

**A Descriptive Metasynthesis of Cultural Care Expressions, Beliefs, and Practices of
African Americans Using the Ethnonursing Research Method**

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Dedication

This study is dedicated to African Americans throughout our nation. Through this research we have gained a deeper understanding of their worldviews, beliefs, and health practices. They inspire us to reach out and embrace the differences that make cultures unique, yet hold fast to the similarities of our human race.

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This research project spans two years and reflects the tireless work and dedication of many, including graduate nursing students and faculty. This work was made possible by Dr. Madeleine M. Leininger, foundress of the worldwide Transcultural Nursing movement and pioneer of the study of human caring. We wish to extend our deepest appreciation to our thesis chairs Dr. Hiba Wehbe-Alamah, Dr. Marilyn M. McFarland, and Dr. Margaret Andrews whose scholarship and expertise are evident in this work. We thank you for your thoughtful review, genuine interest, and suggestions that have made this thesis a substantive work. We would like to give special thanks to our families, who have shared this experience, and staunchly supported us in making our academic dreams a reality.

Abstract

According to the Office of Minority Health, there is a disparity in health care among minority populations (OMH, 2009). Nursing is faced with the challenge of increasing transcultural diversity and awareness if they are to be positioned to help bridge the gap in the health disparities that exist today. The purpose of this metasynthesis is to discover culture care meanings, expressions, actions, and decisions that promote health, well-being, and beneficial lifeways within the African American culture; thereby enhancing the understanding of how this disparity can be eradicated. Leininger's theory of Culture Care Diversity and Universality, ethnography, and ethnonursing were used to guide this inquiry. The researchers hope that this scholarly work honors the collective voice of this undeserved population.

CHAPTER 1

Introduction

According to the Office of Minority Health (2009), a disparity in health care exists among minority cultural groups. African Americans experience a much higher death rate from heart disease, stroke, cancer, asthma, diabetes, HIV/AIDs, homicide, influenza, and pneumonia than the non-Hispanic White groups. Gaining an understanding of their cultural care beliefs, expectations and expressions will enable practitioners to understand how to provide care that will encourage and promote positive healthy practices in this population. Elimination of health disparities, a goal of Healthy People 2010, can only be achieved with the provision of culturally competent health care. Nursing is faced with meeting the challenge of increasing transcultural diversity and awareness if they are to be positioned to help bridge this gap in the health disparities that exists today.

Dr. Leininger predicted that by the year 2020 all nurses would need to be knowledgeable and culturally competent to work with people of diverse cultures (Leininger & McFarland, 2002, chap. 3). The researchers are looking forward to guiding others toward this goal through this scholarly contribution. This metasynthesis includes 14 published research articles that were guided by Leininger's theory of Culture Care Diversity and Universality using the ethnonursing and/or ethnographic research methods. A detailed meta-ethnonursing analysis of qualitative data guided by this framework discovered patterns and themes that are culturally specific to African Americans. This synthesis of culture care patterns is predicted to contribute to the enhancement and improvement of cultural care practices, inspire further research, and facilitate the formation of future health care policies. This discovery of meta-themes and meta-patterns combined with the use of Leininger's three decision modes (culture care preservation,

accommodation, and repatterning) is predicted to influence nursing actions and decisions aimed at providing culturally competent care for African Americans.

Domain of Inquiry

The domain of inquiry (DOI) was the culture care expressions, beliefs, and practices of African American (AA) care. The primary purpose within this DOI was to discover culture care meanings, expressions, actions and decisions that promoted health, well-being, and beneficial lifeways for AA cultures. To ensure the DOI was fully studied, specific research questions were formulated that served as a guide to the researchers.

Purpose/Goal of Study

The purpose of this study was to discover, describe, and systematically synthesize the culture care meanings, expressions, beliefs, and practices that promote health, well-being, and beneficial lifeways for African Americans. The goal of this metasynthesis was to provide culturally congruent care decisions and actions for African Americans to promote their health, well-being, and healthy lifeways. It will create and contribute to a new domain of inquiry in transcultural care and research. Research findings will not only offer new evidence-based care decisions and actions for health care professionals, but also will contribute to the generation of knowledge guided by Leininger's Culture Care theory and to ethnonursing research methods. Bridging transcultural care with current health care practices could prove to be essential to satisfying Healthy People 2010 initiatives, potentially contributing to efforts to eliminate health disparities and provide culturally competent and congruent health care to African Americans.

Rationale for the Study

The United States is one of the most technologically advanced countries for healthcare diagnosis and delivery. In stark contrast, however, is the disparity of outcomes experienced by

minority populations throughout the country. As of July 2007, 13.5% of the non-institutionalized population in the United States was African American. This is the second largest minority population. According to the OMH (2009), “In 2005, the death rate for African Americans was higher than Whites for heart diseases, stroke, cancer, asthma, influenza and pneumonia, diabetes, HIV/AIDS, and homicide.” As compared to non-Hispanic Whites, the incidence of disease remains higher for new cases of lung and prostate cancer, diabetes, hypertension, and obesity. African American men experience seven times the rate for AIDS and AA women 21 times the rate for AIDS compared to their non-Hispanic White counterparts. The incidence of stroke is twice as likely, and they are 60% more likely to die than their White counterparts (OMH, 2009).

Vulnerable populations are groups of individuals who are at greatest risk of adverse physical, psychological or social health outcomes (Pender, Mardaugh, and Parsons, 2006). It is believed that ethnic and racial minorities are very often considered vulnerable due to their low socioeconomic status. According to the National Center on Minority Health and Health Disparities, “Scientists believed health disparities resulted from the complex interaction among several factors such as biology, the environment, and specific behaviors that were significantly impacted by a shortage of racial and ethnic minority health professionals, discrimination, and inequities in income, education, and access to health care” (n.d., ¶ 1). Populations who have been poor over several generations and who suffer ongoing discrimination without upward movement are also vulnerable to inequalities.

The medical healthcare system has contributed to the dilemma through unethical research practices during the last century. The Tuskegee experiment perpetuated by the U.S. Public Health Service (PHS) was a 40 year longitudinal study conducted from 1932 to 1972 with the purpose of collecting autopsy data on AA men who had died from tertiary syphilis. The intent of

the study was to allow men to die without care or intervention and was an experiment conducted on human beings. By the time the experiment was terminated, 28 men had died of syphilis, 100 were dead of related complications, 40 wives had been infected, and 19 children had been born with congenital syphilis. A deep distrust of medical care was reinforced by the PHS. This distrust continues today resulting in delays for diagnosis and treatment of health conditions (Pearson Education, Inc., 2007).

The elimination of health disparities is a goal of Healthy People 2010 (U.S. Department of Health and Human Services, n.d.). To achieve this goal, health care providers must move beyond ethnocentrism and become culturally competent. Pender et al. has defined cultural competence:

. . . appropriate and effective communications that requires one to be willing to listen and learn from members of diverse populations, and the provision of information and services in appropriate languages, at appropriate comprehension and literacy levels, and in the context of the individual's health beliefs and practices. (2006, p. 308)

In an effort to further understand human care in a culturally sensitive manner, qualitative research began in the 1960s through the use of the grounded theory tradition. These roots are in sociology with the goal of understanding key social psychological and structural processes that occur in a social setting. Nursing cultural research has built on this tradition and often uses an ethnographic or anthropological approach. Ethnography explores the patterns, lifeways, and experiences of a cultural group in a holistic fashion (Polit & Beck, 2008). Ethnonursing is a qualitative research approach that is focused on nursing phenomena by obtaining data naturally through the informants' worldview (Leininger, 1997).

It is widely recognized, however, that qualitative analysis produces islands of information. Efforts to synthesize studies are a response to the need for development of evidence-based care guidelines. According to Thorne, Jensen, Kearney, Noblit, & Sandelowski (2004), metasynthesis of numerous qualitative studies is a family of methodological approaches used for developing new knowledge based upon rigorous analysis of existing research findings. Metasynthesis is a critical approach to building nursing knowledge for culturally competent human care. This metasynthesis study of African American culture care was guided by the Culture Care theory using the ethnonursing method, and is thus referred to as a meta-ethnonursing study.

Research Questions

The research questions were explored in detail for each research study selected for the metasynthesis. In addition, the researchers utilized ethnonursing enablers as an integral guide within the ethnonursing research method. The research questions were:

1. What social and structural factors affect AA health and assist to promote well-being?
2. What similarities and differences in generic and professional care exist among and between AAs that affect their health, well-being, and beneficial lifeways?
3. What are the cultural care nursing decisions and actions that are most effective in promoting health and well-being within the AA culture?

Theoretical Framework

Leininger's theory of Culture Care Diversity and Universality is the framework that guided this inquiry. A major tenet of this theory is that "culture care expressions, meaning, patterns, and practices are diverse and yet there are shared commonalities and some universal attributes" (Leininger, 2006, p. 17). The purpose of the theory is to discover human care

universalities and diversities. Universality focuses on commonalities in patterns of care between and among different cultures. Diversity focuses on different meanings or patterns of care indicative of health for a specific culture. This inquiry focuses on universal as well as diverse patterns of care specific to the AA culture.

Leininger's theory is based on the belief that people of different cultures are capable of informing and guiding professionals to receive the kind of care they desire or need. Leininger describes the meaning of culture:

Culture is the patterned and valued lifeways of people that influence their decisions and actions; therefore, the theory is directed toward nurses to discover and document the world of the client and to use their emic viewpoints, knowledge, and practices with appropriate etic (professional knowledge), as bases for making culturally congruent professional care actions and decisions. (McFarland, 2006)

Leininger's Theory of Culture Care is the only theory that is focused explicitly on discovering holistic care including factors such as worldview, social structure factors, language, generic and professional care, ethnohistory, and the environmental context (McFarland, 2006).

The ethnonursing method was designed by Leininger to study transcultural nursing phenomena in a systematic manner and assist the researcher in obtaining in-depth informant emic data (McFarland, 2006). It is the first research method designed to fit a theory and is a qualitative research approach that focuses on natural discovery (Leininger, 1997).

Leininger developed enablers to guide ethnonursing researchers in obtaining in-depth data as it related to the theory (Leininger, 1997). Enablers assist with probing people's care views, beliefs, practices and environmental contexts to discover covert, unknown, and ambiguous nursing phenomena. It is important to distinguish enablers from quantitative tools and

scales. Enablers are used to enable researchers to gather culturally related data in a nonthreatening and natural manner in order to explicate nursing research findings and care actions and decisions.

Leininger proposed six major criteria for evaluating qualitative research results and interpretations which include (a) credibility, (b) confirmability, (c) meaning-in-context, (d) recurrent patterning, (e) saturation, and (f) transferability. The findings of a qualitative research study are strengthened by satisfying these six criteria, thus providing reliable and credible implications for nursing practice (Leininger, 1997). The research studies included for this metasynthesis were analyzed against these six criteria helping to strengthen the resultant recommendations for future nursing practice.

Only studies guided by the Culture Care theory and ethnonursing research method, with a focus on African Americans were selected for inclusion in this metasynthesis. Culturally based research findings guided the development of this metasynthesis that focused on the AA community.

Orientational Definitions

Orientational definitions are used within the ethnonursing method to discover culture care phenomena. Emic and etic discoveries are made in a naturalistic way that complements the Culture Care theory. The orientational definitions used to discover care, health, and illness within the AA culture were (derived from Leininger, 2002):

1. Human Care/Caring – expressions and provision of assistive, supportive, enabling, and facilitating ways [for AAs] to help themselves or others with evident or anticipated needs to improve health, well-being, or beneficial lifeways (p. 83).

2. Culture Care – the subjectively and objectively learned and transmitted values, beliefs, and patterned lifeways that assist, support, facilitate, or enable an [AA or groups of AAs] to maintain their well being, health, and to improve their human condition and lifeway (p. 83).
3. Culture Care Diversity – cultural variabilities or differences in care beliefs, meanings, patterns, values, symbols, and lifeways within and between [AAs] (p. 83).
4. Culture Care Universality – the commonalties or similar culturally based care (“truths”), patterns, values, symbols, and lifeways [of AAs] that reflect care as a universal humanity (p. 83).
5. Cultural and Social Structure Dimensions – the dynamic, holistic, and interrelated patterns of structured features of [the AA] culture... including religion (or spirituality), kinship (social), political (legal), economic, education, technology, cultural values, philosophy, history, and language (p.83).
6. Health – a state of well-being or restorative state that is culturally constituted, defined, valued, and practiced by [AA] individuals or groups that enable them to function in their daily lives (p. 84).
7. Emic- the local, indigenous, or insider’s views and values [of AAs or] ... a phenomenon (p. 84).
8. Etic- the outsider’s or more universal views and values about [AAs or] ... a phenomenon (p. 84).
9. Culture Care Preservation and/ or Maintenance – assistive, supportive, facilitative, or enabling professional acts or decisions that help [AAs] to retain and/or maintain meaningful care values, beliefs and lifeways for their well-being, to recover from illness, or to deal with handicaps or dying (p. 84).

10. Culture Care Accommodation and/or Negotiation - assistive, supportive, facilitative, or enabling creative professional actions or decisions that help [AA]...to adapt to or negotiate with others for... [culturally] congruent health outcomes (p.84).
11. Culture Care Repatterning and/or Restructuring - assistive, supportive, facilitative, or enabling professional actions and decisions that help [AAs] reorder, change, or modify their lifeways for new, different, and beneficial health care outcomes (p.84).
12. African American – a person who identifies oneself as having African heritage, values, beliefs, and lifeways and as having been born in the United States.

Assumptive Premises of the Research

Assumptive premises of the Culture Care theory led to the formation of specific theoretical hunches and assumptions that guided this study (derived from Leininger, 2006, chap. 3):

1. African American culture-care values, beliefs, and practices are influenced by and tend to be embedded in worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental context of the culture (p. 79).
2. The AA culture has generic (lay, folk, or indigenous) care knowledge and practices and professional care knowledge and practices, which vary transculturally and individually (p.79).
3. Culturally congruent and beneficial nursing care can only occur when AA care values, expressions, or patterns are known and used explicitly for appropriate, safe, and meaningful care (p. 79).

The first assumptive premise is that cultural care values, beliefs, and practices of AAs are critically influenced and embedded in their worldview, ethnohistory, environmental context, and

social structure. This premise focuses on powerful influencers on the understanding of culturally based care. Worldview is influenced by a group's cultural heritage and experiences. Social structure factors include religion, economics, education, technology, politics, and kinship. This premise takes into account the variability that exists among AAs living in different places and/or different environments. Consideration must be given to both different and shared beliefs, values, and lifeways of AAs when providing and planning care for them. Not responding to variabilities between and among cultural groups can lead to nontherapeutic outcomes (Morgan, 2002).

The second assumptive premise is that the AA culture has generic and professional care practices that must be discovered and understood. Cultural conflicts and gaps between generic and professional care were predicted, with the latter leading to "cultural clashes, racism, cultural imposition, and other nontherapeutic outcomes" (Leininger, 2002, p. 78). Leininger proposed that all of these dimensional factors not only need to be discovered in order for holistic and meaningful care to be provided, but they need to be discovered directly with cultural informants from emic data (Leininger, 2002).

The third assumptive premise focuses on culturally congruent nursing care that can contribute to the health and well-being of AAs and help them to face disabilities, death or dying. Three modes were conceptualized and incorporated within the Culture Care theory and include: a) culture care preservation and/or maintenance; b) culture care accommodation and/or negotiation; c) culture care repatterning and/or restructuring. Findings from the aforementioned influencing factors (e.g. social structure, generic and professional care practices) can assist healthcare practitioners in using the appropriate modes to care for individuals, families, or groups. The findings of this study substantiate the fact that members from 'within' must serve as co-participants in this decision making process in order for the most appropriate, beneficial, safe,

and meaningful ways that fit the values, beliefs, and lifeways of the cultural group are used (Leininger, 2002).

Chapter 2

Review of the Literature

Defining Metasynthesis

According to Polit & Beck (2008), "...descriptive metasynthesis involves a comprehensive analysis of a phenomenon based on a synthesis of qualitative findings" (p. 679). This type of inquiry does not deconstruct and reconstruct statements for theory development and building. Finfgeld describes a metasynthesis:

[not the] systematic review of the literature, nor the collating of research findings...its not the aggregation of research outcomes or a concept analysis...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. (Finfgeld, 2003, p. 894)

It creates a rich description of individual theme findings and attempts to describe the inter-relationships, universal elements, and the diversity encountered within the data. It can often be considered a narrative summary. A metasynthesis is a complete study where researchers rigorously examine and interpret findings (rather than raw data) of a number of qualitative research studies using qualitative methods (Finfgeld, 2003).

A descriptive approach involves a thematic analysis with an identification of major themes within the research findings and a summary of the findings within these themes (Dixon-Woods, Agarwal, Young, Jones, & Sutton (2004). The unaltered text within the research is used to translate data across studies (Finfgeld, 2003). This method assists researchers in coping with the diverse evidence types and methods utilized within the primary research. This descriptive study design consists of six distinct phases (Dixon-Woods et al., 2004):

1. Identify the focus of the study: Based upon the theoretical framework and the study questions, the inclusion criteria are defined, which will bind the studies together.
2. Locate the studies meeting the defined inclusion criteria.
3. Read and re-read the studies. Ratings are given for inclusion criteria and an evaluation for scientific merit. An audit trail of accepted and rejected studies is maintained for future reference.
4. Identify relationships between studies: Homogeneity is identified across studies and sorted according to characteristics. Grouping according to methods ensured compatibility for analysis.
5. Translate studies into one another: Data is merged into a common data pool utilizing NVivo and studied for common elements. The data is then collapsed into patterns or explanatory themes through analysis and synthesis.
6. Describe the synthesis using narrating patterns and/or themes. This narrative is similar to the method used in primary qualitative research.

The goal of a metasynthesis is to create a new and integrative interpretation of nursing phenomena that is more substantive than those founded from individual investigations (Finfgeld, 2003).

Historical background of Metasynthesis

The research methodology of metasynthesis can be traced to a variety of disciplines. Bondas and Hall (2007) indicated that metasynthesis has many roots in science, the first being traced to the social sciences. It was during this time that “sociological metatheorizing” was defined as the systematic study of the underlying structure of theory (p.114). In sociology, the need to carefully study the overwhelming body of classical and contemporary sociological

theories led to metastudies. Metatheorizing began to evolve when the middle-range theories and studies that were inspired by postmodern and poststructural thinking began to increasingly be compared with previous grand theories from the 1970s to the 1990s (Bondas and Hall, 2007).

Meta-ethnography is another source of metastudies within anthropology. Its development began when theorists saw the importance of synthesizing large bodies of field research. Meta-ethnography has become increasingly adopted in nursing metastudies, and has become the most common methodological choice in nursing science. The final source of metasynthesis can be attributed to quantitative meta-analysis. Quantitative meta-analysis is a research strategy where the outcomes of quantitative studies using similar instruments, data sets, and analytic methods are reanalyzed and aggregated in order to formulate new conclusions (Bondas and Hall, 2007).

Tracing research methodology to its historical origins assists modern day researchers to understand the development and foundation of the qualitative metasynthesis. In 1994, Eastabrooks, Field, and Morse, qualitative researchers, urged other researchers to perform more metasynthesis-type projects. Later, in 1988, the International Association for Human Caring responded to this urge by challenging researchers to synthesize qualitative findings and offered criteria for evaluating such projects (Finfgeld, 2003). The number of qualitative studies is rising, as is the need to synthesize these new research findings.

Types of Metasynthesis Methods

As in a quantitative meta-analysis, there are several approaches that can be used to conduct a metasynthesis. A popular approach within the nursing profession is the Noblit and Hare approach. This is considered a metaethnography approach. It is also considered a theory explication whereby researchers attempt to reconceptualize abstract concepts (Finfgeld, 2003). It utilizes seven phases to enhance the rigor of the methodology. The phases include (1) deciding

on the phenomenon, (2) deciding which studies are relevant, (3) reading the studies, (4) creating themes, perspectives, or concepts, (5) translating the studies into one another, (6) synthesizing translations, and (7) publishing the findings through written word (Polit & Beck, 2008).

A second method, theory-building metasynthesis (Finfgeld, 2003), has the purpose of extending current levels of theories. One approach termed the Paterson, Thorne, Canam, and Jillings approach involves three components. These include a meta-data analysis, a study of the results reported; meta-method, the study of the methodologic rigor of the individual studies; and meta-theory, the analysis of the theoretical underpinnings from which each study is based (Polit & Beck, 2008).

Finally, the Sandelowski and Barroso approach moves beyond summaries and focuses on synthesis. This technique reviews interpretive and explanatory findings in order to understand a conceptual or metaphorical basis. It is a method of reframing the original individual results into a larger theoretical result which has applicability in broader context and situations. The meta-summary is the basis of the metasynthesis. A meta-summary includes a manifest effect size which is a quantitative calculation of the frequency and intensity of qualitative findings. The purpose of the reanalysis is to create a new “coherent description or explanation of a target event or experience” (Polit & Beck, 2008, p. 683).

Sample size (in a metasynthesis)

To date, there is no consensus regarding the best type of data source for inclusion in metasynthesis studies. Qualitative researchers have utilized a range of databases, attributing their data resources to peer-reviewed journals, unpublished reports, and dissertations. Finfgeld (2003) indicates that the reason for lack of strict criteria for research report selection is that valuable data may be missed due to unnecessary restrictions. None-the-less, two fundamental selection

criteria are offered: (1) Information within the reports should substantiate that the studies were conducted using widely accepted qualitative studies. (2) Findings should appear well supported by the raw data. As a result of liberal selection guidelines, researchers are encouraged to disclose criteria they have used in the selection of studies for their metasynthesis (Finfgeld, 2003).

The sample size, as with all qualitative investigations, is an important element in a metasynthesis. Sample sizes vary when comparing metasynthesis studies, which is attributed to a variety of factors including the breadth of the topic being discussed. Finfgeld (2003) described several basic sampling principles that are utilized for the purposes of conducting a metasynthesis. The first principle indicates that sampling should be conducted across disciplines and demographic elements in order to uphold generalizability of findings. The second principle states that more data is required if the scope of the project is broad and the topic is vague or difficult to define. The third principle alludes to the number of reports depends on the amount and quality of information found within them. Lastly, as a general rule, expert qualitative investigators will require fewer reports because of their ability to draw inferences and see relationships more easily and quickly. It is important that sample sizes are not excessively large as experts warn that this may impede deep analysis, threaten the interpretative validity of metasynthesis findings, and result in gross generalizability that are not practical to practice (Finfgeld, 2003). As a general rule, qualitative researchers aiming to conduct a metasynthesis need to keep their study inquiry in mind when making decisions regarding sample size.

Metasynthesis Methodology/Studies

Review of current metasynthesis literature for Leininger's theory or ethnonursing methodology indicates significant gaps. A search specific for studies of the AA culture with a metasynthesis approach produced no appreciable results. A search for ethnonursing

metasynthesis studies revealed no published studies. However, a recent unpublished ethnonursing metasynthesis presented by McFarland et al. (2010) was found. The study design followed Leininger's theory and a metasynthesis approach derived from ethnonursing methodology which included ethnonursing dissertation studies with the Culture Care theory. Three metathemes that were considered universal in application to cultures were discovered in the study:

1. Metatheme 1 - "Cultural care for diverse and similar cultures was viewed as generic 'family care' encompassing presence, listening, respect, reciprocity, and protection" (p. 25).
2. Metatheme 2 - "Social structure factors including family and kinship, religion and spirituality, economics, and cultural values and lifeways are influencers on cultural care to predict health and well-being" (p. 29).
3. Metatheme 3 - "Culturally congruent professional and generic care for diverse and similar cultures in different environmental contexts influence health, well-being, and illness outcomes" (p. 33).

A metasynthesis focused on the Australian culture (Harvey, 2007) described cultural themes for health and well-being for women in general and Australian rural women specifically. Themes included a sense of isolation, yet spiritual belonging and an ability to cope with adversity.

Specific to women, Roux, Dingley, & Bush (2002) conducted a metasynthesis and developed a theory of inner strength related to health described through five reformulated concepts. Constructs of women's inner strength include (a) knowing and searching, (b) nurturing through connection, (c) dwelling in a different space by recreating the spirit within, (d) healing

through movement in the present, and (e) connecting with the future by living a new normal. It was reported that these were universal concepts relevant to women regardless of culture.

In a metasynthesis that focused on end of life care and decision making, Meeker and Jezewski (2008) developed themes considered applicable to family and kinship. The reality of illness and death was reframed through cues and information as understanding was sought of the patient's status. Decision making was greatly impacted by kinship and relationships. The process included intrapersonal and interpersonal aspects as family members found meaning in the experience and moved forward with their lives. Family relationships were also exemplified in a metasynthesis of parenting for chronically ill children (Coffey, 2006). Universal elements were identified common to parents caring for children who are living at home but considered to have a chronic illness due to ongoing treatments or medical care beyond the normal preventive services. Themes included (a) living worried, (b) staying in the struggle, (c) carrying the burden, (d) survival as a family, (e) bridge to the outside world, (f) critical times, and (g) taking charge.

In a metasynthesis focused on chronic illness (Paterson, 2001), The Shifting Perspectives Model described two contextual paradigms: illness-in-the-foreground and wellness-in-the-foreground. These perspectives shifted based upon social, psychological, and environmental impacts. As an example, threats to control caused a person to shift from a wellness perspective to an illness perspective if their tolerance threshold is exceeded. Paradoxically, a patient could not be wellness focused unless they are first illness focused to create treatment stability of their chronic condition. This model was considered universal in application.

Current metasynthesis is predominately focused on results that are considered applicable to cultures in a universal context. They may be specific to gender, kinship (as in family or parenting examples), or focused on health status or specific disease processes. Qualitative

research for specific cultures continues to be isolated in nature. These current universal elements may be verified in a culturally specific analysis, but it is imperative for nursing approaches to be culturally sensitive. It is through this metasynthesis of AA culture care that diverse and universal care can be appreciated and integrated to assist nurses in providing culturally specific and congruent care.

Why Metasynthesis

There have been numerous ethnonursing and ethnographic studies using Leininger's Culture Care theory focused on the AA culture. Lacking, however, is an aggregation or metasynthesis of these research studies. This metasynthesis study is necessary to continue to build cultural knowledge for future nursing care actions and decisions. Metasynthesis refers to both an interpretative product and to an analytical process by which the findings in studies are put together (Kärkkäinen, Bondas, & Eriksson, 2005). Methods of qualitative aggregation can assist in the development of cross-study themes or higher order analytical categories (Dixon-Woods et al., 2004). The specific approach utilized for this inquiry was a descriptive metasynthesis.

As described, there is a gap in the research on culture care as it pertains to African Americans. A comprehensive review of the literature revealed no metasynthesis studies on the culture care of African Americans. Metasynthesis is a critical approach to the nursing discipline building nursing knowledge. In addition, using this approach a contribution to nursing practice is made by substantiating current cultural information applicable to the care of the AA population that will assist practitioners in culture specific care actions and decisions.

Ethnonursing African American Studies

Only published articles guided by the Culture Care theory, ethnonursing, and/or ethnographic research method, with a focus on African Americans were used for the sample for the study. Culturally based research findings guided the development of a metasynthesis that focused on culture care in the AA community.

Range of findings

Among the 14 articles found, seven spoke about care of AA women and their beliefs, perceptions, support systems, and resilience in their struggle with different types of illnesses. Three of the articles focused on AA men and their perception of trust, beliefs, accessibility to health care, and factors that influenced their participation in health screening. One article discussed the use of the Culture Care theory in studying AA elders living in an institutional setting. Likewise, only one article utilizing Leininger's theory and the ethnonursing method was found within each of the remaining categories of children/adolescent care, spiritual/holistic care, and care in a community context.

The lack of previous metasynthesis research findings indicated that a metasynthesis on this topic would be beneficial and would support the need for further study related to care for AA's. According to Young & Lundenberg (2005) knowledge has resided in models and theories which have influenced the research activities of knowledge creation deemed the research process. In regards to domain inquiry, the "inquiry" can be defined as a human learning process known as sensemaking. This involves clarification of how nursing care can evolve to include culturally congruent nursing actions and decisions that will benefit AAs.

Ethnonursing

The ethnonursing method is a qualitative research approach that focuses on naturalistic and open discoveries. This method incorporates explicitly inductive means for documenting, describing, explaining, and interpreting the informants' worldview, life experiences, and their influences on actual or potential nursing phenomena (Leininger, 1997). Leininger emphasized that data is not controlled nor manipulated in ethnonursing research investigations; rather they are obtained naturally through the informants' worldview. Explicit data collection and detailed descriptions from key and general informants are tape-recorded or notes are taken by hand and kept in journals for record keeping, saturation, and data analysis purposes. The data collection phase involves probing the informants with questions regarding the domain of inquiry and allowing the informants to dictate what information is obtained; thus, giving room for new and emerging questions that may influence the domain of inquiry. Consistent with qualitative research methods, the data is neither manipulated nor controlled. In addition, the results can stand alone as emerging discoveries to explain phenomena without needing statistical and quantitative analysis to be credible. (Leininger, 1997)

Ethnography

Ethnography is a primary research tradition stemming from anthropology. It is a type of qualitative research that is primarily focused on describing and interpreting cultural behavior. Essentially, ethnography creates a framework for evaluating the patterns, lifeways, and experiences of a cultural group in a holistic manner. "An underlying assumption of the ethnographer is that every human group eventually evolves a culture that guides the members' view of the world and the way they structure their experiences" (Polit & Beck, 2008, p. 224). The goal of ethnographers is to learn from the individuals of a cultural group and understand

their worldviews as they perceive and live it. The three categories of information that ethnographers inquire about are cultural behaviors, cultural artifacts, and cultural speech (Polit & Beck, 2008).

Based on the type of information needed for collection, ethnographers rely on a variety of data resources such as observations, in-depth interviews, records, charts, and other types of physical evidence (e.g. photographs or letters). Ethnographers also utilize the method of participant observation, where the researchers make observations of the culture being studied while participating in cultural activities. Like Leininger's ethnonursing research method, ethnographers use key informants to guide their understanding and interpretations regarding events and activities under study. In addition, ethnography uses emic (insider's view) and etic perspectives (outsiders view) provided by individuals regarding the culture being studied in order gain more knowledge in understanding the culture's world view (Polit & Beck, 2008).

Plowden and Young (2003) utilized ethnographic methods to develop open-ended questions to obtain in-depth individual interviews with urban AA men. Gates, Lackey, and Brown (2001) used ethnographic research methods to collect data by using photography as well as participation observation. Ethnographic research methods were also employed in the studies conducted by Ehrmin (2002), Plowden (2006), Plowden, John, Vasquez, and Kimani (2006), and Prince (2008). The ethnographic research method was chosen by these investigators because it provided them with a systematic process for observing, documenting, and analyzing the domain of inquiry in the cultural contexts under study (see Appendix B for complete study attributes).

Ethnography explores the patterns, lifeways, and experiences of a cultural group in a holistic fashion (Polit & Beck, 2008). Leininger's theory of Culture Care offers a means to

discover, describe, and systemically synthesize the culture care expressions, beliefs, and practices of African Americans across ethnonursing and ethnographic studies.

CHAPTER 3

Research Design / Method

Meta-ethnonursing

It was realized through a previous metasynthesis of doctoral dissertations that a new research method was taking shape. This previous study was originally undertaken to synthesize cultural care expressions, beliefs, and practices of diverse and similar cultures. The dissertation was completed in 2010 by faculty and graduate nursing students of University of Michigan – Flint and inspired this current research study. Like this metasynthesis, the prior study was also guided by the Culture Care theory, ethnonursing, and ethnographic methods. It was proposed that a new metasynthesis method emerged that could be used to guide future qualitative nursing research; hence the birth of the term “**meta-ethnonursing**”. In the prior study, meta-ethnonursing referred to a synthesis of multiple studies (metasynthesis) guided by the Culture Care theory using the ethnonursing method, allowing for expansion of ideas, higher levels abstraction and ultimately theory building (McFarland et al., 2010).

To improved understanding, the terms of ethnonursing and metasynthesis in the context of the Culture Care theory are presented. According to Leininger, ethnonursing is defined as “a qualitative nursing research method focused on naturalistic, open discovery and largely inductive (emic) modes to document, describe, explain, and interpret informants’ worldview, meaning, symbols, and life experiences as they bear on actual or potential nursing care phenomena” (1997, p. 85). Metasynthesis, on the other hand, is defined as “the bringing together of findings, examination of them, discovery of essential features, and in some way combining phenomena into a transformed whole” (Schreiber, Crooks & Stern, 1997, p. 314). Jensen and Allen (1996) described metasynthesis as a complete study that involves rigorously examining and interpreting

the findings (which may include raw data at times) of a number of qualitative research studies using qualitative methods.

In the prior metasynthesis study, aforementioned, the researchers were able to combine metasynthesis and ethnonursing. As a result, the term “meta-ethnonursing” can now be further defined as a concise detailed discovery, examination, and elucidation of qualitative data from studies guided by the Culture Care theory as it relates to an interpretation of a person’s cultural care experiences within the context of nursing care received. Use of the meta-ethnonursing method, has been a venture into uncharted territory to promote and enhance the richness of culture care knowledge. Diverse cultures have evolved over time. Health care professionals are challenged to discover, understand, and respect the similarities and differences of human caring. These findings will add to previous body of knowledge and advance awareness of human care practices and cultural relationships between nursing professionals and their clients.

Human Subject Considerations (IRB Process)

Study participant’s rights must be protected when conducting research. As in the undertaking of all studies, it was a prerequisite to submit research plans to an institutional review board (IRB) for approval prior to beginning the research study.

Because this particular study was a metasynthesis of 14 published articles, a secondary data set, the IRB process was completed in an abbreviated format. The concentration was on published articles that included research studies using the term African American in conjunction with Leininger’s Culture Care theory, ethnography, or ethnonursing. The IRB forms were processed though an online format that followed procedural regulations. Moreover, the 14 published research articles were absent of specific patient identifiers. Because human subjects were not directly contacted, individual informed consent was not necessary for this project. In

addition, these data sets were publicly available, so the possibility of apparent risk to human subjects was nonexistent. The University Institutional Review Board's decision letter provided notice of determination referred to as a "Not Regulated" status dated July 13, 2009.

Confirmatory documentation is included in Appendix C.

Major Features /Enablers of Ethnonursing Method for Metasynthesis

Establishing trustworthiness and accurate conclusions about culture care for people in their contexts is determined by the measures taken to ensure trustworthiness of the data collected. Leininger developed precise enablers to guide her ethnonursing research method for the theory of Culture Care Diversity and Universality. These enablers help explicate and tease out culture care phenomena as it is portrayed from the emic viewpoints of the informants; thus establishing confidence that the information is authentic and trustworthy. Enablers also assist with probing people and environmental contexts to discover covert, unknown, and ambiguous nursing phenomena (Leininger, 1997).

The Sunrise Enabler, Stranger-Friend Enabler, and the Observation-Participation Enabler are three enablers Leininger developed to guide ethno-researchers in obtaining accurate and credible data (Leininger, 2006). As part of this metasynthesis of 14 published articles, it was important to have an understanding of how enablers were used to guide the 14 research studies. Therefore, a through description of the enablers used will be discussed here.

The Sunrise Enabler is a conceptual holistic research enabler that allows multiple theoretical factors to emerge and be discovered (Leininger & McFarland, 2002, chap 3). "It serves as a cognitive guide to tease out culture care phenomena from a holistic perspective of multiple factors that can potentially influence care and the well-being of people" (Leininger & McFarland, 2002, p. 79). Researchers using the Sunrise Enabler are guided to evaluate many

potential influencers that may impact the domain of inquiry and explain care phenomena as it is related to historical, cultural, social structure, world view, and environmental factors.

The Sunrise Enabler was developed by Leininger to illustrate the major components of her theory and depicts the inter-relationships of the Culture Care Diversity and Universality Theory (see Figure 1 for visual depiction of Leininger's Sunrise Enabler). Human beings are depicted as inseparable from their cultural background and social structure, worldview, history, and environmental context. As described by Leininger, the upper half of the circle (see model) depicts components of the social structure and worldview factors that influence care and health. These factors also influence the folk, professional, and nursing system(s), and form the middle part of the model. The two halves together form a full sun, representing the universe that nurses must consider to appreciate human care and health; thus the name The Sunrise Enabler Model (as cited in McFarland, 2006). Nurses serve as a bridge between the folk and professional system. Leininger predicted three transcultural care decisions and actions to assist in providing culturally congruent care and bridging this gap: (a) culture care preservation or maintenance, (b) culture care accommodation or negotiation, and (c) culture care repatterning or restructuring (Leininger & McFarland 2002, chap. 3, 2006, chap. 1). The Sunrise Enabler along with the three modes of culture-care actions and decisions allows for consideration and blending of emic and etic viewpoints and the researchers' perceptions.

Essentially, the Sunrise Enabler depicts all influencers or potential influencers of human care as it may be related to the domain of inquiry. As new culture care phenomena emerge, researchers can expand on existing theory to explicate culture care competence and develop a comprehensive database of influencers on care, health, illness, death and disability in and across

cultures. This process assures that culture care of people and their environment is depicted as precisely as possible (Leininger & McFarland, 2002, chap. 3).

The Stranger-Friend Enabler for the ethnonursing research method is a systematic process where the researcher proceeds from a stranger to a trusted friend to the people within their contextual environment. This method ensures that accurate, sensitive, meaningful, and credible culture care discoveries emerge from solid and trusting relationships. This enabler also uses a reflection tool for researchers to consciously become more aware of their own behaviors, feelings, and reactions as they work with the informants to collect data. This is another way to confirm credibility in the cultural truths of the informants and their contexts. The Stranger-Friend Enabler is molded by specific indicators for gathering data over a period of time in order to identify patterned lifeways and behaviors. Each characteristic of the enabler was designed to assure that the data collected is interpreted accurately in order to represent culturally congruent findings as defined by the informants under study (Leininger & McFarland, 2006, chap. 2).

The Observation-Participation-Reflection Enabler (OPR) was also designed to assist the researcher in confirming the trustworthiness of the data collected and interpretation of results. The researcher begins their study on the domain of inquiry from observation only before becoming an active participant. This results in the researcher becoming fully aware of the situation and contextual environment prior to engaging with people and their lifeways. Reflection is an integral part of the OPR Enabler and was incorporated to provide vital and essential confirmatory data from the people under study (Leininger & McFarland, 2006, chap. 2). The ethno-researcher uses reflection in four phases of the research study to insure that data, people, and contexts are interpreted accurately.

Reflection on the phenomena observed or ideas heard help the nurse to focus on all contextual aspects of the research before proclaiming or interpreting an idea or experience. At the conclusion of the study, the researcher reflects back on all findings to recheck and confirm them primarily with key informants. (Leininger & McFarland, 2006, p. 61)

Leininger focused on reflection as an essential part of the OPR enabler in order for the researcher to evaluate meaning-in-context of all aspects of the data and to ensure trustworthiness in observations and interpretations of findings (Leininger & McFarland, 2006, chap. 2).

Ohm (2003) explicated the Sunrise Enabler as well as Leininger's Observation-Participation-Reflection Enabler to systemically assess and develop a comprehensive database on AA's experience in the Islamic Faith. Canty-Mitchell (1996) also used the Observation-Participation-Reflection Enabler to gather data about the behaviors, activities, and communication styles of AA juvenile offenders. Plowden and Wenger (2001) used the Stranger to Trusted Friend Enabler to develop trust with an AA community in order to move into their community and discover caring processes as it relates to their culture. Wittig (2001) also used the Stranger to Trusted Friend Enabler in order to develop trust between the interviewer and the participants. The researchers in Wittig's study developed trust by visiting the community under study for more than two years, which created a comfort level between the participants and the researchers that fostered trust and eventually lead to acceptance into their culture (Wittig, 2001). Ehrmin (2005) incorporated the Sunrise Enabler to help conceptualize the domain of inquiry, then utilized the Stranger to Trusted Friend Enabler to gain entry at the research site and gain the trust of AA women. Ehrmin utilized the Observation-Participation-Reflection Enabler to discover the meanings and expressions of recovery care for substance-dependent AA women

living in an inner-city transitional home for substance abuse. This enabler facilitated Ehrmin's methods for gathering data, which were (a) through observation, (b) active listening, and (c) reflection on the women's expressions and behaviors prior to becoming an active participant among the women. The Sunrise Enabler and ethnonursing research methods were used by McFarland (1997) to discover culture care with Anglo- and African American elders in a long-term care environment. Morgan (1996) used ethnonursing research methods; the use of the Observation-Participation-Reflection Enabler was implied but not specifically indicated. Morgan (1996) was interested in discovering and describing the beliefs, practices, and values that AA women have about prenatal care. Augustus (2002) used ethnographic as well as Leininger's ethnonursing research methods to identify the cultural beliefs of AA women towards having a hysterectomy; but precise use of enablers were not indicated, only implied. Explicit method details for the published study data collection can be obtained in Appendix B.

The ethnonursing research method uses open-ended questions that allow the informants to provide information freely and validates accuracy in the data offered. Open-ended questions are used in a friendly and nonconfrontational manner in order to gather rich and meaningful data. The researcher must be genuinely skilled in listening and confirming informants' ideas and thoughts. This method provides an opportunity for the researcher to gather new and emerging phenomena as well as identify other potential influencers. The premise behind the use of open-ended questions is that trustworthiness of the data and interpretations prove to be more accurate and meaningful when the informants serve as the primary sharers and definers of ideas (Leininger & McFarland, 2006, chap. 2). The ethnonurse-researcher must be cognizant of following the ethnonursing research method in addition to using the enablers as facilitators in ensuring trustworthiness in data interpretation.

Thesis Timeline

Construction of a project timeline assisted the researchers in a visualization of the schedule necessary to complete research tasks over a period of time. Full consideration of the researchers' knowledge, resources available and time required to complete the tasks assisted in the planning for this project. Reference to this time line kept the project running smoothly and allowed for adjustments to the schedule as necessary.

Phase I of the timeline consisted of a comprehensive literature review regarding ethnonursing, ethnography, and metasynthesis application and techniques. The sample published studies for this metasynthesis effort were screened and selected. Phase II included an intense review of the selected published studies with initial categorization of study themes, techniques, and potential patterns. Discussion occurred regarding coding methods and organization of the data. Phase III commenced with actual data entry and codification of the 14 published research studies. The information was input into the NVivo-8 qualitative software program. Finally, in Phase IV, the themes and patterns began to emerge through data manipulation, queries and analysis of the information. This new information was clarified and reflected upon with researchers seasoned in ethnonursing qualitative methods, producing the rich information and recommendations for this study.

NVivo8 is a data analysis computer software program produced by QSR International that provides qualitative researchers with a way to understand phenomena and answer research questions through careful analysis of data. The project timeline is displayed in relation to Leininger's Phases of Ethnonursing Analysis. This timeline appears as Appendix D.

Sample

Discovery of research published (from 1980 to present) included all articles guided by a focus on AA culture, Leininger's Theory of Culture Care Diversity and Universality, and the ethnonursing framework. Following careful inspection of the data contained in each article, the study of literature was narrowed to 14 qualitative articles. The articles were color coded and the data categorized allowing similarities and differences in target groups of the AA culture to become evident.

The sample size for this metasynthesis of AA culture included 14 qualitative research articles previously published that contained the keywords (a) Culture Care theory, (b) ethnonursing and (c) ethnography. Location of pertinent data and findings was accomplished by thoroughly searching several electronic library databases. Keywords used to conduct the literature search included African American, ethnonursing, ethnography, Leininger, and transcultural nursing care. Four researchers pursued an individual literature search with these key words using CINAHL (through First Search), SAGE publications, OVID, and Pub Med. Once the search was completed, these published studies were carefully reviewed with experienced qualitative researchers to confirm that all possibilities had been exhausted related to this study.

Inclusion / Exclusion Criteria

Only studies guided by the Culture Care theory, ethnonursing and ethnographic research methods, with a focus on African Americans were used to compile the sample of studies for this metasynthesis. Although only 14 published articles were found that met the inclusion criteria; it is important to note that the original search produced 24 documents. Each article was individually reviewed for relevance to the AA culture and use of Leininger's theory with the

ethnonursing and/or ethnographic methods. The inclusion criteria were based on use of Leininger's theory and the ethnonursing or ethnographic methods. Of the twenty-four articles initially found, there were ten articles that did not adhere to these elements and were excluded, leaving only the 14 articles used in this metasynthesis.

The list of articles was colored coded to represent diverse and similar groups within the AA culture in hopes of categorizing the research into smaller, more manageable units of information. The six groups identified were (a) women, (b) men, (c) children/adolescents, (d) elderly, and (e) spiritual/holistic care. The methods and emergent themes of each article were placed into a table for ease of reference and to enable the researchers to discover recurrent themes (see Appendix B for study attributes and Appendix E for category coding).

Data Collection / Analysis Using Excel and NVivo 8

All 14 studies identified used Leininger's Phases of Ethnonursing Qualitative Data Analysis for data processing, interpretation, and theory building.

Procedure of project

The primary procedure for this research project remained consistent with Leininger's Cultural Care theory and ethnonursing method. The data analysis consisted of four general phases (Leininger, 1997, p. 50):

1. Phase I – Collecting, describing, and recording raw data.
2. Phase II – Identification and categorization of descriptors and components.
3. Phase III – Analysis to discover repetitive patterns and contextual meaning.
4. Phase IV – Abstracting major metathemes, theoretical formulations, and recommendations.

The four phases are illustrated in Appendix A and were carefully followed, allowing for a systematic data analysis. This analysis helped to ensure rigor and accuracy in the research findings. “In general, the Phases of Ethnonursing Analysis for Qualitative Data are essential and most important to show how the data needs to be collected, processed, and analyzed in a systematic, credible, consistent, and accurate way” (Leininger, 1997, p. 50). Critical evaluation of the research studies included in this metasynthesis indicated accurate use of Leininger’s phases of analysis. Based on this process of analysis, the individual studies were credible evidence; thus providing substantive data implications and truth to the theory and domain of inquiry.

Data analysis: Microsoft Excel

Ethnodemographic data was sorted which included a number of study informants, from the 14 published research articles including their ages, sex, participant settings, and demographic location where the studies took place. To include an aspect of quantitative data in this study, numerical data was entered into Microsoft Excel rendering three separate spreadsheets that represented informant populations, settings, and demographic locations where data collection had occurred. The informants of the study were further sorted into the following groups: male, female, teens, and elderly. It was noted that the informants had voluntarily joined these study groups in response to advertisements posted at several community locations. Within the multiple studies, the majority of the study informants were 18 and older except for the juveniles who ranged in age from 12 to 15 years.

Once the graphical representation of the 14 studies using the bar graph was completed, it was apparent that the male informants totaling 194 was the gender most represented in the research examined. Female informants totaled 137, teens were 75, and the elderly only 40 for a

grand total of 446 informants (Refer to fig. 1). Interestingly, of the 14 published articles included, only three were strictly related to the men; whereas seven, the largest number of articles, were published about women. These findings led the researchers to question why there was greater participation amongst the men as a group given the smaller number of articles that focused on men. Could it be that women tended to remain at home caring for their families and men are more likely to be “out and about” in the community on a daily basis? Or were men specifically invited to participate in these studies more than women. Additional research is recommended to explore these questions.

Locales where studies took place were also entered into Microsoft Excel to illustrate the number of informants in the different areas and environmental contexts where studies were carried out. These were divided into the following settings: urban, rural, prison, transitional home, assisted living, and clinics. Completing a pie graph representation of study settings demonstrated that 301 of the informants were observed in urban areas, which was also found to be the most common area where the 14 studies took place. Additional locations of study included (a) a prison with 75 participants, (b) rural areas with 57, (c) a transitional home with 55, (d) assisted living with 40, and (e) clinics with 13. The prison setting comprised the teen population. Substance abuse and prostitution groups were found in the transitional home settings and elderly primarily in long term care settings.

Upon analyzing this pie chart it is clear that urban areas were very well represented with more than 50% of studies occurring there. This finding raised further questions: Are African American populations more concentrated in urban areas? Were urban areas more convenient locations to study this population? Should future studies focus on AA populations outside of urban areas? Conducting studies across all settings is imperative if the information discovered is

to be deemed transferable and useful to the AA population as a whole. A map of the United States prepared by the Secretary for Health for Policy and Planning that compared urban vs. rural areas in the United States and shows how vast rural areas are in comparison to urban areas. This directed the researchers to note that an investigation of rural areas is required and can provide inclusion of additional information useful to future research (Refer to fig. 2 and 3).

Lastly, demographic locations were entered into Microsoft Excel to represent the areas in the United States where the 14 studies were conducted. The following areas in the country of the United States are established as geographic divisions: Midwest, Southwest, Southeast, Southern Metropolitan, Southern Mississippi, South Carolina costal, and Northeast. Numbers of informants in each of these locations were entered into Excel and an upright bar graph was prepared. This bar graph representation indicated that the Northeast was the largest demographic location area in which the studies occurred, representing 110 informants. The Midwest was second with 76 informants and the Southeast third with 75 informants. If all of the southern locations are combined it becomes the largest area studied, with a total of 155 informants (Refer to fig. 4).

When comparing both locale and geographical data of the studies, it becomes apparent they were concentrated within areas near university campuses and conducted by educated professionals. Researchers had essentially accessed informants from groups that resided in close proximity to their places of higher learning or employment. This finding may mean that groups studied were included out of convenience for both the researcher and the study informants. If long distances had to be traveled, it may have been more time consuming and less accessible for both parties to conduct or participate in these studies.

Analysis/Coding Scheme

As previously noted, NVivo8 was used to code the data for this research project. This program is specifically designed for qualitative research studies that have very rich text-based and/or multimedia data. For this metasynthesis, NVivo8 was utilized to help organize and analyze the complex non-numerical and unstructured data from the text of the articles. Also utilized was the Leininger, Templin, and Thompson Field Research Ethnoscrypt. This set of “codes” used to classify the data was specifically developed by Leininger to represent the Culture Care theory depicted in Leininger’s Sunrise Model. For example, Category II: Domain of Cultural and Social Structural Data includes nine subcategories used as representations of pieces that comprise the whole Sunrise Model itself (see Appendix F).

NVivo8 facilitated the organization of data through classifying, sorting, and arranging various pieces of information within the ethnoscrypt representing Leininger’s Sunrise Model (see Appendix F). NVivo8 was also used to (a) examine complex relationships in the data, and (b) combine subtle analysis with linking, shaping, searching and modeling (QRS International, 2008). 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 are 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* (See Appendix F).]
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. **Source:** Data physically stored inside the NVivo project file. [For this study, the sources are the 14 published articles.]

4. **Coding:** The process by which nodes are linked to certain segments of the text within each article. [As an example within this study, the node *kinship* was linked to text citations containing references to family interactions or family perceptions.]
5. **Query:** A method within NVivo that allows the asking of questions and linking of nodes to attributes for pattern and theme discovery. [As an example within this study, a query was built identifying segments of text reflecting religious influence on health and wellbeing.]

Dr. Elaine Welsh 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. (as cited in McFarland et al., 2010, p. 44)

With the use of NVivo8, theoretical assumptions were supported, trends were identified, and information was cross-examined in a multitude of ways using the program's search engine and query functions. Observations made included discovery of themes and care patterns using the NVivo8 software and a body of evidence was developed to answer the research questions. This was accomplished by the program's ability to allow unstructured data and information to be managed and shaped in a way that has provided the researchers with a framework for emerging discoveries. The entire text of each of the 14 research articles was uploaded into the NVivo8 program. As the data was extrapolated from the sample of the 14 studies that met the criteria for

inclusion, themes and categories were discovered and coded based on pre-assigned codes included in the Coding Data System for the Leininger, Templin, and Thompson Field Research Ethnoscrypt. This coding structure is made up of assigned constructs of the Culture Care theory and includes categories and subcategories for the theory. This was the primary system utilized for coding and collecting data from each article and the categories were entered within NVivo8. First, a parent tree node (referred to as the categories) was created in NVivo8 for each construct listed in the coding structure. (For example, Category I: General Cultural Domains of Inquiry included 9 codes). Secondly, each code description designated specifically within that particular category contained subcategories, such as, number 9: racism, prejudice, and race. Each subcategory was created as a child node, which was located below its parent tree node. Within this ethnoscrypt new nodes were added to allow the addition of discovered information. All the articles were double coded individually in a process of sorting and arranging information. After the complete content of each article was carefully coded, the files were merged and queries were performed to identify data patterns. This information was then analyzed and themes discovered which created insight and meaningful conclusions based on these codes.

Leininger's Phases of Ethnonursing Analysis for Qualitative Data is presented in Appendix A. This metasynthesis study utilized these phases of analysis to guide the analytical process. The first two phases of ethnonursing analysis can be summarized as collecting, providing description, and documentation of raw data; along with identification and categorization of emic or etic descriptors and study of recurrent components. Phase three requires the researchers to identify recurring patterns and themes. Phase four also requires identifying recurring themes; however, researchers develop formulations based on the findings from the first three phases and abstractly synthesize those findings into themes that support the

raw data. It is here where an audit trail is often utilized to substantiate evidence found in the raw data, verifying confirmability and credibility of the data analysis (Leininger, 1997). As the researchers progressed through each phase, a deeper and richer understanding of the data emerged, leading to the formulation of major themes and research findings.

During the first phase of analysis a group of four researchers methodically read through designated articles making observations and identifying contextual meanings related to the domain of inquiry and the phenomena under study (Leininger, 1997).

Within the second phase of analysis the researchers began looking deeper at the preliminary data, coding and classifying the data directly to both the domain of inquiry and the research study questions. The researchers then compared content and data between the research studies to find similarities and differences. Recurrent ideas were evaluated for their meanings and used to identify patterns and themes (Leininger, 1997).

The third phase of analysis proceeded with further evaluation of the data. The data that was collected and coded was scrutinized in order “to discover saturation of ideas and recurrent patterns of similar or different meanings” (Leininger, 1997, p 50). To ensure saturation of ideas and create inter-researcher confirmability, each article was double coded by two researchers. The codes were merged and queries created to identify major themes and research findings.

The fourth phase of analysis involved synthesizing the findings and interpretations from the previous phases. Abstractly analyzing the information and finding meanings-in-context enabled the researchers to identify a preliminary set of (a) emerging themes, (b) research findings, and (c) theoretical formulations.

Substantiating the Research

Study Credibility, Confirmability, Meaning-in-context, Recurrent patterning, and Saturation

The qualitative research paradigm has methods for establishing the trustworthiness of a study that differ from quantitative research. Credibility, transferability, confirmability, and dependability are four criteria used to instill trustworthiness in qualitative research (Polit & Beck, 2008).

Credibility is established through research methods building confidence in the truth and validity of the data, conclusions, and researchers' interpretations. Triangulation is an important facet of credibility; therefore, creating triangulation in qualitative studies is fundamental. In triangulation, conclusions about what represents the truth are drawn from several sources. Qualitative researchers can ensure triangulation by using multiple means of data collection (interviews, tape-recordings, etc), thus allowing the truth to emerge from different sources. As discoveries emerge through triangulation methods, related themes and truths can be joined together; therefore, building additive evidence to support the credibility and validity of the research data (Polit & Beck, 2008).

This research was initiated using published works contained in scholarly journals. These previous studies had rigorous evaluation for worthiness before acceptance for publication in peer review journals. The peer review process requires credibility as a specific publication criterion. As a result, the findings in this metasynthesis can be appreciated to demonstrate credibility through their aggregation and use. Truthfulness of the findings was established through replication of themes and patterns revealed in the independently published studies.

Recent research trends have shown that synthesizing data that has been generated from various qualitative studies, such as a metasynthesis, has the potential to become a respected form

of triangulation (Finfgeld, 2003). Finfgeld explained that in a metasynthesis, triangulation can be expedited through analyzing findings that are produced from multiple theories and methods. Finfgeld also supported this method by stating that credibility and rigor of the study is enhanced when “new translations are metasynthesized from findings that have been generated from differing philosophical and methodological perspectives” (p. 902).

Madeleine Leininger (1997) expanded on the four criteria to fit the ethnonursing research method as it relates to her Theory of Culture Care Diversity and Universality. She chose six major criteria for evaluating qualitative results and interpretations as it relates to the theory, which include: credibility, confirmability, meaning-in-context, recurrent patterning, saturation, and transferability. A qualitative research study satisfying these six criteria provides dependable and trustworthy evidence that may have a significant impact to nursing practice. Leininger (1997) indicated that credibility regarding truths about people is established through direct evidence from the people and their environmental context.

Qualitative research can illustrate confirmability through evidence of documented verbatim from the people who can verify and confirm the truth of the data and findings. Throughout this study, two researchers coded the selected articles independently. This process of double coding helped to ensure data confirmability. In addition, it generated conversations between researchers regarding orientational definitions of the names of codes in the coding structure. The findings were sorted into categories that were then carefully evaluated for similarities and differences. Care was taken to remove personal biases, motivations, or perceptions of the researchers and to ensure that the participants of the 14 individual studies had their perceptions and voices accurately interpreted.

Leininger defined meaning-in-context as the meaningful data and truths that are known and relevant to the people within their natural living environmental contexts. The researchers in this study used meta-ethnonursing as the research method along with Leininger's Culture Care theory and Sunrise Enabler to create a common language. The individual studies met the criteria for Leininger's ethnonursing research method which required exploration of meaning in context of statements made by the participants. The studies reviewed took place in several different environments and included a range of ages; thus, applying a wide representation of the cultures studied. The entire contexts of the articles were reviewed and coded by researchers and established recurrent patterning through documented evidence of repeated care themes, patterns, and practices over time; thus revealing consistency in lifeways and behaviors. Evaluation of emerging themes from data analysis on AA culture was completed through NVivo text searches with a specific focus on the previously developed research questions. Confirmability was obtained through double coding and individual analysis. Additionally, a deliberate effort was made to analyze coded data, as well as to synthesize data leading to metathemes and metapatterns. Thus, saturation was achieved by reviewing all the information and data that could possibly be known about a domain of inquiry.

Transferability of study findings

Transferability, the sixth criterion, is unique in its properties. The goal of transferability is to present the research consumer with enough information to judge the appropriateness of applying the findings to similar settings. Transferability focuses on whether the findings from the study have the potential to have similar implications and relevance in another "similar" context (Leininger, 1997).

From a qualitative perspective, responsibility for recommendations regarding transferability is shared by the researchers who will analyze the study findings, as well as the users of the findings. However, the qualitative researcher can enhance transferability by describing the research context and the assumptions that were central to the study. The person who wishes to “convey ” the results to a different context is then accountable for making the judgment of how useful the results will be in their setting. To make certain that a sample is representative of a particular clinical population, dense background information must be obtained about the participants (Henderson & Rheault, 2004). The context must be described so adequately that a judgment of transferability can be made by readers (Koch, 2006). According to Polit & Beck (2008), “it will be our responsibility...as qualitative investigators to provide a “thick description” of our findings and purposeful sampling of results” (p. 550). This term, ‘thick description’, is widely used in literature and refers to a rich, thorough description of the settings, observed transactions, and processes. Thick descriptions include themes, labels, categories, or constructs of a study. Providing clear imagery of sampling and data analysis procedures will support the veracity of the researchers’ work and increase the credibility of the findings. In doing so, other researches will be able to assess, utilize, and apply the evidence revealed.

As described, there is a gap in the research supporting the importance of culture care as it pertains to African Americans. Leininger’s theory of culture care offers a means to discover, describe, and systemically synthesize the culture care expressions, beliefs, and practices of AAs across ethnonursing and ethnographic studies. Efforts have been made to enhance the transferability of these findings and recommendations in various settings. It will be the responsibility of the consumer of this information to determine its applicability to their specific needs and situations.

CHAPTER 4

Results and Findings

Findings

Coding queries within NVivo8 were reviewed to discover similarities and differences among the 14 studies regarding AA influences on health beliefs, practices, well-being, and beneficial lifeways. In addition, the themes from each of the 14 studies were examined for similarities contributing to metatheme development. Four major metathemes were revealed: (1) Socio-structural factors of spirituality, kinship, and family influenced care/non-care health, and wellbeing for African Americans; (2) African Americans expressed both similarities and differences in generic care/non-care beliefs and practices; (3) African Americans expressed both similarities and differences in professional care/non-care beliefs and practices; (4) Cultural care nursing decisions and actions are effective in promoting health and well-being within the African American culture. These metathemes were found to influence the way African American's perceive health and well-being, actively participate in care, and ultimately affect their personal health. Within the 14 individual studies care themes and care patterns were synthesized to develop metathemes that were supported by care and non-care metapatterns.

Metatheme 1.0: Socio-structural factors of spirituality, kinship, and family influenced care/non-care, health, and wellbeing for African Americans

This metasynthesis has revealed that within the AA community there exists two predominate care dimensions that assist to promote health and well-being; a) spiritual or religious care and b) human caring by friends, non-kin, and family. At times, these care dimensions overlap to provide a rich environmental context conducive to caring, support, and

communication networks. The care patterns related to these networks assisted African Americans to promote their own health as well as caring for others who were sick.

Metapattern 1.1: Care as spiritual or religious beliefs and practices.

Universally, a strong spiritual or religious belief care pattern contributed to health and beneficial lifeways. The study by Ohm (2003) discovered the theme that the Islamic faith as a way of life promotes a holistic approach promoting wellness of the individual, family, and community (See Appendix B for complete listing of study themes).

African Americans are arguably the most religious population subgroup in the industrialized world, and it has been suggested that both personal religious involvement and tangible support provided by religious organizations may shield this population from some of the adverse consequences of stress. (Ohm, 2003, p. 479)

Within the Islamic community, illness “is viewed as a ‘fire’ they are suffering from now, so they will not have to suffer in the next world” (Ohm, 2003, p. 482). Thus, an informant’s response when asked about the Muslim response to illness: “Praise be to God for illness” (Ohm, 2003, p. 482). Illness may also be considered atonement; serving to balance some of the bad deeds done. This perception could lead to a shift away from a curative health care approach. Several of the AA Muslims interviewed indicated reaching self-actualization as a goal consistent with their faith: “Health is everything”; having health in all areas helps Muslims reach their full potential as humans” (Ohm, 2003, p. 485). The informants believed, as rooted in the Islam faith, that cleanliness of the body, mind, spirit, and environment should help prevent disease and emotional or mental confusion.

Prince (2008) discussed the theme of spirituality related to resilience for African American women leaving a life of prostitution (See Appendix B for complete listing of study

themes). “According to all the key participants, ‘dealing with difficult times’ was ‘only possible with the help of the Lord, the Holy Spirit, my God, or a Higher Power’” (p. 33). They all voluntarily chose to attend church on Sundays. Their faith was a source of strength that enabled them to refrain from prostitution. A contextual informant in the Prince (2008) study explained:

They [AA women] are very receptive to the spiritual groups and going to church on Sundays. I think this is a piece of their lives that once they start going through recovery that they try to capture a piece of the past and their childhood days that they were taught to go to church, that this played a big part in their life. And once they enter recovery, most of them do reach out to the spiritual part of recovery. They do. They participate in it. There are three different Baptist churches that the women go to. (Prince, 2008, p. 33)

Within the 14 studies, the qualitative research reports by Wittig (2001) as well as Gates et al. (2001) included themes of spiritual care as a form of self-care, especially among African American women (See Appendix B for complete listing of study themes). Women derived support from and gave support to the church. The centrality of the church was a primary form of caring for self. The oldest of the informants showed the researcher the carefully arranged snapshot of her Bible opened to Philippians 4:19 (King James’ Version), “[I’ll] supply all your need[s].” She further elaborated about her snapshot to the researcher:

I feel myself (pause) I won’t say depressed, but a little dark creep in. I go back to these words where He said “you know whatever you ask in my name without a doubt I shall do it,” (John 14:13), you know. It doesn’t matter about my problem—He (pause) has (pause) promised us. (Gates et al, 2001, p. 533)

Metapattern 1.2: Non-care as expressed by spiritual fatalistic beliefs.

However, religion also plays a large role in African American’s perception of illness and

health that can lead to a negative impact on health care choices and decisions. Several of the studies revealed concepts that a higher being is in control of health and well-being rather than the person leading to potential non-caring actions. Wittig's (2001) theme development described the negative impact of religion in discussing the decision for organ donation (See Appendix B for complete listing of study themes).

The AA women in this study were adamant in the belief that God would take care of them, regardless of their decisions relating to organ donation. For the women in this study, the decision to donate organs was directly linked to the idea that God cures illnesses among the "righteous" and that organ donation is unnecessary for those who "live right." Of the women who did not wish to be organ donors, they all expressed this belief. For these participants, the negative response was related to the notion that God cures illness "for the righteous and people who live for the Lord." They related health outcomes to "His grace," and future health was frequently viewed as the result of possible divine intervention. (Wittig, 2001, p. 5)

Gates et al. (2001) also described the theme of non-caring as women delaying to seek diagnosis or treatment of breast cancer and the relationship to religion (See Appendix B for complete listing of study themes). This resigned acceptance or trust in the Lord was also observed in women with breast cancer and many chose not to seek treatment.

Spirituality and religious values, beliefs, and practices have been indicated as a significant social structure dimension that has extended to every aspect of life in AA culture. The influence of spirituality on the beliefs and practices of care, health, and well-being were strongly evident in these studies.

Metapattern 1.3: Care as kinship, family, and social psychological support.

Within the culture of African Americans there exists a strong relationship between kinship and healthcare. Beneficial lifeways depend upon a sustained extended family or social network. Multiple studies provided theme development of kinship care patterns.

Several studies discovered data for development of care themes and patterns related to kinship as helping one in need or being emotionally and physically supported by family, friends, neighbors, work colleagues, and church members. Gates et al. (2001) described the theme of caring for others and self as meaningful (See Appendix B for complete listing of study themes). One descriptor indicated the importance of the caring actions by others in seeking early treatment for breast cancer, “I would walk from [city in the mid-South] to San Jose, CA, if I had to, to be sure my niece went to see someone about that lump and got the right treatment for it” (p. 533). The caring actions by those supporting women suffering from breast cancer or the possibility of being diagnosed with breast cancer gave the women the strength to care for their own health and well-being.

In Gates et al. (2001), participants were asked to take photographs of places where caring took place. The photographs depicted scenes from the workplace, homes, to their religious institutions.

At least half of the informants had pictures of places, their “havens” of caring: work, church, beauty salons, restaurants, special areas in their homes, or gathering places with their friends. These places enabled the women to talk and “let their hair down,” even when that hair was no longer there. (p. 533)

The architectural structure was not important. It was the presence of people who could provide psychological support through friendship and verbal interactions. The concept of caring was not

discussed as physical ministrations, but much greater value was placed upon the heartfelt psychosocial mechanism of caring.

Although these women did not report a connection of caring [with] delay [in treatment for breast cancer], they did report a strong connection of caring to support and in preventing delay, especially toward other women in making sure they sought early diagnosis and treatment for their breast cancer symptoms. It came across as a “missionary zeal”. (Gates et al., 2001, p. 535)

Unconditional love, support, and respect as a form of caring were important influences on health and well-being. One theme from Prince’s study (2008) substantiated the importance of support and guidance from staff, support groups, and family during recovery from prostitution and substance abuse (See Appendix B for complete listing of study themes):

Today, when I go through difficult moments, I don’t have long periods of difficult times. I have difficult moments. I have a support system that I call. I belong to a fellowship that I go regularly and be able to share where I’m at and I get suggestions today. The recovery home that I come from. I come back regularly because they’re my support system when I go through difficult times today. I have a sister that’s among in the fellowship that I talk to and I have a sponsor that I talk to when I have difficult moments in my life and I don’t have the answer for them. My family is very supportive, has always been supportive through my prostitution and drug addiction. (p. 34)

Ehrmin’s (2005) study on substance-dependent AA women also described the influence support systems have on recovery. The women in this study indicated the importance of positive caring actions and support by their traditional family, religious, spiritual, and cultural lifeways. They indicated the need to be listened to and understood in a nonjudgmental manner. One

descriptor from a key informant described the need for love and the impact on her health and well-being: “That’s what it really all about, somebody lovin’ you until you are able to love yourself again” (p. 120).

Canty-Mitchell (1996) described the social and cultural care needs of AA juvenile offenders. Mitchell discovered that “juveniles value and need the caring, presence, support, protection, discipline, and involvement of parents, extended family networks, and significant others in the community” (p. 9). Encouraging reinforcement in these areas was found to be crucial for developing positive outcomes for health and well-being.

Metapattern 1.4: Non-care as kinship, family, and social negative influence.

Gates et al. (2001) explored the theme of kinship care response to non-caring influence (See Appendix B for complete listing of study themes). The non-caring actions by loved ones affected the women’s personal feelings about their own health and well-being. These negative actions caused the women to delay seeking further diagnosis or ongoing treatment. A primary example for women delaying seeking health care was the negative response by their partners. One descriptor from a woman diagnosed with breast cancer portrayed the non-caring support from her partner:

One telling example was reported by Linda, whose male partner did not want to be with “no one-titty bitch.” Linda quickly got “rid” of him. As she firmly stated, “Twenty to thirty percent of men are not good about it, not good about staying with their women. But so what? It’s your life, and you can’t let any man make a difference in what you are going to do about his”. (Gates et al, 2001, p. 534)

The researchers in this study provided a significant amount of data through field notes of discussions with the women indicating that lack of partner support was a significant contributor

to women's decision to either not participate in treatment or to stop treatment once it was initiated.

Social networks and kinship may be cutoff as a form of punishment when behaviors were not considered socially acceptable. Behaviors such as homosexuality, drug use, and sexual promiscuity could cause individuals to lose their support network essential to healing.

Battle's study found that "inadequate psychological support is one of the leading reasons that AA women "are more likely to suffer relapses after completing alcohol treatment" (as cited in Ehrmin, 2005, p. 117). A higher prevalence of what Battle identified as "escape alcoholism," described as drinking to numb the pain from the numerous grief experiences encountered throughout women's lives, has been found to be higher among AA women than other cultural groups of women (as cited in Ehrmin, 2002, p. 789).

This finding was similar in a study of the caring needs of African American male juvenile offenders. Canty-Mitchell (1996) developed a major theme of survival in the face of loss. This study discovered subthemes include loss of caring, loss of protection, loss of discipline, and a loss of support (See Appendix B for complete listing of study themes). The psychological impact of the opinions of spouses, parents, or peers could help heal or become a barrier to adequate timely care.

Based on the query results, AA feelings towards their health and well-being were affected by the care and non-caring actions of family, friends, and support groups. Key and general informants described how caring actions created emotionally and physically healthy feelings. On the other hand, non-caring actions create emotional labile feelings, affecting overall physical health and well-being.

Metatheme 2.0: African Americans expressed both similarities and differences in generic care/non-care beliefs and practices

The 14 studies revealed deeply rooted generic beliefs and practices within the AA culture. Generic care can occur within the family and within the community setting. Care, health and well-being were affected by generic care choices and decisions made within these cultural social contexts.

Metapattern 2.1: Care and non-care of self as a generic view of health and well-being.

Gates et al. (2001) also discovered women were more likely to seek medical attention for their spouses or other family members and set aside their own care because they felt other family members came first and before themselves, as illustrated in this quote:

For midlife and older AA women, health is considered good even if it is not because of sociocultural and historical influences. Diminishing their own illness symptoms may be a coping strategy, especially when taking on care giving roles for children or sick family members. Regardless of their age or own state of health, African American women are assumed to have obligations to others. (Gates et al., 2001, p. 530)

Plowden and Young (2003) conducted a study on AA men that inquired about health and well-being, asking “What does it mean to be healthy?” The study discovered that health was defined by a number of men in this study as the ability to perform normal activities of life. Both key and general informants reported that health seeking behavior was strongly influenced by the ability to perform such activities. Only when behavior was compromised did these men seek care.

According to Plowden and Young (2003), as long as these men were able to carry out normal activities throughout the day without difficulty, they perceived themselves as feeling healthy. Only when physically uncomfortable did they seek out medical care for ill health. One informant stated that the definition of health was a learned behavior because he was required to attend school unless he was too ill to navigate (p. 47). Due to this belief, many participants had not visited a healthcare provider or dentist; thus, only physical symptoms prompted a visit.

An informant commented, “I would define health as being awake with no pains, aches, able to go to the job, if you don’t have to take medicine. I am healthy because I can perform my job, no aches or pains.” The informant had not seen a physician in three years. This belief was defined as a learned behavior. An informant comments, “I grew up, if I wasn’t physically half way dead, I had to go to school. If you are physically able to walk, move or function then you are in good health.” The informant had not been to a doctor or dentist in 5 years. Primary prevention was not seen as a need by most men in this study. (Plowden & Young, 2003, p. 47)

Plowden and Young’s (2003) theme of a perceived benefit must be achieved before AA men will seek preventive healthcare services directly related to this definition of health (See Appendix B for complete listing of study themes). It was found that it was difficult to motivate men to seek care if they did not appreciate the benefit to their health and well-being.

Metapattern 2.2: Care as generic community involvement and support.

Gates et al. (2001) expanded the theme of generic care by describing several supportive community caring responses (See Appendix B for complete listing of study themes). The additional generic care patterns included monetary gifts, food, transportation, and/or childcare. It was evident there existed a strong sense of community care within the AA culture for supporting

families or specific individuals for the good of the whole. “Gifts, especially monetary ones or the loan of a car, enabled them to continue going for treatment. The extent of care as monetary support provided to the women was reported as surprising to several of them” (Gates et al, 2001, p. 535). Gates discovered coworkers were willing to rearrange their work schedules to assist with running errands and performing labor-intensive tasks as a form of generic care.

McFarland (1997) discovered a similar theme in her study of elderly African Americans in a long-term care setting.

Care as spiritual or religious help was received by African American residents from their church friends as direct personal help in a variety of ways. Church friends ran errands, did banking, paid bills, did laundry, brought communion to the residents, and visited with residents, which confirmed this care pattern. (p. 189)

Metapattern 2.3: Non-care as generic folk beliefs, views, and practices.

Guilt, shame, and emotional upheaval were experienced if the cultural norm was violated when decisions were made. Augustus (2002) conducted a study on the impact of having a hysterectomy on AA women. Themes within the study define the impact of cultural myths, fears, and sexual symbolism on care patterns. (See Appendix B for complete listing of study themes). The decision for surgery was at a great emotional cost due to the fear of losing a mate, decreased sexual desires, and becoming undesirable. One woman in the study portrayed her fears and beliefs:

When you have a hysterectomy you aren't the woman you used to be. [I believed] that your vagina got all [cut] away...you were taught this way and you believed it all your life and when it happens to you, you're thinking, “Oh my God, I'm not going to be the same person that I used to be and what's going to happen to me? And the fear of it. (p. 298)

These negative perceptions were based on the myths and perceptions of family, friends and particularly male partners and other AA men. Men in the study also suffered from a lack of education about hysterectomies and believed that having this procedure made the woman less satisfying sexually. African American women reported the use of derogatory terms used by AA men for women who had undergone a hysterectomy; some even terminating a relationship after learning that the woman had the procedure. This led to many women developing strategies to hide this information from others. One informant who traveled 85 miles away from home to have the surgery emotionally recalled, “they call it stripped, you know...they figure you’re ruined...they just figure you’re different” (Augustus, 2002, p. 299).

Morgan (1996) explored the theme of folk health beliefs and practices upon prenatal care of African American women (See Appendix B for complete listing of study themes). The researchers found that women failed to seek prenatal services based on the premise that professional services did not reflect the generic cultural care values, beliefs, and practices of the women. The researchers discovered older experienced women would traditionally share information with the younger women allowing them to adjust to the pregnancy process and be better prepared for childbirth. A descriptor indicating the importance of midwifery among AA women stated: “Midwives are called by God to practice and that the Lord protected their practices” (p. 4). Researchers found that women used indigenous or granny midwives, pointing out that it was a cultural lifeway pattern with many older family members preceding younger midwives in practice.

Metatheme 3.0: African Americans expressed both similarities and differences in professional care/non-care beliefs and practices

Metapattern 3.1: Care as embedded within a community culture.

Plowden (2006) looked at factors that influenced the decision of urban AA men to participate in prostate cancer screening. These men were more likely to participate in screening programs when providers were of the same race. Physician-patient race congruence increased receipt of preventive health services and improved overall satisfaction with health care. One informant who was successful in his community outreach emphasized the importance of the men having someone they can identify with. When asked about his strategy, he stated:

I developed trust with them. Some would say they were coming [to an outreach] and not show up. I would go down in my car and find them. They didn't expect to see me again. They trust me. I told them a lot of us [African American men] tend not to take care of ourselves. I had to use the word us in communicating with them to develop their trust. (p. 154)

Plowden (2006) discovered themes regarding the decision to receive screening included the importance of significant others and knowledge of disease and screening recommendations (See Appendix B for complete listing of study themes).

Availability and accessibility to community resources are other socio-structural factors that affected AA health and well-being. "Availability assumes that necessary preventive resources are available in the community. When preventive factors are lacking, people are more likely to participate in risky behaviors and less likely to seek care" (Plowden et al., 2006, p. 148). Accessibility involved being able to get to the services that are offered within the community. Barriers to access described by informants included lack of knowledge/education, lack of economic resources, lack of transportation, inconvenient office hours and wait times, and unsafe physical environments. Morgan (1996) found that making simple environmental changes like

having locks on doors, a security guard, and areas being well-lighted encouraged attendance at prenatal clinics.

Metapattern 3.2: Non-care as expressed by distrust of the professional healthcare system.

Non-caring patterns by both healthcare care providers and healthcare institutions can serve as barriers to African Americans seeking healthcare. Gates et al. (2001) described the influence of caring on AA women newly diagnosed with breast cancer and barriers that contributed to a delay in seeking care. “Barriers related to healthcare providers included lack of knowledge, attitudes, and discriminatory practices based on race or class, whereas barriers related to the healthcare system included discrimination in health policy and healthcare delivery” (p. 530). When someone did not feel accepted, they were less likely to participate in preventive health programs and are more likely to practice high-risk behaviors (Plowden et al., 2006). This finding supported their theme that a perceived safe and caring environment must be in place during outreach activities (See Appendix B for complete listing of study themes). Professional caring was perceived by AA women as being “listened to and understood, not judged, shown respect, and loved unconditionally” (Ehrmin, 2005, p. 123) in the theme related to the pain of rejection (See Appendix B for complete listing of study themes).

Metatheme 4.0: Cultural care nursing decisions and actions are effective in promoting health and well-being within the African American culture

Metapattern 4.1: Care as psychological and emotional nursing support.

Plowden and Young (2003) discovered the importance of caring and non-caring nursing actions and the influence it had on how African American’s defined health and well-being. One descriptor from a key informant described two experiences where a caring environment influenced his beliefs and perceptions about health and the health care system, ultimately

influencing his health seeking behaviors:

Compassionate, listens, empathetic, and shows that they care. Follow ups on things that you can ask them to do. I had surgery 15 years ago and I came from the operating room and didn't want any pain medication but the nurse encouraged me to take the pain medication. She came in the room and it showed on my face. She had the pain medication with her. She anticipated the needs of the patients. I felt like she really cared and was aware of what was going on. I've had the experience of going to the emergency room with my mother where we waited 2 hours. The nurse came out and said they were all full so where did we expect them to put her. I explained to her about my mother's condition. My mother ended up with a stroke, and I thought it could have been prevented. (p. 48)

Receiving treatment in a caring manner was seen by these men as an important aspect of health and well-being, thus, affecting health seeking practices for health promotion and prevention.

Augustus (2002) revealed that a surgery, such as a hysterectomy, could leave African American women exposed to negative perceptions and beliefs. In such cases, effective social and emotional support is a critical element affecting the value of their medical experience. For this reason, nursing care must remain aware of the negative cultural connotations of hysterectomy in the African American community. Augustus (2002) defined the need for culturally congruent nursing interventions to address educational programs, aspects of treatment, and the emotional support required when dealing with clients concerns prior to treatment serving to improve understanding of disease management.

Metapattern 4.2: Care as culturally congruent repatterning.

Ehrmin (2005) outlined a nursing theme of taking time to listen, acknowledge, and respect plus guidance that fits the cultural values of African Americans (See Appendix B for complete listing of study themes). It was important for substance abusing women to develop caring relationships based on reciprocity, equality, and respect for others. This was keeping within culturally held values of giving to one's brothers and sisters. Culturally congruent nursing care was considered necessary to encourage these women to discuss their experiences, express their feelings, and assist them in understanding they did not cause the abuse was discovered in this study. Ehrmin (2005) revealed the need for cultural repatterning to assist these women to explore a different lifestyle. Providing an environment via support groups or individual counseling was beneficial for working through their unresolved painful experiences and preventing further substance abuse. Gates et al. (2001) discovered this same theme as the need of supportive cultural repatterning to influence patient responses to care and treatment (See Appendix B for complete listing of study themes). Women with breast cancer reported that professional supportive care provided women the knowledge and strength for moving forward in what needed to be done; whereas, non-caring actions delayed care seeking decisions.

Prince (2008) discovered women transitioning from prostitution developed a form of empowerment when clinicians fostered self-care.

I didn't know how to stop using. I didn't know how to stop prostituting. It didn't finally sink in until I began living here and having the support from staff members and the volunteers that came in that gave me the opportunity to begin to look at me and not blame other people for the situations and circumstances that were in my life. (p. 34)

Allowing time for self-evaluation and guidance during transitional periods was defined as a form of cultural care accommodation assisting with the healing process. Telling their stories

also became part of the healing process. Nurses were viewed as persons who would provide care through support, listening, understanding, and giving encouragement and guidance.

Healthcare outcomes are affected by the relationships developed with healthcare professionals. Nursing care actions and decisions encompass the ability to influence healthcare outcomes by providing appropriate knowledge, unconditional care, on going support, cultural sensitive actions and decisions, a non-judgmental attitude, recommending community resources, and participating in the political realm to affect changes and elicit funding for client programs. Nurses repeatedly have initial contact with clients visiting emergency rooms and healthcare provider offices. As a result, their representation of the health care system can either facilitate or impede health care outcomes.

The socio-structural, generic care, and professional care similarities and differences discovered in this metasynthesis substantiate the Leininger's Culture Care Theory and Sunrise Enabler. Culturally congruent nursing actions were discovered as necessary for change in the majority of the 14 studies. These factors influenced not only African American's worldview, but their cultural values, beliefs, and lifeways regarding care, health, and wellbeing. This then is represented in care expressions, patterns, and practices within the community and healthcare system.

In summary, the findings from the metasynthesis analysis were presented in this chapter. The individual 14 studies began to reflect patterns of care similarities and differences through their themes and descriptors. These individual themes and patterns have been synthesized into care metathemes and care metapatterns providing guidance for future healthcare endeavors.

CHAPTER 5

Discussion of the Findings

Reflections on the Study

The purpose of this study was to discover, describe, and systematically synthesize the culture care expressions, beliefs, and practices of African Americans (AA). Socio-structural, generic and professional cultural care actions and decisions that promoted health, well-being, and beneficial lifeways for African Americans were gathered and synthesized from prior studies. In addition, nursing actions and decisions were synthesized from the 14 studies to identify culturally congruent care modes. This metasynthesis discovered four metathemes with supporting care metapatterns. The care metapatterns demonstrated both similarities and occasional diversities among the 14 studies.

Metatheme 1.0: Socio-structural factors of spirituality, kinship, and family influenced care/non-care, health, and wellbeing for African Americans

Metapattern 1.1: Care as spiritual or religious beliefs and practices

From the data analysis, it has become obvious that the AA culture is a profoundly influenced by social factors and dimensions. Intertwined within this community context is a strong spiritual or religious care network. Similarities of spiritual and religious beliefs and practices emerged from the studies. There is a rich history of religion being a sustaining force in the African American culture in times of hardship and when faced with difficulties or challenges. In addition, devout religious practices promote good health by advocating care as supporting cleanliness, abstinence from premarital sexual relationships, and supportive family relationships. The spiritual nature of African Americans needs to be considered within the context of health and well-being. Spiritual care can be a form of self-care discussed as the concept of resilience.

Resilience is considered especially necessary when the primary social network is cutoff. The primary social network may not exist due to death, divorce, abandonment, or punishment for not following societal norms.

Metapattern 1.2: Non-care as expressed by spiritual fatalistic beliefs

However, two studies demonstrated diversity by discussing a spiritually fatalistic view. Control of health and well-being was perceived to be that of a higher being rather than the person; it is described as the absence of physical symptoms and an ability to carry out daily activities. This belief led to non-care health practices instead of actively seeking primary or secondary healthcare support.

The social structure of the AA community has a significant influence on the health and well-being of the individuals and their families. Proactive integration and engagement of these social components will assist in promoting care including ongoing health screening, and early treatment intervention to improve the current health disparities observed within the AA cultural group. Regardless of source, community or religious, a strong social network must be integrated into the act of caring and the approaches for primary, secondary, or tertiary healthcare practices.

Metapattern 1.3: Care as kinship, family, and social psychological support

Metapattern 1.4: Non-care as kinship, family, and social negative influence

Opinions of relatives or friends who had previously experienced a similar health condition were of great importance and influenced whether a visit to the healthcare provider was warranted. There exists a pattern of a strong social and kinship network to provide both caring and non-caring actions that have an influence on the health and well-being of African Americans. The strength of this network influences individual healthcare views and decisions, and ultimately health outcomes. The influence of the social structural factors was exhibited

differently in rural versus the urban groups. The rural community was found to be predominately extended family and kinship relationships. The individuals often live in close proximity to each other providing social, economic, and other caring actions. Generic care practices were passed down through generations and story-telling. AA's help care for each other economically with food, babysitting, and elder care. In the urban setting, the same care pattern emerges, however the social network is less family oriented and more dependent on friends or community resources.

Metatheme 2.0: African Americans expressed both similarities and differences in generic care/non-care beliefs and practices

Metapattern 2.1: Care and non-care of self as a generic view of health and well-being

Metapattern 2.2: Care as generic community involvement and support

Within both settings, generic care patterns included psychological support and community involvement. The men and women in the studies described their health and well-being as being influenced by love, support, and respect provided by family, friends, and support groups. The studies reported a relationship between support and beneficial health outcomes. African Americans will seek care within the community setting first (e.g. family, friends, or professionals) before reaching beyond these boundaries for assistance.

Metapattern 2.3: Non-care as generic folk beliefs, views, and practices

The woman played a significant role providing generic care in this social structure. She is responsible for much of the coordination of care and for physically providing care, often to the exclusion of her own health. The AA culture appears to reinforce the status of the woman as a provider of care and as a sexual figure as several studies indicated women would seek healthcare

secretly for procedures such as hysterectomies or breast procedures to avoid public knowledge of disfigurement, sexual rejection, or spousal opinion.

Healthcare professionals need to be ever mindful of the internal communication networks of the AA communities. These internal communications are a primary source of information exchange and should be considered a cultural care preservation opportunity. The preservation of caring networks includes close family relationships, religious circles, and neighbors or friends. Education and inclusion of these individuals to help provide generic care physically, emotionally, and economically will advance the health of both the person and the AA community at large.

Metatheme 3.0: African Americans expressed both similarities and differences in professional care/non-care beliefs and practices

Metapattern 3.1: Care as embedded within a community culture

Metapattern 3.2: Non-care as expressed by distrust of the professional healthcare system

Within the context of professional care, the social community theme again emerges with several studies replicating similar results. Barriers to seeking professional care included (a) distrust of the healthcare system, (b) absence of same-race healthcare providers, and (c) lack of knowledge or community resources. As previously discussed, African Americans will seek caring assistance within their own community setting first. Effective primary care must be close in geographic proximity to be useful and successful. By placing services close to the patients the challenging economic issues of transportation and childcare can be averted. In addition, same-race healthcare practitioners that are integrated within the community setting would effectively assist to provide health education and professional care where it is most needed. The use of

familiar community leaders, either formally or informally would improve outreach and educational endeavors for improving care.

Metatheme 4.0: Cultural care nursing decisions and actions are effective in promoting health and well-being within the African American culture

Metapattern 4.1: Care as psychological and emotional nursing support

Professional caring and trust are essential to influencing health behaviors for culture care repatterning. Within the AA setting, presence and caring are highly valued and almost considered synonymous with each other. Caring expressions include asking questions and being sincere. Presence can be silent or it can be active listening and reflection. Care as presence creates a nonjudgmental atmosphere promoting trust.

Metapattern 4.2: Care as culturally congruent repatterning

Professional supportive healthcare includes actions that will assist African Americans in successful repatterning of care practices. The strength to change, whether this means pursuing a life-saving treatment for cancer or moving away from a destructive lifestyle requires enabling the person to change behaviors. Empowerment comes from culturally congruent care, support groups, counseling, and reflection upon barriers within environment.

Strengths of the Study

This qualitative metasynthesis was conducted with published research studies of African Americans utilizing the qualitative ethnonursing/meta-ethnonursing method. Leininger's theoretical approach (the Culture Care theory) was not only a core requirement of the selected studies, but used within the meta-ethnonursing method creating a congruent and homogenous research process. The use of a common language from the Culture Care theory with orientational definitions guiding the study supported the credibility and confirmability of the metasynthesis

findings. In addition, the research team was led by doctorally-prepared transcultural nurse researchers who have completed multiple research projects and published extensively utilizing Leininger's theory.

An additional strength was the diverse cultural backgrounds of the research team leaders and members. The cultural diversity within the research team assisted the members to internally discuss and compare the themes with personal life experiences. This process provided a deeper understanding of the meaning in context of various study findings as well as sought in depth relationships among qualitative data and the findings. This self-reflection is an important aspect of qualitative research techniques to improve credibility and confirmability.

The purpose of a metasynthesis study is to synthesize results of individual studies thereby increasing the credibility and transferability of the findings. This ethnonursing metasynthesis has implications in the development of evidence-based guidelines for the culture care of African Americans. The results can be the basis for the development of health care programs and preventive services creating culturally congruent care ultimately improving the health outcomes for this group.

Limitations of the Study

This metasynthesis study was limited to published peer review studies utilizing a qualitative ethnonursing methods and Leininger's cultural care theory. However, published articles are often an abbreviated version of other more comprehensive documents such as doctoral dissertations or master theses. Expanded information from the primary data sources could potentially have strengthened the findings of this analysis.

An additional limitation is related to the current collection of studies available for this metasynthesis. The majority of study participants were located geographically in the eastern half

of the United States and predominately urban based. This may limit the transferability of results to other economic and geographic settings.

Internal bias may exist within the research team. One researcher is African American and the other researchers are Caucasian. All carry care beliefs and practices from past care experiences creating the potential for bias. Qualitative analysis coding requires the researcher to interpret a statement and application of codes to create themes across the various studies. The application of the codes may vary from researcher to researcher based upon lived experiences. Attempts were made to minimize this internal bias by double-coding documents and confirming codes prior to analysis thereby improving the credibility of the results. Research team members exchanged published studies, not only reviewing the coding of others, but supplementing this coding with their own interpretation of the documents.

Implications for Nursing

This metasynthesis was designed to discover universalities and diversities in the culture care expressions, meanings, patterns, and practices of the AA culture. Analysis was conducted throughout the study establishing goals to discover culturally congruent care as it related to the domain of inquiry for this metasynthesis. It is through research, as from this metasynthesis, that the body of knowledge for the development of culturally congruent professional and generic care can be discovered and utilized by nursing professionals. Based on a critical evaluation of research findings discovered within this metasynthesis, implications for nursing practice were discovered.

Cultural Care Practice Modes

Leininger (1996) developed the culture care diversity and universality theory realizing that cultural factors and humanistic care in nursing were vastly overlooked dimensions in nursing

practices. The goal of the theory is to discover culture care expressions, beliefs, and practices that are holistic and culturally congruent in order to provide appropriate care that will render better health care outcomes for culturally diverse groups of people. Leininger developed three action and decision modes within the theory: (a) culture care preservation and maintenance, (b) culture care accommodation and/or negotiation, and (c) culture care restructuring and repatterning (Leininger, 1996). These modes were developed to assist in identifying and confirming data with informants in order to discover congruent and meaningful nursing actions and decisions. “The researcher and informants can decide together appropriate care actions and decisions, which frequently leads to accepting the care offered” (Leininger, 2002, p. 82). In review of the nursing action queries, the results revealed several patterns across studies that resulted in metatheme development. It was discovered that health care providers have the ability to improve care within this culture by incorporating the following suggestions and interventions specific to this population.

Culture care preservation or maintenance refers to the assistive, supporting, facilitative, or enabling actions and decisions by professionals that aid people of a particular culture to retain and/or preserve relevant care values in order for them to maintain their well-being, recover from illness, or face handicaps and/or death (Leininger, 1997). Health care providers must practice care as active listening to seek understanding and gain insight into the client’s interpretation of care, health, and well-being. Providers must remain sensitive to the varied implications of acceptable treatment options within diverse environmental contexts. This metasynthesis discovered that facilitating generic spiritual care expressions within the context of professional caring helps African Americans retain beneficial care beliefs and values. In several studies, spirituality or faith was found to be used as a caring modality during times of illness or death and

provides and promotes a sense of well-being. Cultural care preservation actions would include providing access to religious icons, bibles, and prayer books in the healthcare settings and providing time for prayer and religious expression.

Culture care accommodation or negotiation refers to the assistive, supportive, facilitative, or enabling creative actions and decisions by professionals that aid people of a designated culture to adapt to or to negotiate with others in order to create a beneficial or satisfying health outcome with the professional care provider (Leininger, 1997). In AA families, individuals were likely to seek help from family and friends when a problem or crisis arises. Communication and involvement within their own and by their own culture improves health seeking behaviors. Lay persons from within the community who have personal experience or involvement with specific diseases should be recruited by professionals or supported by professionals to assist in developing support groups, preventative screening, and educational strategies. Providing professional primary care providers of the same race and culture within the geographic community will assist to promote care seeking behaviors and ongoing health maintenance.

Culture care repatterning or restructuring refers to those assistive, supporting, facilitative, or enabling actions and decisions by professionals that help clients reorder, change, or greatly modify their lifeways for new, different, and beneficial health care patterns while respecting the clients culture values and beliefs; therefore still providing beneficial and healthier lifeways than prior to changes being co-established with the clients (Leininger, 1997). This metasynthesis discovered several repatterning and restructuring culture care modes and actions. Culturally congruent educational programs provide important information, aspects of treatment, and the emotional support required when dealing with clients concerns prior to procedures/ treatments serving to improve understanding of disease management. Also, health care providers can use

internal social networks, including the media and religious institutions to promote health screening and early treatment intervention. Incorporation of religious, spiritual, philosophical and cultural values into care can provide support and strength for African Americans as many attempt to change their lives from destructive habits. Nurses are in a position to provide culturally congruent care by referring clients to various support groups and counseling centers.

Nursing professionals can provide care to the AA community, serve on advisory boards at local and state levels, develop interdisciplinary projects, seek funding for these projects and services, and work with federal policy makers to extend programs to reach those in need. Targeting the community at a grass roots level provides a powerful caring opportunity to modify health care patterns, practices, and outcomes.

Recommendations for Future Research

From the beginning of this research came the realization that few studies were available incorporating the qualitative ethnonursing and/or ethnographic method and Culture Care theory. This metasynthesis was conducted by means of the meta-ethnonursing method discovered in “A Descriptive Metasynthesis of Doctoral Dissertations Guided by the Culture Care theory and Using the Ethnonursing Research Method”, by a previous group of graduate nurse researchers (McFarland, et al., 2010). This second metasynthesis was dedicated specifically to the culture care expressions, beliefs, and practices of African Americans.

While conducting this metasynthesis it was discovered that rural areas were not well represented, as the predominance of studies took place in southeastern urban areas within close proximity to higher education facilities. Additionally, the frequency of men taking part surpassed those of women participants; resulting in under representation of female African

Americans. Extrapolated data brought to light the need for further exploration in other environmental contexts of the United States with equal representation of all ages and genders.

Expanding future research to broader geographical regions may assist in discerning evidence-based practice guidelines that may lead to the development of strategies toward elimination of current health care disparities that exist for African Americans and other cultural groups. As researchers further explore the care similarities, expectations, and differences between AA men and women, new discoveries may be helpful in the implementation of care decisions and actions that promote culturally competent care.

Conclusion

Despite advances in healthcare and technology, health care disparities continue to exist for minority groups in the United States. Elimination of health disparities was one of several goals for the Healthy People 2010 effort. However, with entry into the next decade beyond 2010, the nation has fallen short in addressing healthcare disparities concerning some cultural groups. Our current healthcare delivery system has not been successful in improving outcomes for many American subcultures. The African American culture has been especially vulnerable to disparate outcomes not completely explained by traditional quantitative research. The use of qualitative research methods is a relatively new age approach within traditional healthcare research for understanding health disparities.

Implications for Theory Development

Dr. Madeline Leininger has been a pioneer in transcultural nursing research. With her roots in nursing and anthropology, she has brought together the two disciplines in efforts to define theories that help understand the cultural dynamics driving health outcomes for similar and diverse cultures. The concept of care is a critical component of many nursing theorists.

However, Dr. Leininger has focused and expanded on the impact of care through the development of the Sunrise Enabler depicting the Culture Care theory of diversity and universality. Within the care enabler expressions, patterns, and practices are interactive and the result of many environmental influencers. The environmental context molds the social structure and defines diverse cultures' worldview. This dynamic process needs to be understood for successful generic and professional culturally congruent care actions and decisions. The professional healthcare community is only beginning to understand successful healthcare must have an emic approach.

Further implications of this study include theory building, theory development, and discovery of new evidence-based practice care guidelines and standards that can be utilized in expanding nursing knowledge. Expanding on existing knowledge and nursing theories will allow health care professionals to close the gaps between health care disparities and people of diverse cultures. Health care outcomes are affected by the relationships developed with the problem groups of health care professionals. Health care providers possess the ability to influence health care outcomes by providing appropriate knowledge, unconditional care, ongoing support, cultural sensitivity, a non-judgmental attitude, recommending community resources, and participating in the political realm to affect changes and elicit funding for client care.

Cultural Care Theory Assumptive Premises

The metatheme and metapatterns within socio-structural factors of spirituality, kinship, and family support the assumptive premise in the Cultural Care theory which states that “culture-care values, beliefs, and practices are influenced by and tend to be embedded in the worldview, language, philosophy, religion (and spirituality), kinship, social, political, legal, educational, economic, technological, ethnohistorical, and environmental context of cultures” (Leininger,

2002, p. 79). There were strong spiritual, kinship, and social findings that affected African American views, beliefs, and ultimate choices of care or non-care for health conditions. These metapatterns of care were critical to the discovery of culturally congruent nursing actions to influence and current healthcare choices.

Based on the current findings of this metasynthesis, major theoretical tenets and assumptive premises of the Culture Care theory have been substantiated. Culture care diversities and universalities do exist among cultures, including the AA culture. Social structure, religion, education, kinship (social), and generic and professional care factors greatly influence care meanings and expressions (Leininger, 1997). The caring metathemes and metapatterns with both generic and professional care supported the assumptive premise in the Cultural Care theory which states that “every human culture has generic (lay, folk, or indigenous) care knowledge and practices and usually professional care knowledge and practices, which vary transculturally and individually” (Leininger, 2002, p. 79). The caring metapatterns discovered help to understand the African American definitions of care, health, and wellbeing. These current health beliefs and views of care will require both community engagement and professional involvement to assist cultural care negotiation with eventual repatterning of self-care, family, and community behaviors.

Finally, this metasynthesis emphasizes the importance of the assumptive premise in the Cultural Care theory which states that “culturally congruent and beneficial nursing care can only occur when care values, expressions, or patterns are known and used explicitly for appropriate, safe, and meaningful care” (Leininger, 2002, p. 79). The purpose of this study was to discover, describe, and systematically synthesize the culture care meanings, expressions, beliefs, and practices that promote health, well-being, and beneficial lifeways for African Americans.

Evidence based research has supported that preventive care in the form of health awareness, self, and community care are primary care actions taken to prevent chronic disease such as cardiovascular disease, diabetes, and hypertension. The ability to tailor primary care prevention actions in a culturally congruent manner will improve future health and wellness behaviors within the African American cultural group.

Utilizing Leininger's Culture Care theory and ethnonursing research methods in published studies as a base, this research team analyzed the information into a metasynthesis of common metathemes and metapatterns of care that will assist to provide future direction for healthcare professionals. Leininger's theory and Sunrise Enabler (see Figure 1) assisted in translating study findings into nursing care decisions and actions through cultural care preservation/maintenance, culture care accommodation/negotiation, and cultural care repatterning/restructuring. Culturally congruent nursing care could alter the milieu of care in a way that will positively influence African American care expressions, patterns, and practices moving towards holistic health and well-being.

In addition, the studies demonstrated a need for change at the socio-structural level to remove barriers of care and enhance care patterns. Incorporating an emic approach to healthcare requires incorporating professionals, resources and support within the AA community setting. A change of this magnitude cannot be accomplished without a broad political base. It would require sweeping legislative changes and financial support to create incentives for developing and moving resources to the AA cultural community level. Providing care practices from within may remove barriers to care, increase opportunities for interaction, improve trust of the healthcare system, and allow culture care accommodation and repatterning to emerge.

Healthcare is evolving with a greater focus than ever on maintaining and preserving health and wellbeing. The development of beneficial lifeways is a major strategy and new direction from the current illness models that proliferate in the United States healthcare system. Nursing has been a leader in health promotion and health teaching since the days of Florence Nightingale. The essence of nursing has been the holistic approach to care that includes social factors, human relationships, and the impact of the environment upon the body. The ability to apply qualitative meta-ethnonursing research to discover and understand the driving force of culture care beliefs, values, and practices will significantly impact the reduction of disparities that both the healthcare system and the professional healthcare providers aspire to.

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Appendix A

Table 3 Leininger's Phases of Ethnonursing Analysis for Qualitative Data
Fourth Phase <i>Major Themes, Research Findings, Theoretical Formulations, and Recommendations</i> This is the highest phase of data analysis, synthesis, and interpretation. It requires synthesis of thinking, configurations, analysis, interpreting findings, and creative formulations from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and sometimes theoretical formulations.
Third Phase <i>Pattern and Contextual Analysis</i> Data are scrutinized to discover saturation ideas and recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. Data are examined to show patterning with respect to meanings-in-context and along with further credibility and confirmation of findings.
Second Phase <i>Identification and Categorization of Descriptors and Components</i> Data are coded and classified as related to the domain of inquiry and sometimes the questions under study. Emic or etic descriptors are studied within context and for similarities and differences. Recurrent components are studied for their meanings.
First Phase <i>Collecting, Describing, and Documenting Raw Data (Use of Field Journal and Computer)</i> The researcher collects, describes, records, and begins to analyze data related to the purposes, domain of inquiry, or questions under study. This phase includes: recording interview data from key and general informants; making observations and having participatory experiences; identifying contextual meanings; making preliminary interpretations; identifying symbols; and recording data related to the phenomena under study, mainly from an emic focus, but attentive to etic ideas. Field data from the condensed and full field journal is processed directly into the computer and coded.
Leininger, M. (1991). <i>Culture Care Diversity and Universality: A Theory of Nursing</i> . New York, NY: National League for Nursing (p. 95).

(Leininger, 1997, p. 50)

Appendix B

Research Study Attributes

Citation/Source in APA	Category	Theoretical Framework	Methods	Results/Themes	Application to Practice
1-Morgan, M. (1996). Prenatal Care of African American Women in Selected USA Urban and Rural Cultural Contexts. <i>Journal of Transcultural Nursing</i> , 7(2), 3-9.	Women	Leininger	<p>Qualitative ethn nursing study guided by Leininger's Culture Care Diversity and Universality theory.</p> <p>To discover beliefs, practices, and values of African American women related to prenatal care.</p> <p>Discrepancies exist for infant mortality rates between different cultures.</p>	<p>Themes:</p> <ul style="list-style-type: none"> • Health and well being • Professional Health Care • Social Structural Factors • Folk health beliefs and Practices 	<p>Development of care with a trusting relationship, which was found as an important need.</p> <p>Provide safe physical environment for prenatal clinics.</p> <p>Social and educational support through formation of group sessions. Promote alleviation of barriers to prenatal care.</p> <p>Nurses need to explore and understand the folk health care beliefs and practices of the AA women.</p>
Gates, M.F, Lackey, N.R. & Brown, G (2001). . Caring Demands and Delay in Seeking Care in African American Women Newly Diagnosed With Breast Cancer: An Ethnographic, Photographic Study, <i>Oncology Nursing Forum</i> , 28(3), 529-537.	Women	Leininger	<p>Qualitative ethn nursing study guided by Leininger's theory of culture care diversity and universality.</p> <p>Data collected through recorded notes, journal entries, photographs. Information coded using Leininger's phases of ethnographic analysis.</p>	<p>Themes:</p> <ul style="list-style-type: none"> • Caring for others and self as meaningful. • Generic and professional caring from others as supportive response. • Non-caring as delaying women to seek treatment and diagnosis. 	<p>Development of nurses to advocate assertiveness of African American women in seeking help for breast cancer symptoms. The fostering of this research was particularly helpful as an intervention for the women and their experiences during the treatment process.</p>
3-Prince, L. M., (2008). Resilience	Women	Leininger	<p>Qualitative ethnographic research method</p>	<p>Themes -</p> <ul style="list-style-type: none"> • How they viewed 	<p>Development of positive social connectedness and the ability to maintain a strong</p>

<p>in African American Women Formerly Involved in Street Prostitution. <i>The Association of Black Nursing Faculty, Winter 2008, 31-36.</i></p>			<p>used to discover the emic views of minority women in relation to their culture and resilience during their transition from prostitution. Leininger's theory of culture care was used to guide nursing care decisions and actions for this group of African American women recovering from prostitution.</p>	<p>resilience</p> <ul style="list-style-type: none"> • Contextual Process of Growth • Spirituality • Support Systems 	<p>spiritual belief was found to be a focus for nurses wishing to work closely with the private sector and hospitals who serve the African American women in these situations.</p>
<p>4-Ehrmin, J.T. (2002). "That feeling of not feeling": Numbing the pain for substance-dependent African American women. <i>Qualitative Health Research, 12(6), 780-791.</i></p>	<p>Women</p>	<p>Leininger</p>	<p>Leininger's Culture Care Diversity and Universality Theory of Nursing was used to conceptualize themes and results from this qualitative study. Ethnographic methods were used to determine the meanings and expressions of recovery care that was specific to culture with ideas formulated from the women themselves.</p>	<p>Two Major Themes: 1) Numbing the pain 2) Sources of emotional pain: subthemes developed here</p> <ul style="list-style-type: none"> • The pain of the death of loved ones • The pain of prejudice • The pain of rejection • The pain of physical abuse • The pain of incest and sexual abuse 	<p>It is essential or African American Women to exclude drugs and/or alcohol as a means for numbing their pain and to successfully move through treatment and maintain sobriety through other coping strategies. Expression of emotions is a key component to working with African American women based on cultural values and beliefs.</p>
<p>5-Wittig, D. (2001). Organ donation beliefs of African American women residing in a small</p>	<p>Women</p>	<p>Leininger</p>	<p>Qualitative ethn nursing study to discover the cultural care beliefs and practices of selected African</p>	<p>Theme development of religion and kinship ties related to decision for organ donation.</p>	<p>Development of cultural care modalities utilizing the Sunrise Enabler for the provision of culturally congruent care.</p>

Southern community. <i>Journal of Transcultural Nursing</i> , 12(3), 203-210.			American women regarding organ donation.		
6-Augustus, C. (2002). Beliefs and perceptions of African American women who have had hysterectomy. <i>Journal of Transcultural Nursing</i> , 13(4), 296-302.	Women	Leininger	Qualitative ethn nursing, ethnographic design to identify cultural beliefs within an African American community related to beliefs surrounding hysterectomy care	Theme development <ul style="list-style-type: none"> • Cultural myths, fears, sexual symbolism • Benefits including freedom from pain, public embarrassment, and risk of pregnancy • Improved self-esteem and sexuality 	Development of cultural sensitive care to avoid unnecessary delays for treatment of African American women.
7- Ehrmin, J. T. (2005). Dimensions of Culture Care for Substance-Dependent African American Women. <i>Journal of Transcultural Nursing</i> , 16(2), 117-125.	Women	Leininger's Sunrise Enabler	Ethnonursing qualitative research study. Ethnonursing techniques of participant observation and focused in-depth interviews were used to collect data.	Four universal culture care themes: <ul style="list-style-type: none"> • Taking time to listen, acknowledgement, respect • Learning reciprocal support with other recovering women • Guidance that fits cultural values • Concern about resolving past cultural pain experiences 	Findings can be used to assist nurses in providing culturally congruent care when practicing with women from diverse cultural backgrounds in treatment and recovery for substance abuse.
8-Canty-Mitchell, J. (1996). The caring needs of African American male juvenile offenders. <i>Journal of Transcultural Nursing</i> , 8(1), 3-12	Adolescent	Leininger	Ethnonursing methods were used to obtain and describe the social and cultural care needs of this population. Data were collected and analyzed using Leininger's Observation-Participation-	The major theme developed: Survival in the face of loss <ul style="list-style-type: none"> • Subthemes of losses: loss of caring, loss of protection, a loss of discipline, and a loss of support. • Losses were then sub- 	Implications developed from Leininger's three modes of culture care: culture care preservation, cultural care accommodation, and cultural care re-patterning. These three modes are essential for guiding nursing actions and decisions when caring for African American male juvenile offenders.

			Reflection Enabler method.	categorized into domains three domains: family losses, social losses, and self-identity losses. (Each subtheme posses these three domains.)	
9- Ohm, R. (2003). The African American experience in the Islamic faith. <i>Public Health Nursing</i> , 20(6), 478-486	Holistic Care	Leininger's Sunrise Enabler	Ethnonursing model of data collection served as the framework for data collection and analysis. Qualitative approach	The Islamic faith and "way of life" is an example of a holistic approach to promoting wellness of the individual, family, and community. Many of the restrictions central to the religion serve to prevent disease.	Identification of health protectors may prove key in decreasing health disparities.
10. McFarland, M. R. (1997). Use of Culture Care theory With Anglo-and African American Elders in a Long-Term Care Setting. <i>Nursing Science Quarterly</i> , 10, 186-192	Elders	Leininger	Ethnonursing qualitative research method	Four major themes: <ul style="list-style-type: none"> • Residents expressed and lived generic care to maintain their preadmission lifeways • Nursing staff provided care to support satisfying lifeways • Institutional care patterns viewed as a continuing life experience but with major differences • Culture of retirement home reflected unique lifeways 	Themes revealed new modes of care for the elderly in an institutional setting.
11- Plowden, K. O. (2006). To Screen or Not To screen: Factors influencing the decision to participate in	Men	Leininger	Ethnographic interviews conducted to explore social factors influencing a decision to participate in prostate cancer	A decision to receive screening was based on three critical factors: <ul style="list-style-type: none"> • Importance of significant others • Receiving knowledge 	These factors should be considered in the design of prostate cancer programs targeting urban African-American men.

prostate cancer screening among urban African American men. <i>Urologic Nursing</i> , 26 (6), 477-482.			screening among urban African-American men age 40 and over	<ul style="list-style-type: none"> • Having adequate knowledge of the disease and screening recommendation 	
12. Plowden, K.O., John, W., Vasquez, E., & Kimani, J. (2006). Reaching African American men: A qualitative analysis. <i>Journal of Community Health Nursing</i> , 23 (3), 147-158.	Men	Leininger	<p>Ethnographic methods were used to guide this qualitative study and satisfy three goals:</p> <ul style="list-style-type: none"> • Identify new and unexplored data of interest to gain new understanding of health beliefs and practices of African American men and ways of reaching them. • Support other established hypothesis about reaching African American men. • Generate new research questions in an area of men's health with where little data is available. 	<p>Three major themes were discovered:</p> <ul style="list-style-type: none"> • A trusted and respected community member providing the outreach • A perceived safe and caring environment during outreach • A perceived benefit from participating in the outreach 	Health care professionals need to be conscientious about culture care considerations related to African American Men in developing effective outreach initiative program
13- Plowden, K., & Young, A. (2003). Sociostructural factors influencing health behaviors of urban African-American men. <i>Journal of</i>	Men	Leininger	<p>Qualitative, ethnography, study to explore social structure factors that motivate urban African American men to seek care. Interviews to understand and explore</p>	<p>Theme development critical social factors:</p> <ul style="list-style-type: none"> • Kinship / Significant others • Accessibility of resources • Ethnohealth belief • Accepting caring environment 	Development of health promotion strategies targeting AA men. Correct motivators and removing t. obstacles for seeking care. Creating a community of caring for program implementation. Public policy development of effective prevention and control strategies

<i>National Black Nurses' Association, 14(1), 45-51.</i>			understanding, attitudes, and beliefs about health.		
14- Plowden, K., & Wenger, A. (2001). Stranger to friend enabler: creating a community of caring in African American research using ethnonursing methods. <i>Journal of Transcultural Nursing, 12(1), 34-39.</i>	Faith Community	Leininger Enablers Ethno-nursing	Explores/identifies enablers to assist development of a caring environment for African Americans within an ethnonursing research design.	Describes Leininger's Strangers to Friend research enabler for successful data collection within 2 faith communities	Demonstrates ethnonursing methods in two faith community studies

Appendix C

Notification of Institutional Review Board Approval

Subject: eResearch System-Generated Notice of “Not Regulated” Status for HUM00030844

SUBMISSION INFORMATION

Title: A Metasynthesis of culture care expressions, beliefs, and practices of African American care utilizing Leininger’s Theory of Culture Care Diversity and Universality

Full Study Title (if applicable): A Metasynthesis of culture care expressions, beliefs, and practices of African American care utilizing Leininger’s Theory of Culture Care Diversity and Universality

Study eResearch ID: HUM00030844

Date of this System-Generated Notice: 9/18/2009

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 approval is not required as the data cannot be tracked to a human subject.

Appendix D

Research Activity Timeline (Using Leininger Phases of Ethnonursing Analysis)

Phases	I	II	III	IV
Phases	Collecting Raw Data	Categorization of Descriptors and Components	Pattern and Contextual Analysis	Theme, Findings, and Recommendations
Time Frame	9/ 2009-12/2009	1/2010-5/2010	6/2010-9/2010	10/2010-3/2011
Types of Activities	Research/Search, Review of Literature, Review Metasynthesis & Methodology, Careful Selection of Studies w/use of Inclusion/Exclusion Criteria	Reading studies and comparing Commonalities & Differences, Begin Coding Process	Coding & Input to NVivo-8 Qualitative Software	Reclarification, Saturation, Reflection on Studies, Reconfirming with Researchers and Seasoned Thesis Chairpersons

Appendix E

Published African American Ethnonursing Studies (Category Coding)

1. Prenatal Care of AA women in Selected USA Urban and Rural Cultural Contexts
2. Caring Demands and Delay in Seeking Care in African American Women Newly Diagnosed with Breast Cancer: An Ethnographic, Photographic Study
3. Resilience in African American Women Formerly Involved in Street Prostitution
4. That Feeling of Not Feeling: Numbing the Pain for Substance Dependent AA Women.
5. Organ Donation Belief of AA Women Residing in a Small Southern Community
6. Beliefs and Perceptions of AA Women Who Have Had Hysterectomy
7. Dimensions of Culture Care for Substance Dependent AA Women
8. The Caring Needs of AA Male Juvenile Offenders (child/Adolescent)
9. The AA Experience in the Islamic Faith (Holistic)
10. Use of Culture Care theory With Anglo-and African American Elders in a Long-Term Care Setting.
11. To Screen or Not to Screen: Factors Influencing the Decision to Participate in Prostate Cancer Screening Among Urban AA Men
12. Reaching AA Men A Qualitative Analysis
13. Sociocultural Factors influencing health behaviors of urban AA men
14. Stranger to Friend Enabler: Creating a Community of Caring in AA Research Using Ethnonursing Methods.

Categories

- Red**: Women (7)
- Green**: Elderly (1)
- Blue**: Men (3)
- Pink**: Child/Adolescent (1)
- Black**: Spirituality/Holistic Care (1)
- Purple**: Community (1)

Appendix F

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>
10	<i>Disparities*</i>
11	<i>Disparities of a population*</i>

CATEGORY II: DOMAIN OF CULTURAL AND SOCIAL STRUCTURAL DATA

(Includes normative values, patterns, function and conflict)

12	Cultural values, beliefs, norms
13	Economic factors
14	Educational factors

- 15 Kinship (family ties, social network, social relationships, etc)
- 16 Political and legal factors
- 17 Religious, philosophical, and ethical values and beliefs
- 18 Technological factors
- 19 Interpersonal relationships (individual groups or institutions)
- 20 *Recreation**

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

- 21 Folk (includes popular health and illness beliefs, values, and practices)
- 22 Professional health
- 23 Human care/caring and nursing (general beliefs, values, and practices)
- 24 Folk care/caring (emic or indigenous beliefs, values, and lifeways)
- 25 Professional care/caring (etic beliefs, values, lifeways)
- 26 Professional nursing care/caring (etic and emic) lifeways (congruence and conflict areas)
- 27 Non-care/caring beliefs, values, and practices
- 28 Human cure/curing (general ideas, beliefs, values, and practices)
- 29 Folk cure/curing (emic beliefs and practices)
- 30 Professional cure/curing (emic and etic perspectives)
- 31 Alternative (new) or emergency care/cure systems
- 32 *Caring for others (resident to resident)**
- 33 *Reciprocal care**
- 34 *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**
- 48 *Prevention and health promotion**

CATEGORY V: LIFE CYCLES AND INTERGENERATIONAL PATTERNS

(Includes Ceremonies and Rituals)

- 49 Life cycle male and female socialization and enculturation
- 50 Infancy and early childhood
- 51 Adolescence or transitions to adulthood
- 52 Middlescence
- 53 Advanced years
- 54 Cultural life cycle values, beliefs, and practices
- 55 Cultural life cycle conflicts and congruence areas (i.e., intergenerational)

- (independence vs. dependence)
- 56 Special subculture
- 57 Life passages (i.e., birth, marriage, death, etc)
- 58 *Additional life passages in retirement home (nursing home to apartment, apartment to nursing home, entering home)**
- 59 *Acculturation, assimilation, adjustment to retirement home**
- 60 *Anger, emotional pain, guilt, and shame**
- 61 *Incest, sexual abuse, physical abuse, and rape**
- 62 *Trust**

CATEGORY VI: METHODOLOGICAL AND OTHER RESEARCH

FEATURES OF THE STUDY

- 63 Specific methods of techniques used
- 64 Key informants
- 65 General informants
- 66 Enabling tools or instruments used
- 67 Problem areas, concerns, or conflicts
- 68 Strengths, favorable and unanticipated outcomes of researcher and informants
(i.e., subjective data and questions)
- 69 Unusual incidents, interpretations, and questions, etc.
- 70 Factors facilitating or hindering the study (i.e., time, staff, money, etc)
- 71 Emic data
- 72 Etic data
- 73 Dialogue by interviewer

- 74 Dialogue by someone other than informant or interviewer
- 75 Additional contextual data (including non-verbal symbols, total view, environmental features, etc)
- 76 Informed consent factors

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

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April 27, 2011

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Paula Stock, Author
Dr. Hiba Wehbe-Alamah, Chairperson
Dr. Marilyn McFarland, Co-Chairperson
Dr. Margaret Andrews, Co-Chairperson

Greetings,

Based on the information you provided:

Title: *A Descriptive Metasynthesis of Culture Care Expressions, Beliefs, and Practices of African Americans Using the Ethnonursing Research Method*

Purpose: *Masters Thesis*

You have been granted the use of Dr. Leininger's Theory and Enablers for your project providing you agree to the following:

- (1) The enablers are not altered in any way with the exception of rendering it to black and white during copying or preparation for publishing.
- (2) The enablers are not translated into another language.
- (3) The enablers are not distributed in a for-profit publication other than the inclusion of your work in a peer-reviewed journal.
- (4) You provide proper citation of Dr. Leininger's work.
- (5) You provide a copy of your work in electronic form to the Leininger Archive at Florida Atlantic University (nurarchives@fau.edu).

Dr. Leininger wishes you well in your endeavors.

Cordially,

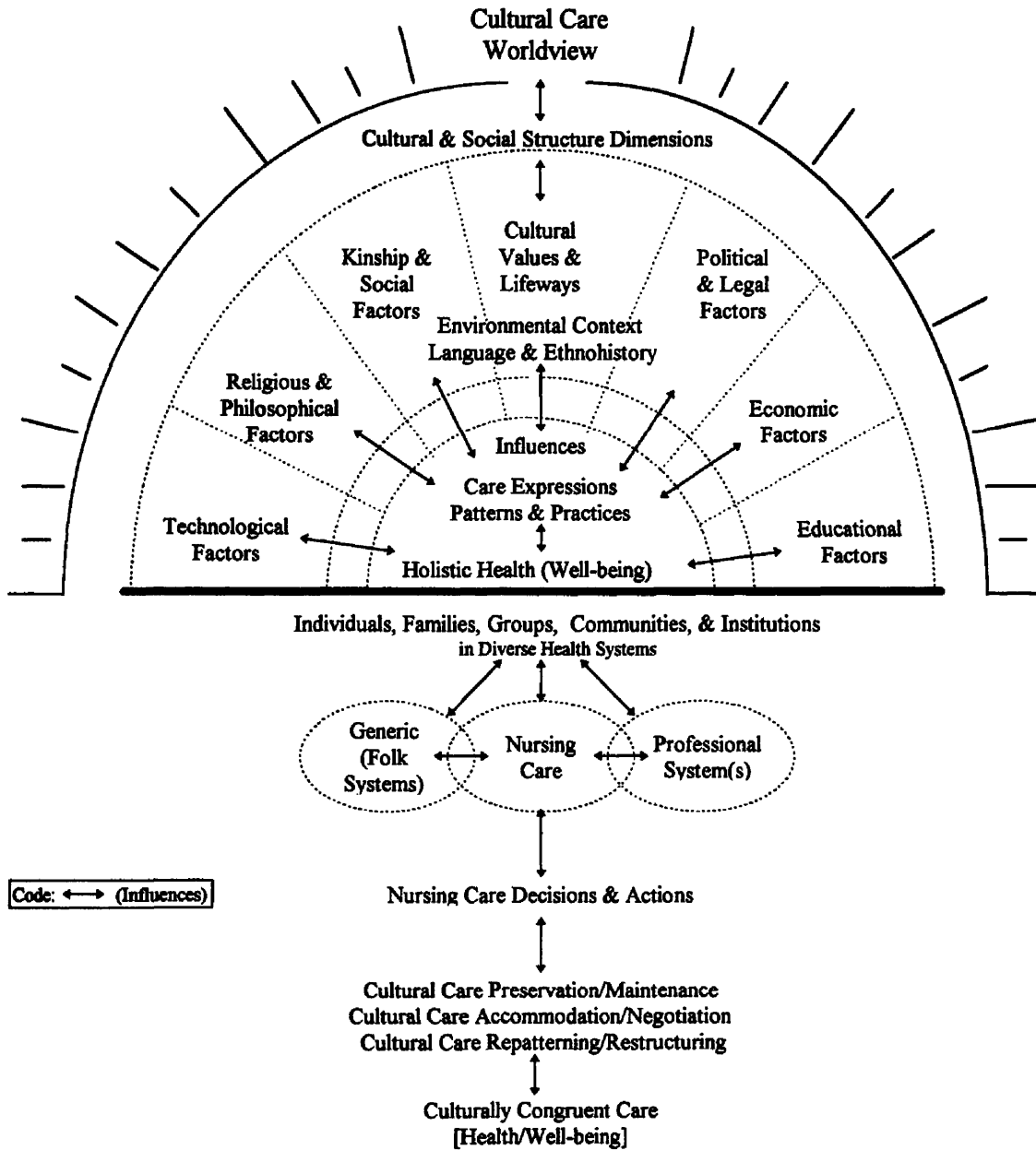


John S. Vanderlaan, RN, MSN, CEN, CTN-A
Assistant to Dr. Leininger

cc: Dr. Madeleine Leininger

Figure 1

Figure 1
Leininger's Sunrise Model to Depict the Theory of Culture Care Diversity and Universality



Note: From *Culture Care Diversity and Universality: A Theory of Nursing* (p. 43, Fig. 1, Sunrise Model), by M. M. Leininger, 1991, New York: National League for Nursing Press. Copyright 1991 by National League for Nursing Press. Adapted with permission.

Figure 2: Study participant's ages and gender.

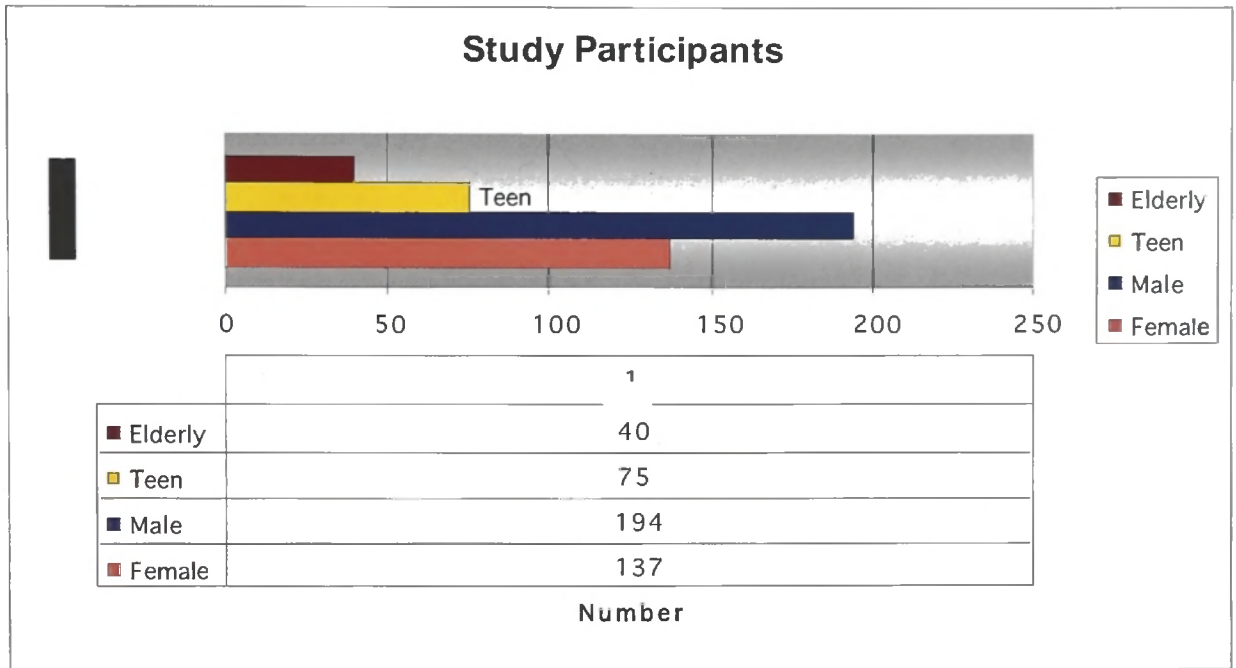


Figure 3: Settings where studies occurred and number of participants in those areas.

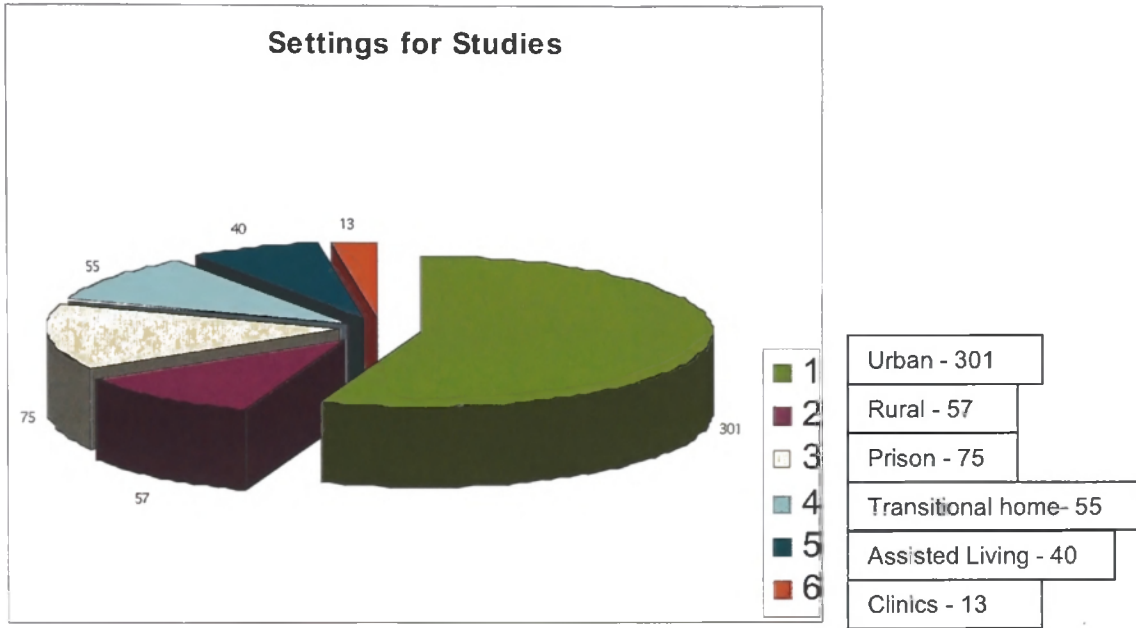


Figure 4: Map of Urban vs. Rural areas in the United States prepared by the Secretary for Health for Policy and Planning.

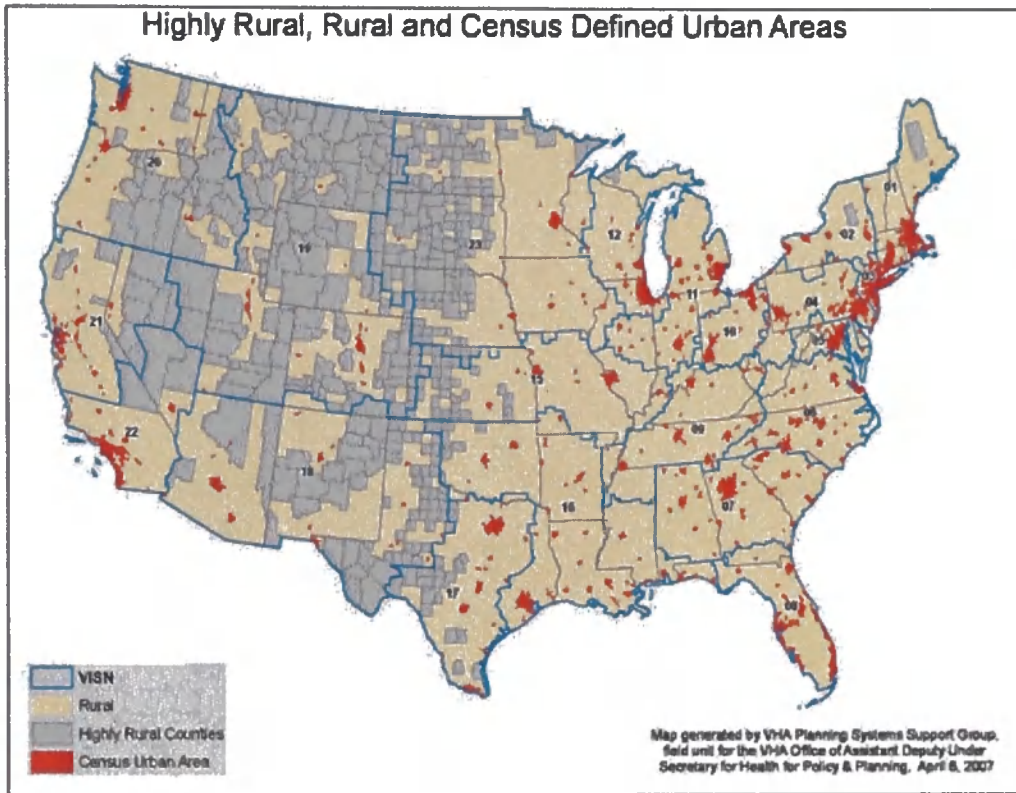


Figure 5: Demographic Locations in the United States where studies were concentrated.

