruent care that promotes healthy outcomes (Leininger, 2006). Culture care diversity refers to the differences or diversities among cultural groups with respect to their culture care meanings, patterns, lifeways and values and must serve as a guide for caregivers to provide culturally congruent care that promotes healthy outcomes (Leininger, 2006). Universality and diversity both serve as important constructs within the culture care theory, providing for culturally congruent nursing care.

### ***Strengths of the Study***

This descriptive metasynthesis is unique in its design and execution. The use of Leininger's qualitative and evaluative criteria of credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability was a definite strength and are criteria that have been used for other culture care qualitative studies. Furthermore, this study also has strength in that while the graduate researchers were novices working within the qualitative research paradigm and using the framework of descriptive metasynthesis, the project was always guided by the seasoned University of Michigan-Flint faculty research team of McFarland, Wehbe-Alamah, and Andrews. These faculty members are doctorally-prepared transcultural nurse researchers, all well-versed in Leininger's theory and extensively published in subject matter relating to culture and care within the context of the nursing profession. Because of the immensity, scope and high-level abstraction that characterized this project, getting "off in the weeds" could have easily occurred, and sometimes did. However, the faculty team kept the novice researchers on-track, ever mindful of the "bigger picture," that the project was larger than any of the individual studies, and that synthesis of findings was always the ultimate goal and objective.

This metasynthesis is also the first of its kind dealing with a sampling of doctoral dissertations that have been guided by a particular theory (culture care) and a particular method

(ethnonursing). This study also has impact in that it can potentially serve as a source for evidence-based best practice guidelines for the nursing profession within the context of culture and care. This study also has global perspective in that cultures from all over the world were studied within the pages of the 24 individual doctoral dissertations, lending to the basic premise that care is universal and cultures, while different and unique, have commonalities and recurrent threads running through them from which nursing as a profession can glean important findings for the future of the discipline and practice.

### ***Limitations of the Study***

According to Polit & Beck (2008), “The researcher is in the best position possible to point out sample deficiencies, design problems, weaknesses in data collection...limitations demonstrate to readers that the author was aware...and took them [limitations] into account in interpreting the findings” (p.74). One of the limitations that the researchers identified was time; in other words, new doctoral dissertations using the ethnonursing method and guided by the culture care theory have been published since the original literature search, and they are not part of this study. The 24 doctoral dissertations used for this metasynthesis were acquired through UMI from October 2007 through March 2008. Secondly, this sample is limited to doctoral dissertations and there have been studies published using the ethnonursing method and the culture care theory, such as book chapters, monographs, and peer-reviewed articles, to name a few, which are also not part of this discussion.

Secondly, the NVivo 8 qualitative software program was difficult to navigate with its complexity, although it was designed to support the analysis of large amounts of qualitative data. The software program was difficult to learn, files had to be converted from .pdf format into Word format prior to entering data and this caused some concern for a possible deficiency or loss

of data. The researchers were cognizant of the complex software, and there was a period of trial-and-error, trying to determine which queries would produce the largest amount of pertinent data needed to adequately answer the research questions posed at the outset of the project. Many days were devoted to this endeavor, adding to the tedious and time-intensive nature of the project, with clarity achieved after meeting with seasoned nurse researchers. Four novice researchers and three seasoned nurse researchers dedicated time to ensuring all data was included in the software for this study.

### ***Implications for Nursing***

From careful evaluation of the study findings, implications for nursing practice can be developed. According to Oermann (2002), “It is important, though, to avoid overstating the implications. The author should avoid unqualified statements and conclusions that are not completely supported by the data...they [implications] need to be based on the results of the study, considering its methods and limitations” (p.135).

The implications for nursing discovered within the study findings include culture care expressions, meaning, practices and social structure context for diverse and similar cultures have commonalities that influence their healthcare practices and beliefs. According to the study findings, diverse and similar cultural groups express the acceptance of both generic and professional care. This is an important finding that has been discovered and can be used to provide culturally congruent care using Leininger’s culture care action and decision modes. All 24 dissertation findings included Leininger’s action and decision modes that are considered to be critical in providing culturally congruent care that is both safe and satisfying to cultural groups.

The use of culture care action and decision modes such as preservation and/or maintenance are essential for preserving and maintaining the health and well-being of diverse and similar



cultures and should be implemented in nursing practice. For example, McNeil (1994) reported that healthcare professionals promoted the maintenance of Baganda women as AIDS caregivers for the preservation of a state of helping, assistance, or to face handicap or death.

The use of culture care action and decision modes such as negotiation and/or accommodation are essential for negotiating and accommodating unhealthy cultural practices to facilitate the health and well-being of diverse and similar cultures and should be implemented in nursing practice. For example, Morgan (1993) reported healthcare professionals facilitated and accommodated free transportation for African-American working class women to take advantage of prenatal care. This action alleviated healthcare barriers and negotiated for an improved maternal care pattern and more favorable health outcome.

The use of culture care action and decision modes such as repatterning and/or restructuring are essential for repatterning and/or restructuring unhealthy folk and alternative healthcare practices which will promote safe and culturally congruent care for diverse and similar cultures and should be implemented in nursing practice. A stellar example of this is found in Lamp's (1998) study that reported healthcare professionals facilitated Finnish pregnant women restructuring a shorter length of time and cooler temperatures in the sauna in an effort to promote safer maternal cultural care practice.

The use of Leininger's culture care action and decision modes is an important theoretical contribution with implications for nursing practice. These modes allow for the practice of culturally congruent nursing care that contributes to the promotion of the health and well-being of diverse and similar cultures. In addition to nursing care, nursing research will be impacted by the discovery of the metasynthesis of 24 doctoral dissertations describing diverse and similar cultural healthcare practices, beliefs and expressions. It is imperative that more cultural groups

be studied to embellish the existing body of knowledge in order to expand the construct of culturally congruent care within the nursing profession.

Implications of this study for nursing include theory building, theory development, and a higher level of abstraction of findings beyond the themes from individual studies. Knowledge has been added to nursing's evidence base for practice, education, consultation, research and administration (including policy making) for providing culturally congruent nursing care. Culture care represents the synthesis of two major constructs, culture within anthropology and care within nursing. The synthesis of these two major constructs guided the researchers to discover, explain and account for health, well-being, care expressions and other human conditions. Culture care expressions, meanings, patterns, processes and structural forms are diverse, but many commonalities exist among and between cultures. Culture care values, beliefs and practices are influenced by and embedded in the worldview, social structure factors, ethnohistorical, and environmental contexts. Every culture has generic and professional care to be discovered and used for culturally congruent care practices.

In recent years, there have been an increasing number of ethnonursing studies guided by the culture care theory that have been conducted within the discipline of nursing. Leininger (1991, 1995, 2002, 2006), has been a pioneer in synthesizing findings from these studies and has shared culture care patterns, themes, values, meanings and care constructs from her studies and the studies of her graduate students. In building upon Leininger's work, the researchers are attempting to move the research forward that has been done with the culture care theory and the ethnonursing method, hoping to contribute to development of the culture care theory. Findings gleaned from this metasynthesis study could be influential in healthcare policy and evidence-based best nursing practice for culturally congruent care among diverse cultural groups.

### ***Recommendations for Future Research***

As novice researchers, it was realized early on in this process that a paucity of studies had been done using the descriptive metasynthesis methodology. However, metasynthesis, and more specifically, descriptive metasynthesis, is a burgeoning method that is gaining popularity in the qualitative research world. An interesting use of the metasynthesis method for future work would be to explore other research studies using the culture care theory and the ethnonursing method, focusing on diverse cultural groups, diverse gender groups, and/or diverse environmental contexts, to name a few. For example, another group of graduate researchers is focusing on the culture care and health of African-Americans using the culture care theory and ethnonursing method. Rather than using dissertations, they are using peer-reviewed articles. This represents a metasynthesis phase II study (M.R. McFarland, personal communication, November 18, 2009).

A recommendation for future research study might also include the continuance of knowledge building for providing evidence-based best practices for culturally congruent care within the framework of Leininger's culture care action modes, which have been expanded and enhanced through this study. Culture care action and decision meta-modes may be used to provide culturally congruent care that contributes to the health and well-being of similar and diverse cultures within their respective environmental contexts. It is imperative that additional research be conducted, as other diverse cultural groups have yet to be studied.

### ***Conclusion***

This ethnonursing qualitative metasynthesis study has discovered metathemes, metapatterns and metamodes which have contributed to the discipline and practice of nursing for providing culturally congruent nursing care. This research study has blazed a trail for future meta-ethnonursing research studies, providing an opportunity for further discovery of culturally

congruent conceptual practices, beliefs, meanings, expressions and care patterns that are essential for focusing on health and well-being for diverse and similar cultures. Themes, patterns and action/decision modes discussed have contributed to the discovery of diverse and similar culture care actions and decisions to maintain beneficial lifeways. “Every human culture has generic...care knowledge and practices and usually professional care knowledge and practices which vary transculturally” (Derived from Leininger, 1991, p.475). This knowledge is essential for the care practices of nurses every day and theoretical framework expansion. This study is not a simple synthesis or a meta-analysis, but rather a descriptive metasynthesis of 24 doctoral dissertations comprehensively guided by Leininger’s assumptive premises and culture care theory using the ethnonursing method for diverse and similar cultural groups. The voluminous amount of data contained within all of these dissertations provided the theoretical framework for the burgeoning concept of meta-ethnonursing which was supported by metathemes, metapatterns and metamodes, allowing for overall expansion of ideas and ultimately theory building.

This metasynthesis study retained the essence of dedicated nursing research authors from all of the 24 dissertations along with Dr. Madeline Leininger’s Culture Care Diversity and Universality theoretical framework enveloped in a grand research study. This study adds to the body of culture care knowledge and offers implications for nurses to provide culturally congruent care and has blazed a trail for future research. All cultures both diverse and similar have cultural themes, care patterns and corresponding rich descriptors which have led the nurse researchers to the discovery of culture care meanings, expressions, beliefs, patterns, practices and values related to promoting beneficial health, well-being and lifeways. The new discovery of metathemes, metapatterns and metamodes has provided the expanded theoretical framework for

meta-ethnonursing and the future studies of diverse and similar cultures in hopes to provide continued culturally congruent care.

Nursing research, rather qualitative or quantitative, is of little value if it is not made available for practice within the nursing profession. The discipline of nursing has a duty and an obligation to continue adding to the existing body of knowledge for potential use in the clinical, the academic, and the management settings. We, as nurse researchers, have an ethical responsibility to continue to expand existing theory and take it to new and uncharted levels, building the knowledge base specific to the nursing profession. According to William K. Cody (1997) who has written extensively through the years on the link between nursing research and clinical practice wrote, “Theory-based nursing practice...which is missing from the lives of most people now...offers a unique and invaluable opportunity for enrichment of the human health experience across continents, cultures, socioeconomic levels, and lifespans...The challenge today is to translate the knowledge base nurtured and grown in the world of scholarship into practice in the worlds of nurses’ direct experiences (p.5).

This challenge described by Cody in a publication from 1997 was taken on by Dr. Madeleine Leininger decades earlier in 1954, when she observed and wrote about the cultural differences between nurses and patients while working with emotionally disturbed children. Being doctorally prepared in anthropology, she clearly understood that one of anthropology’s most important contributions to nursing was the undeniable influence culture had on health and illness for people (Andrews & Boyle, 2008).

The concept of care within the nursing profession is clearly fundamental and at the heart of everything nurses do and stand for; whether in the clinical, the academic/research, or the public policy-making arena. Care, oftentimes difficult to define, in reality, defines us as nurses. The

concept of culture within the context of care is a conceptual duet that has been the hallmark of Leininger's life's work. As one ponders the two concepts of culture and care, it is blatantly obvious that they are critically important to the health and well-being of clients, but no one has devoted as much time and energy to this as Leininger. The culture care theory and the ethnonursing research method, the two recurrent threads running through all the doctoral dissertations studied in this meta-ethnonursing study, were created and designed by Leininger to work in tandem. Culture and care are intimately connected, and when culturally congruent care is delivered by nurses, health outcomes are improved for individual clients and cultural groups as a whole. Leininger (1988) articulated this idea when she wrote, "The purpose of the theory is to describe, account for, interpret and predict cultural congruent care in order to attain the ultimate goal of the theory, namely, to provide quality care to clients of diverse cultures that is congruent, satisfying, and beneficial to them" (p.155).

The researchers have poured over many of Leininger's literary publications, both in book and in article forms in an effort to prepare for this study, and to familiarize themselves with her thoughts, her musings, and her stance on important topics related to nursing. She has written extensively and, as a group, we have read extensively. Many of her writings spoke directly to us and hit at the heart of the work we were trying to accomplish. But, one in particular resonated with the researchers throughout the process of the study. "People are born, live, become ill, and die within a cultural belief and practice system, but are dependent upon human care for growth and survival" (Leininger, 1988, p.155). This single assumptive premise, amongst all the others, speaks to the importance of the work she has done and we have done in moving the culture care theory and the ethnonursing research method forward. According to Leininger's (2006) theoretical assumptions which are scientific and humanistic care is essential for human growth.

well-being, survival, and to face disabilities and death among diverse and similar cultural groups in urban and rural settings. As researchers and as nurses, we understand the importance of Leininger's conceptual duet of care and culture. They are embedded within the lives of all humans worldwide.

APPENDIX A

Sunrise Enabler

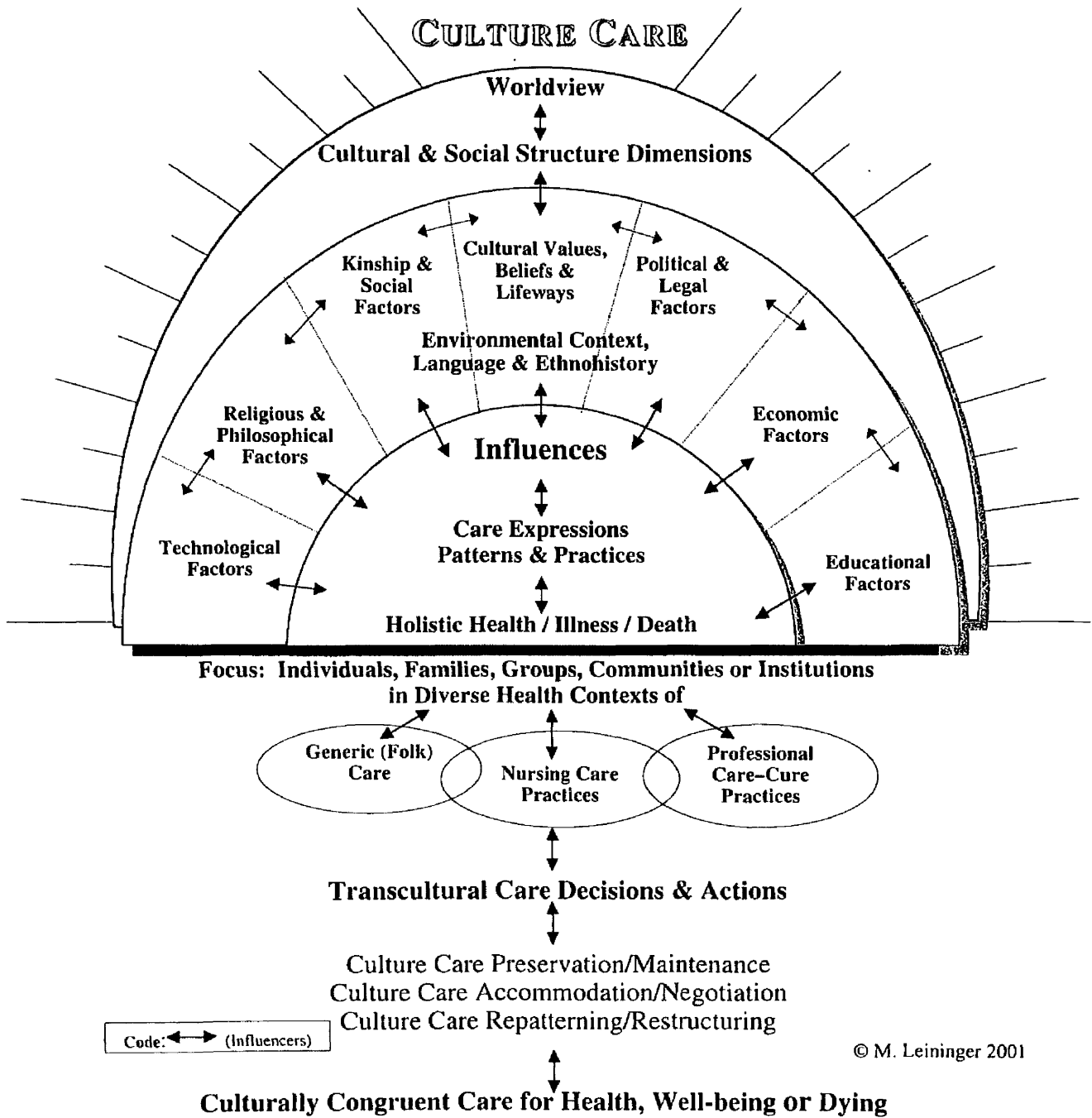


Figure 3.1

Leininger's Sunrise Model to depict the Theory of Cultural Care Diversity and Universality.

(Leininger & McFarland, 2002).



## APPENDIX B

### Stranger to Trusted Friend Enabler

The purpose of this Enabler is to facilitate the researcher (or it can be used by a clinician) to move from mainly a distrusted stranger to a trusted friend in order to obtain authentic, credible, and dependable data (or establish favorable relationships as a clinician). The user assesses oneself by reflecting on the indicators while moving from stranger to trusted friend. These are dynamic indicators from cultures.			
Indicators of Stranger (Largely emic or outsider's views)	Dates Noted	Indicators of a Trusted Friend (Largely emic or insider's views)	Dates Noted
Active to protect self and others. They <i>are gate-keepers</i> and guard against outside intrusions. Suspicious and questioning.		Less active to protect self. More trusting of researchers (their <i>gate-keeping is down or less</i> ). Less suspicious and less questioning of researcher.	
Actively watch and are attentive to what researcher does and says. Limited signs of trusting the researcher or stranger.		Less watching the researcher's words and actions. More signs of trusting and accepting a new friend.	
Skeptical about the researcher's motives and work. May question how findings will be used by the researcher or stranger.		Less questioning of the researcher's motives, work and behavior. Signs of working with and helping the researcher as a friend.	
Reluctant to share cultural secrets and views as private knowledge. Protective of local lifeways, values, and beliefs. Dislikes probing by the researcher or strangers.		Willing to share cultural secrets and private world information and experiences. Offers mostly local views, values, and interpretations spontaneously or without probes.	
Uncomfortable to become friend or to confide in stranger. May come late, be absent, and withdraw at times from researcher.		Signs of being comfortable and enjoying friendship—a sharing relationship. Gives presence, is on time, and gives evidence of being a <i>genuine "true" friend</i> .	
Tends to offer inaccurate data. Modifies <i>truths</i> to protect self, family, community, and cultural lifeways. Emic values, beliefs, and practices are not shared spontaneously.		Wants research <i>truths</i> to be accurate regarding beliefs, people, values, and lifeways. Explains and interprets emic ideas so researcher has accurate data of the culture and informant.	

**Figure 3.3**

Leininger's Stranger--to--Trusted--Friend Enabler.

(Leininger & McFarland, 2002).

## APPENDIX C

### O-P-R Enabler

<b>Leininger's Ethnonursing Observation—Participation—Reflection Enabler</b>				
<b>Phases</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
<b>Focus</b>	Primarily Observation and Active Listening (no active participation)	Primarily Observation with Limited Participation	Primarily Participation with Continued Observations	Primarily Reflection and Reconfirmation of Findings with Informants

**Figure 3.2**

Leininger's ethnonursing Observation--Participation--Reflection Enabler.

(Leininger & McFarland, 2002).

## APPENDIX D

### Coding Data System for the Leininger, Templin, and Thompson Field Research Ethnoscrypt

**CATEGORIES AND DOMAINS OF INFORMATION** (Includes observations, interviews, interpretive material, and non-material data)

#### CATEGORY I: GENERAL CULTURAL DOMAINS OF INQUIRY

CODE	DESCRIPTION
1	Worldview
2	Cultural-social lifeways and activities (typical day/night)
3	Ethnohistorical (includes chrono-data, acculturation, cultural contracts, etc)
4	Environmental contexts (i.e., physical, ecological, cultural, social)
5	Linguistic terms and meanings
6	Cultural foods related to care, health, illness and environment
7	Material and non-material culture (includes symbols and meanings)
8	Ethnodemographics (numerical facts, dates, population size & other numerical data)
9	<i>Racism, prejudice, race*</i>

#### CATEGORY II: DOMAIN OF CULTURAL AND SOCIAL STRUCTURAL DATA

(Includes normative values, patterns, function and conflict)

10	Cultural values, beliefs, norms
11	Economic factors
12	Educational factors
13	Kinship (family ties, social network, social relationships, etc)
14	Political and legal factors

- 15 Religious, philosophical, and ethical values and beliefs
- 16 Technological factors
- 17 Interpersonal relationships (individual groups or institutions)
- 18 *Recreation\**

**CATEGORY III: CARE, CURE, HEALTH (WELL BEING) AND ILLNESS OF FOLK  
AND PROFESSIONAL LIFEWAYS**

- 20 Folk (includes popular health and illness beliefs, values, and practices)
- 21 Professional health
- 22 Human care/caring and nursing (general beliefs, values, and practices)
- 23 Folk care/caring (emic or indigenous beliefs, values, and lifeways)
- 24 Professional care/caring (etic beliefs, values, lifeways)
- 25 Professional nursing care/caring (etic and emic) lifeways (congruence and conflict areas)
- 26 Non-care/caring beliefs, values, and practices
- 27 Human cure/curing (general ideas, beliefs, values, and practices)
- 28 Folk cure/curing (emic beliefs and practices)
- 29 Professional cure/curing (emic and etic perspectives)
- 30 Alternative (new) or emergency care/cure systems
- 31 *Caring for others (resident to resident)\**
- 32 *Reciprocal care\**
- 33 *Self-care\**

**CATEGORY IV: HEALTH AND SOCIAL SERVICE INSTITUTIONS**

**(Administrative norms, beliefs, and practices with meanings-in-contexts)**

- 35 Cultural-social norms, beliefs, values, and contexts
- 36 Political-legal aspects

- 37 Economic aspects
- 38 Technological factors
- 39 Environmental factors
- 40 Educational factors (formal and informal)
- 41 Social organization or structural features
- 42 Decision and action patterns
- 43 Interdisciplinary norms, values, and collaborative practices with medicine, social work, nursing, auxiliary staff, etc.
- 44 Nursing Specialties and features
- 45 Non-nursing specialties and features
- 46 Ethical/moral aspects
- 47 *Religious aspects\**

#### **CATEGORY V: LIFE CYCLES AND INTERGENERATIONAL PATTERNS**

**(Includes Ceremonies and Rituals)**

- 50 Life cycle male and female socialization and enculturation
- 51 Infancy and early childhood
- 52 Adolescence or transitions to adulthood
- 53 Middlescence
- 54 Advanced years
- 55 Cultural life cycle values, beliefs, and practices
- 56 Cultural life cycle conflicts and congruence areas (i.e., intergenerational)  
(independence vs. dependence)
- 57 Special subculture
- 58 Life passages (i.e., birth, marriage, death, etc)

59 *Additional life passages in retirement home (nursing home to apartment,  
apartment to nursing home, entering home)\**

60 *Acculturation, assimilation, adjustment to retirement home\**

## **CATEGORY VI: METHODOLOGICAL AND OTHER RESEARCH**

### **FEATURES OF THE STUDY**

61 Specific methods of techniques used

62 Key informants

63 General informants

64 Enabling tools or instruments used

65 Problem areas, concerns, or conflicts

66 Strengths, favorable and unanticipated outcomes of researcher and informants  
(i.e., subjective data and questions)

67 Unusual incidents, interpretations, and questions, etc.

68 Factors facilitating or hindering the study (i.e., time, staff, money, etc)

69 Emic data

70 Etic data

71 Dialogue by interviewer

72 Dialogue by someone other than informant or interviewer

73 Additional contextual data (including non-verbal symbols, total view,  
environmental features, etc)

74 Informed consent factors

## **CATEGORY VII: STUDY FINDINGS**

75 *Themes\**

76 *Patterns\**

77 *Descriptors\**

**CATEGORY VIII: CULTURE CARE MODES**

78 *Preservation and/or maintenance\**

79 *Accommodation and/or negotiation\**

80 *Re-patterning and/or restructuring\**

*\*italics indicate codes created specifically for this study*

**APPENDIX E**

**Subject:** eResearch System-Generated Notice of “Not Regulated” Status for HJUM00021651

**SUBMISSION INFORMATION**

**Title:** Metasynthesis of Dissertations Guided by the Culture Care Theory

**Full Study Title (if applicable):** A Descriptive Metasynthesis of Doctoral Dissertations Guided by the Culture Care Theory and Using the Ethnonursing Method

**Study eResearch ID:** HUM00021651

**Date of this System-Generated Notice:** 07/26/2009

**IRB “NOT REGULATED” STATUS:**

Based on the information provided, the proposed study falls under the University of Michigan’s policy for research using publicly available data sets (<http://research.umich.edu/hrpp/Documents/datasets.html>). Under this policy and in accordance with federal regulations for human subjects research (45 CFR Part 46) IRB is not required as the data cannot be tracked



## APPENDIX F

### Research Activity Timeline (Using Leininger's O-P-R Model)

Phases	I	II	III	IV
Phases	Observation	Observation- Participation	Participation	Observation- Reflection & Reconfirmation
Time Frame	9/ 2008-12/2008	1/2009-5/2009	6/2009- 9/2009	10/2009- 3/2010
Types of Activities	Research/Search, Review of Literature, Review Metasynthesis & Methodology, Careful Selection of Dissertations w/use of Inclusion/Exclusion Criteria	Reading all the dissertations and comparing Commonalities & Differences, Begin Coding Process	Coding & Input to NVivo-8 Qualitative Software	Reclarification, Saturation, Reflection on Dissertation Studies, Reconfirming with Researchers and Seasoned Thesis Chairpersons

(Adapted from Leininger & McFarland, 2002).

**APPENDIX G**  
 Doctoral Dissertations

- Berry, A.B. (1996). *Culture care expressions, meanings and experiences of pregnant Mexican American women within Leininger's culture care theory*. (Doctoral dissertation, Wayne State University, 1996). (UMI No. 9628875).
- \*\*Chase-Ziolek, M.A. (1998). *Health ministry in the life of a congregation with a parish nurse: Caring and connecting through Christ*. (Doctoral dissertation, Loyola University, Chicago, 1998). (UMI No. 9837621).
- \*\*Curtis, M.R. (1997). *Culture care by private practice APRNS in community contexts*. (Doctoral dissertation, Wayne State University, 1997). (UMI No. 9815289).
- Ehrmin, J.T.H. (1998). *Culture care: Meanings and expressions of African American women residing in an inner city transitional home for substance abuse*. (Doctoral dissertation, Wayne State University, 1998). (UMI No. 9915650).
- Farrell, L.S. (2001). *Cultural care: Meanings and expressions of caring and non-caring of the Potawatomi who have experienced family violence*. (Doctoral dissertation, Wayne State University, 2001). (UMI No. 3010083).
- \*\*Finn, J.M. (1993). *Professional nurse and generic care of childbirthing women conceptualized within Leininger's culture care theory and using Colaizzi's phenomenological method*. (Doctoral dissertation, Wayne State University, 1993). (UMI No. 9418158).
- Fox-Hill, E.J. (1999). *The experiences of persons with AIDS living-dying in a nursing home*. (Doctoral dissertation, University of Tennessee, 1999). (UMI No. 9935492).
- Gates, M. (1988). *Care and cure meanings, experiences and orientations of persons who are dying in hospital and hospice settings*. (Doctoral dissertation, Wayne State University, 1988). (UMI No.8910325).
- Gelazis, R. (1994). *Humor, care and well-being of Lithuanian Americans: An ethnonursing study using Leininger's theory of culture care diversity and universality*. (Doctoral dissertation, Wayne State University, 1994). (UMI No. 9423710).
- George, T.B. (1998). *Meanings, expressions, and experiences of care of chronically mentally ill in a day treatment center using Leininger's culture care theory*. (Doctoral dissertation, Wayne State University, 1998). (UMI No. 9915656).
- Herp, C.A. (1996). *Meanings of folk and professional health care experienced by Guatemalan Mayans in southeast Florida*. (Doctoral dissertation, Florida Atlantic

- University, 1996). (UMI No. 1380713).
- Higgins, B. (1995). *Puerto-Rican cultural beliefs: Influence on infant feeding practices in western New York*. (Doctoral dissertation, University of Colorado, 1995). (UMI No. 9604699).
- Johnson, C.A. (2005). *Understanding the culture care practices of rural immigrant Mexican women*. (Doctoral dissertation, Duquesne University, 2005). (UMI No. 3175853).
- Kelsey, B.M. (2005). *Culture care values, beliefs, and practices of Mexican American migrant farm workers related to health promoting behaviors*. (Doctoral dissertation, Ball State University, 2005). (UMI No. 3166257).
- Lamp, J.K. (1998). *Generic and professional culture care meanings and practices of Finnish women in birth within Leininger's theory of culture care diversity and universality*. (Doctoral dissertation, Wayne State University, 1998). (UMI No. 9915688).
- \*\*Lapasaran, A.S. (2003). *Learning the ethnonursing research methodology within the domain of Filipino elders residing in a nursing home in northern Nevada*. (Doctoral dissertation, University of Nevada, Reno, 2003). (UMI No. 1414442).
- Luna, L. (1989). *Care and cultural context of Lebanese Muslims in an urban US Community: An ethnographic and ethnonursing study conceptualized within Leininger's theory*. (Doctoral Dissertation, Wayne State University, 1989). (UMI No. 9022423).
- MacNeil, J.M. (1994). *Culture care: Meanings, patterns and expressions for Baganda women as AIDS caregivers within Leininger's theory*. (Doctoral dissertation, Wayne State University, 1994). (UMI No. 9519922).
- McFarland, M.R. (1995). *Cultural care of Anglo and African American elderly residents within the environmental context of a long-term care institution*. (Doctoral dissertation, Wayne State University, 1995). (UMI No. 9530568).
- Miller, J.E. (1997). *Politics and care: A study of Czech Americans within Leininger's theory of culture care diversity and universality*. (Doctoral dissertation, Wayne State University, 1997). (UMI No. 9725851).
- Morgan, M.A. (1994). *Prenatal care of African American women in selected USA urban and rural cultural contexts conceptualized within Leininger's cultural care theory*. (Doctoral dissertation, Wayne State University, 1994). (UMI No. 9519936).
- Morris, E. J. (2004). *An ethnonursing culture care study of the meanings, expressions and lifeways experiences of selected urban African American adolescent gang members*. (Doctoral dissertation, Wayne State University, 2004). (UMI No. 3130357).

- \*\*Ott, R.A. (2003). *Euro-American women substance abusers in an Alcoholics Anonymous program, their culture care needs*. (Doctoral dissertation, Medical College of Ohio, 2003). (UMI No. 1418084).
- \*\*Pietrangelo, M. (1998). *Perceptions of hospital based nurses and community based nurses regarding caring for culturally diverse clients*. (Doctoral dissertation, D'Youville College, 1998). (UMI No. 1393437).
- Prince, L.M. (2005). *Culture care and resilience in minority women residing in a transitional home recovering from prostitution*. (Doctoral dissertation, Loyola University, 2005). (UMI No. 3174259).
- \*\*Rizvi, Z.B.A. (2000). *Phenomenological perspectives on a culturally diverse client-therapist relationship in occupational therapy*. (Doctoral dissertation, D'Youville College 2000). (UMI No. 1398339).
- Rosenbaum, J.N. (1990). *Cultural care, cultural health, and grief phenomena related to older Greek Canadian widow within Leininger's theory of culture care*. (Doctoral dissertation, Wayne State University, 1990). (UMI No. 9118922).
- Schumacher, G.C. (2006). *Culture care meaning, beliefs and practices of rural Dominicans in a rural village of the Dominican Republic: An ethn nursing study conceptualized within the culture care theory*. (Doctoral dissertation, Duquesne University, 2006). (UMI No. 3217484).
- \*\*Vivanco, R.K. (2004). *Folk medicine use among Mexican childbearing women living in the Midwest United States*. (Doctoral dissertation, Capital University, 2004). (UMI No. 1420597).
- \*\*Vlassess, F.R. (1997). *Too familiar for words: An analysis of "invisible" nursing work*. (Doctoral dissertation, Loyola University, Chicago, 1997). (UMI No. 9726404).
- Wehbe-Alamah, H. (2005). *Generic and professional health care beliefs, expressions and practices of Syrian Muslims living in the Midwestern United States*. (Doctoral dissertation, Duquesne University, 2005). (UMI No. 3197399).
- Wekselman, K. (1999). *The culture of natural childbirth*. (Doctoral dissertation, University of Cincinnati, 1999). (UMI No. 9936027).
- Wenger, A. F. Z. (1998). *The phenomenon of care in a high context culture: The old order Amish*. (Doctoral dissertation, Wayne State University, 1998). (UMI No. 8910384)
- \*\*represents outliers

## APPENDIX H

### Dissertation Attributes

Dissertation	Ethnicity	Gender	Age	Study length	Urban/Rural	Setting	Year Published
Berry, A.B.	Mexican American	Female	Gravid age	11 months	Urban	Clinic & Hospital	1996
Ehrmin, J.T.H.	African American	Female	Adult	3 years	Urban	Transition house	1998
Farrell, L.S.	Potawatomi	Male/Female	34-80	1 year	Rural	Rural Medical Care Center	2001
Fox-Hill, E.J.	Varied	Male	20-69	38 months	Urban	Nursing home	1999
Gelazis, R.	Lithuanian	Male/Female	20+	3.5 years	Urban	Church	1994
Gates, M.F.	Varied	Male/Female	21-89	14 months	Urban	Oncology unit & hospice facility	1988
George, T.B.	Chronically mentally ill adults	Male/Female	19-76	11 months	Urban	Day/ partial treatment center	1998
Herp, C.A.	Guatemalan	Male/Female	25-56	13 months	Urban	Offices/homes	1996
Higgins, B.	Puerto-Rican	Female	18-40	9 months	Urban	Roberto Clemente Health Clinic	1995
Johnson, C.A.	Mexican immigrants	Female	22-55	5 months	Rural	Mexican immigrant community	2005
Kelsey, B.M.	Mexican American	Male/Female	18-47	3 months	Rural	Homes & food pantry	2005
Lamp, J.K.	Finnish	Female	27-38	3 years	Urban	Hospital	1998
Luna, L.	Lebanese Muslims	Male/Female	19-63	3 years	Rural	Homes, hospitals	1989
MacNeil, J.M.	Baganda	Female	20-28	1 year	Rural	Homes	1994
McFarland, M.R.	Anglo & African American	Male/Female	Retired elders	2 years	Urban	Long-term care facility	1995
Miller, E.J.	Czech-American	Male/Female	20-78	13 months	Urban	Homes	1997
Morgan, M.A.	African American	Female	18-33	36 months	Mix	Community	1994
Morris, E.J.	African American	Male	10-25	10 months	Urban	Charter school	2004
Prince, L.M.	African American & bi-racial	Female	24-51	Several months	Urban	Transitional house	2005
Rosenbaum, J.N.	Greek Canadian	Female	50-81	17 months	Urban	Hellenic home for the aged and church	1990
Schumacher, G.	Dominicans	Male/Female	19-65	10 years	Rural	Village Center	2006
Wehbe-Alamah, H.	Syrian Muslims	Male/Female	23-79	2 years	Urban	Syrian Muslim home and urban communities	2005
Wekselman, K.	African American & Asian	Female	20-50	11 months	Urban	Greater Cincinnati area	1999
Wenger, A.F.	Amish	Male/Female	6 yr old	3 years	Rural	Amish school	1998

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### **Abstract**

This study presents a descriptive metasynthesis of culture care findings from 24 doctoral dissertations using the ethnonursing research method and conceptualized within Leininger's Culture Care Theory of Diversity and Universality, contained within UMI's Dissertation Abstracts database. Culture care findings will be presented that are both interpretive and explanatory, further conceptualized from the themes and patterns of the original dissertation studies. New theoretical formulations based on the culture care theory and recommendations related to nursing practice will be presented. These findings are predicted to make a significant contribution to the discipline and practice of nursing as well as the epistemic and ontologic basis of culture care knowledge and evidence-based best practices.