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A dimensional analysis of the process Lebanese immigrants use to conceptualize health

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A Dimensional Analysis of the Process Lebanese Immigrants Use to Conceptualize Health

by

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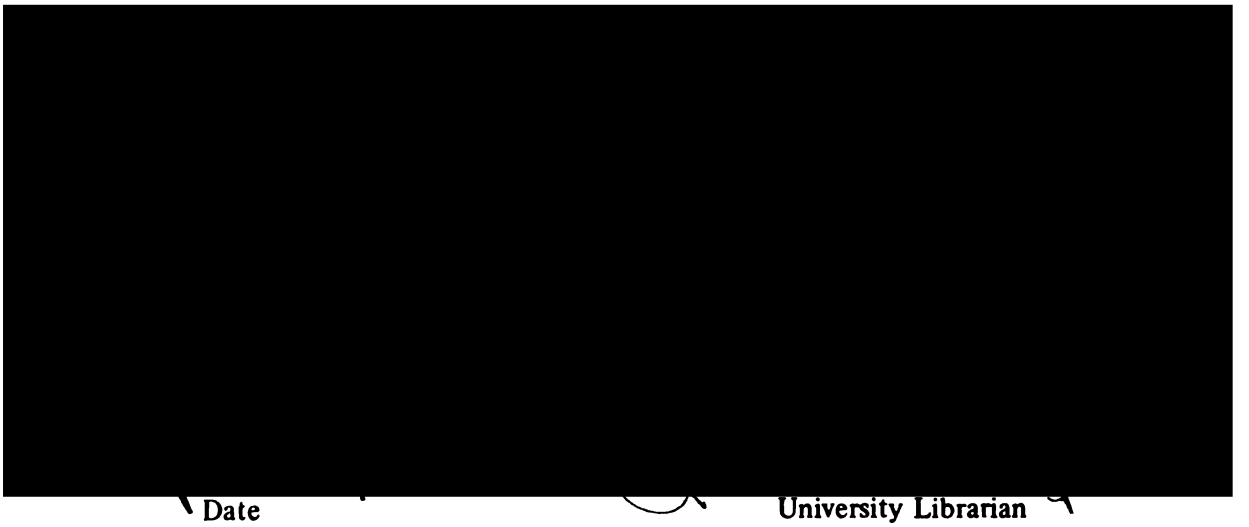

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CHAPTER I

Introduction

My experience working as a midwife in the Yemen Arab Republic for 2 years led to my initial interest in working with the Middle Eastern population in Australia. At a later date I worked for the South Australian Health Commission as a researcher to discover the health needs, practices, and health care services for the major ethnic groups represented in South Australia (Paech, 1983). Of these groups, the Lebanese population represented a majority of the Arab population as a whole and was said to be at risk in terms of health and health care service utilization in Australia (Scott, 1980).

As a continuation of my interests in the health care needs of the Middle Eastern population, my research in the United States has focused upon the health and health care needs of the Lebanese population in the United States. Abraham and Abraham (1983), estimated that 2-3 million Arabs lived in the United States. In 1975, prior to the Lebanese civil war, 90% of the Arabs who immigrated to the United States were Christians of Lebanese descent. Since 1975, the major influx of Middle Eastern immigrants has been Palestinian and Lebanese, due to the ongoing political strife in the Lebanon. Consequently, the need for the health care system to consider the particular health needs of the Lebanese American has increased. Meleis (1981) stated that the Middle Eastern Americans' differences in ideas, concepts, and beliefs pose more complex and subtle issues for health care providers than difficulties with English. Exploration of the actual ideas that Lebanese Americans have

concerning health aid nurses who provide health care to give appropriate and beneficial assistance (Foster, 1976; Leininger, 1978).

Purpose and Related Questions

This study was designed to:

1. Describe the health conceptions of Lebanese Americans.

2. Analyze and interpret data obtained in observations and interviews.

3. Provide nurses with a model for interaction with this specific aggregate.

Specific responses were sought for the following questions:

1. How does this population conceptualize its health?

2. What important factors relate to matters that account for health that are significant for the people?

3. What factors relate closely to health conceptualization that have significance for health care providers?

Statement of Concern

The issue of concern for this study was to discover the health conceptions of Lebanese Americans. This statement focuses the inquiry, but it is also recognized as a limitation on the perspectives that may occur in the social context of the phenomena under investigation.

Significance of the Study

Boulding (1961) has stated that any person has a largely unself-conscious image of one's own society. The representation of the society is handed down by others in an unquestioning and unself-conscious manner. A visiting inquirer, on the other hand, has a self-conscious image of the same society. An emic analysis actually

defines the perceptions and classifications made by members of a particular community (Tripp-Reimer, 1984).

Laffrey (1983) stated that how one defines health is more closely related to one's reason for engaging in health behavior than to how healthy or unhealthy one believes oneself to be. Consequently, an inquiry describing health conceptions and health practices among Lebanese Americans not only furthers understanding, but provides practical ideas for implementation of health care, information which can be transferred to nurses. Nurses who are relatively unfamiliar with the socio-cultural and historical context of the Lebanese American people can gain some factual information about their conceptions of health in order to overcome mutual misunderstandings which inhibit the effectiveness of health care (Lipson & Meleis, 1983).

Although numerous articles in the literature focus on health and health care of Arabs in general, relatively few are research-based. Lipson & Meleis (1983) stated that while Middle Easterners differ in their characteristics from country to country, most American health professionals view them as similar. For example, it is virtually impossible to discover the unique characteristics of each ethnic group in a country as heterogeneous as Lebanon from the literature published in English. In a place where ethnic identification has become a matter of life and death due to religious group membership, religious sects assume an importance not commonly found in the West (Starr, 1978). Therefore, it was reasonable to study one particular religious group.

Moslems constitute approximately one half of Lebanon's population. Thirty percent of the Christians are Maronite and 10% Eastern Orthodox. The Eastern Orthodox tended to stay in the English-speaking education

system and the Maronites in the French system (Starr, 1978). American missionaries set up schools as early as the nineteenth century, so it is understandable that Eastern Orthodox members might have made English their second language (to Arabic); Maronite members are likely to be French-speaking. The 90% of Lebanese Christians who arrived in the U.S. before 1924 were either Eastern Orthodox or Eastern Catholics, although since coming to America it is possible that these differentiations have merged to a lesser or larger degree according to availability of churches and a cluster of a specific gathering of people (Wakin, 1974). There is no available research pertaining to the health conceptions of Eastern Orthodox Christians of Lebanese descent, and only scant literature about health rituals and health practices among Christians in general (Howell, 1970; Smith, et al., 1969).

The data analysis of this study hopefully provides nurses with a framework for viewing the health conceptions of Lebanese Americans. The model, developed here, lays a base for further inquiry into health and health care. The knowledge base can assist nurses to assess and evaluate the health needs of the Lebanese American, to plan and make policies for appropriate health services, and provide a guide in respect to expectations about health care practices in the United States. Utilization of these data for group comparison may also help to further understanding of the unique needs and differences, not only of ethnic groups, but of specific aggregates within the Lebanese community, for example, religious groups, and of the dynamics particular to each individual.

Hypothesis

Explicitly formulated hypotheses do not necessarily apply to original research although observations confirm or modify speculations or assumptions in one's own thinking. It is possible that during the analysis a hypothesis may be indicated (Schatzman & Strauss, 1973). Therefore no specific hypothesis was formulated in advance.

Definitions of Terms

Definitions clarify the area of study and help to give the reader an idea of the inquirer's bias.

1. Health: Concepts of health vary from individual to individual and are likely to fall into any of the four categories of health elucidated by Smith (1983). Those four categories included the clinical, in which health was viewed as the absence of disease or symptoms; role performance, in which health was viewed as the ability to fulfill socially defined roles; the adaptive, in which health was viewed as flexible adjustment to the environment; and eudaimonistic, in which health was viewed as exuberant well-being.
2. Conception: an abstraction of an idea or a general notion (Webster, 1970).
3. Lebanese American: a person of Lebanese descent of the 1st, 2nd or 3rd generation, living in the United States.

The general idea of health, rather than a more precise definition of health, was chosen as the focus of this study. According to Meleis (1981), Arabs used generalized and global descriptions to describe health notions rather than concise, individualized ones. Also, Arab Americans sought understanding of phenomena by examining the entire web of circumstances in which they occurred (Lipson & Meleis, 1983).

Any phenomenon, whether an idea or a more concrete reality, has a symbolic quality, and the social determinants of perception are a necessary concomitant of the perceived entity. This way of interpretation is denied by an ideology or epistemology which regards its creations as being "out there." The concept of health must be viewed within the social nexus that gives it life. Otherwise, one may be prone to the illusion, ubiquitous in Western culture, of reification, something in which the biomedical model is expert (Lukacs, 1971). Discussion is needed to discover what is implicit to see how the processes of social relations can be mapped into concepts and their symbolic significance.

Elucidation of a person's model of health aids the health worker's understanding of a different construction of reality. As Kleinman, Eisenberg, and Good (1978) stated, education by the health provider with regard to being able to negotiate different cognitive and value orientations, "may well be the single most important step in engaging the patient's trust" (p. 257).

CHAPTER II

Review of the Literature

This chapter contains two sections: a discussion of literature pertaining to health conceptualizations and health behavior, and a review of the literature available in the English language relating to the notion of health of Lebanese Americans. The review of the literature was carried on in the process of data analysis, largely as a result of the salient ideas which were discussed by participants in the study. Because most of the people interviewed did not know where their knowledge originated, a critical analysis from a historical perspective pertaining to origins of ideas was gained through the literature search.

The use of the grounded theory approach used in this study is enhanced when the researcher is well informed in the literature that deals with both kinds of variables and their associated general ideas. Familiarity with the literature and with the ways of constructing variables in other fields enhance the development of substantive theory. Thus, the review of literature is an important section in any qualitative research.

In fact, the literature review concerning Arab health care can be seen as a legitimate part of the methodology. There is a connection between world view, environment, and behavior. Assumptions about reality depend upon and affect the actual perception of phenomena. The assumption here is that theory and practice are the necessary sides of the same coin. Ideas, the result of mental work, must accurately analyze historic conditions so that they can point the way forward. At the same time, the application of ideas provides a test of validity (Kearney, 1984).

Health Dimensions

Investigators analyzing major theories of nursing have proposed that the health construct is central to nursing (Fawcett, 1980; Stevens, 1979; Winstead-Fry, 1980). Health has been variously defined as an absolute entity, a state, a process, a goal, and an equilibrium. The health construct has been viewed in three ways: (a) a dichotomous variable, (b) a continuum, and (c) a more inclusive holistic state (Tripp-Reimer, 1984). Some leaders in nursing, however, question whether the construct of health is really the foundation of nursing, or if it is used as a vehicle to accomplish professional independence (Fawcett, 1980; Styles, 1982).

The literature is organized according to current studies in the topical field. The first part deals with research carried out in the area of health conceptualization. These studies represent a cross-section of people from the United States, from France, and from Mexican-Americans. The second part deals with health behavior models largely guided by Laffrey's (1984) classification based on Maslow's behavior types (1966).

Health Conceptualizations

Baumann (1961) classified responses to inquiries about what 201 clinic patients and 260 medical studies meant when they said they were in good physical condition: (a) feeling state, defined as a general feeling of well-being; (b) symptom-oriented, defined as the absence of general and specific symptoms of illness; and (c) performance orientation, defined as what a person who is in good physical condition should be able to do.

Furthermore, Hautman and Harrison (1982), in their study of middle-income Anglo-Americans, encountered descriptions of health similar to those found by Baumann (1961), yet they also noted other distinct criteria of health like "having energy," "no pain," "few doctor visits." In this study, the most frequently cited response, however, was the "absence of sickness." Illness-oriented definitions, according to Zola (1983), are traditionally American and can be seen as consistent with the view that persons in a "medicalized society" view themselves in terms of their illnesses.

In fact, Natapoff's (1978) developmental study on children's views of health found that the concept of health was separately defined from illness. As the age of the children increased, health conceptions became broader and included more statements. Herzlich (1973), in a study conducted in France using grounded theory methodology, found that the perception of health was a very individualized process. Each person perceived social reality in a unique way by integrating impressions that were considered to be important in the life context. Illness was thought to be affected by environmental factors, that, aside from their own life styles, were regarded to be beyond their control. Similarly, d'Houtlaud and Field (1984), also in France, found that the factors contributing to a definition of health were life perspective, personal values and attitudes, illness prevention, health maintenance, and certain health measures.

In a study of the perceptions of health and illness associated behaviors among a Mexican-American farm worker population in the United States using the grounded theory approach, O'Brien (1982) found significant relationships between perception and experience of illness,

health-seeking behaviors, and treatment response. Health attitudes and behaviors were aligned to practical survival and folk practices were used more than professional treatments, although both could occur together. Folk healers were preferred because they were interested in caring for the person and involved the family in discussions. Health behavior was influenced by economic constraints, limited education, ethnic and occupational group membership. Health treatment choices were limited according to socioeconomic status. Illness was viewed as a social event and subjective experience of illness was adjusted to meet the expectations of the group. Consequently, after symptom relief was provided, people no longer believed themselves to be ill.

On the other hand, Laffrey (1982) found a significant relationship between a person's health definitions and their reasons for engaging in a variety of health behaviors. The sample population were healthy adults from the Mid-West suburbs in the United States. Persons who defined health as absence of disease or illness gave many more illness prevention reasons for their health behaviors. Persons who defined health as realization of higher potentials gave more health promoting reasons for their behaviors.

Yet, there is a possibility that experience with chronic disease can influence one's concept of health and self. Gendron (1984) points out that persons with diabetes "have a diffuse or conflicted self-concept relative to sickness and wellness" (p. 29). Newquist (1983) proposed that popular conceptions of health, sickness, and disability are a product of an era of acute illness. When applied to chronic illness experiences, these notions are atavistic. In a small sample of persons with arthritis, health was seen as "the absence of

sickness," and the "ability to function." Most of the participants viewed health conceptually as "a transient state in time," some saw it as a possession. When viewed as a possession, health was defined as "resistance capacity," that is, the ability to keep away sickness.

The human experience of health was considered to be the appropriate focus in the studies cited, which is the approach suggested by Idler (1979) for inquiries into "health." As Davis (1978) pointed out, an original experience antecedes clear conceptualizations. Thus, it is important for an inquirer to describe the health experience from the point of view of the participant, rather than impose structures on these experiences by an a priori means such as a hypothesis, thereby allowing for the empirical fact that multiple realities exist. Price-Williams (1975) pointed out the difficulty in characterizing the health state of clients from another culture using the etic perspective (externally derived criteria) of Western biomedicine. The emic approach opposes the etic and is a subjective perspective which describes the phenomena as it is viewed by the person. The information gained by this process of inquiry can be readily translated into clinical terms applicable for practice (Lipson, 1984).

Although concepts of health may vary from individual to individual, an attempt to generalize these concepts is pragmatic. Smith (1983) discovered through a review of the literature that a large number of health definitions can be subsumed within four categories:
(1) clinical, in which health is viewed as absence of disease or symptoms; (2) role performance, in which health is viewed as ability to fulfill socially defined roles; (3) adaptive, in which health is viewed as flexible adjustment to the environment; and (4) eudaimonistic, in

which health is viewed as exuberant well-being. These ideas or conceptions of health were not mutually exclusive, but rather were considered by Smith to be progressively more complex, with each conception including the concerns of the preceding one. Smith (1983) stated that one's practice is directed toward a different goal depending upon the conception of health held. The conception of health needs to be known so that nursing care can be based on an understanding of the patient's experience and perception of reality.

Health Behavior Models

Health behavior has been defined in a number of ways and a wide variety of indicators have been used. Laffrey (1984) described a number of models which are used to help understand and explain people's health behavior. This classification includes illness prevention, health maintenance, and health promoting categories.

Illness prevention models. The National History of Disease (Leavell & Clark, 1965) classified health behavior through the various stages of disease. It recognized three levels of prevention: (a) primary prevention is applied to eliminate disease. Three factors determine causation of disease: the agent, host, and environment, all of which are interrelated. (b) secondary prevention requires early diagnosis and treatment and is applied during the period of pathogenesis. (c) tertiary prevention is applied when the affect of disease has occurred and rehabilitation is indicated. This is an epidemiological model focusing on disease detection, early diagnosis and treatment. Health promotion is a dimension of primary prevention.

According to the Health Belief Model (Becker, et al., 1977), illness preventing behavior is determined by an individual's perceived

susceptibility to an illness coupled with the individual's perceived severity of the consequences of getting the disease. In addition, The Health Belief Model asserts that the individual will be more likely to take preventive action if the perceived benefits outweigh the costs of taking the proposed action. A cue to action, such as a symptom or advice from a friend, must also occur to "trigger" the appropriate action. In asymptomatic diseases, the lack of an inward cue and the salience of susceptibility is noteworthy; it is required that a person believe that he can have the disease in the absence of evidence.

Health maintenance models. Health maintenance models are in fact preventive models, but with a stronger health orientation than the illness preventing models. The Health Protective Behavior Model (Harris & Guten, 1979) was based on self-perceptions of health protective behaviors. The most frequently reported behaviors were nutrition, sleep or relaxation, and physical activity. Some of the reasons given for practicing each behavior were enjoyment and pleasure. The health protective measures included personal routine, safety, environmental hazard avoidance and harmful substance avoidance. Minkler's (1978) research found that low-income respondents did not engage in many health behaviors although they believed in the effectiveness and importance of the behaviors being measured.

Health promotion model. The assumption that people play an active role in improving their health status is the basis for the health promotion model. Pender (1982) identified eight factors which have motivational significance for engaging in health-promoting behaviors: (a) the importance of health, (b) perceived control, (c) desire for competence, (d) self-awareness, (e) self-esteem, (f) definition of

health, (g) perceived health status, and (h) perceived benefits of health-promoting behaviors. Although each factor is important for the motivation of health-promoting behavior, Pender (1982) believes the definition of health not only influences the extent to which an individual engages in health behaviors, but also predicts the nature and course of action. These findings are supported by Dolfman (1973), who noted that different concepts of health represent different courses of action. A study by Laffrey (1983) indicated that persons with a more complex conception of health select more health behavior choices than persons with a less complex conception of health. Here the importance of knowing an individual's conception of health becomes evident, especially when certain actions appear to be inconsistent with the idea of health.

Summary

In order to clarify the information reviewed about health conceptualizations and health behaviors, these two aspects of health are summarized in the form of conceptual frameworks.

There is a significant relationship between a person's conceptualization of health and reasons for engaging in health practices. Conceptualizations among the American population were frequently expressed in terms of feeling, performance orientation, and well-being. Children separated notions of health and illness, but healthy adults expressed health in reference to illness. Those people who had experience with illness were likely to conceptualize health in a diffuse and ambiguous way relative to sickness and wellness.

People in France gave individualized conceptualizations relative to their life perspective. Illness was seen as being beyond the controller. Mexican-Americans chose their health provider on their

ability to be in a caring relationship and their socioeconomic status influenced their choice of health service. Illness was perceived as a social event. There was a relationship between health conception, experience of illness, health-seeking behavior and treatment response. This information gained from the literature concerning health conceptualizations can be expressed as a conceptual framework:

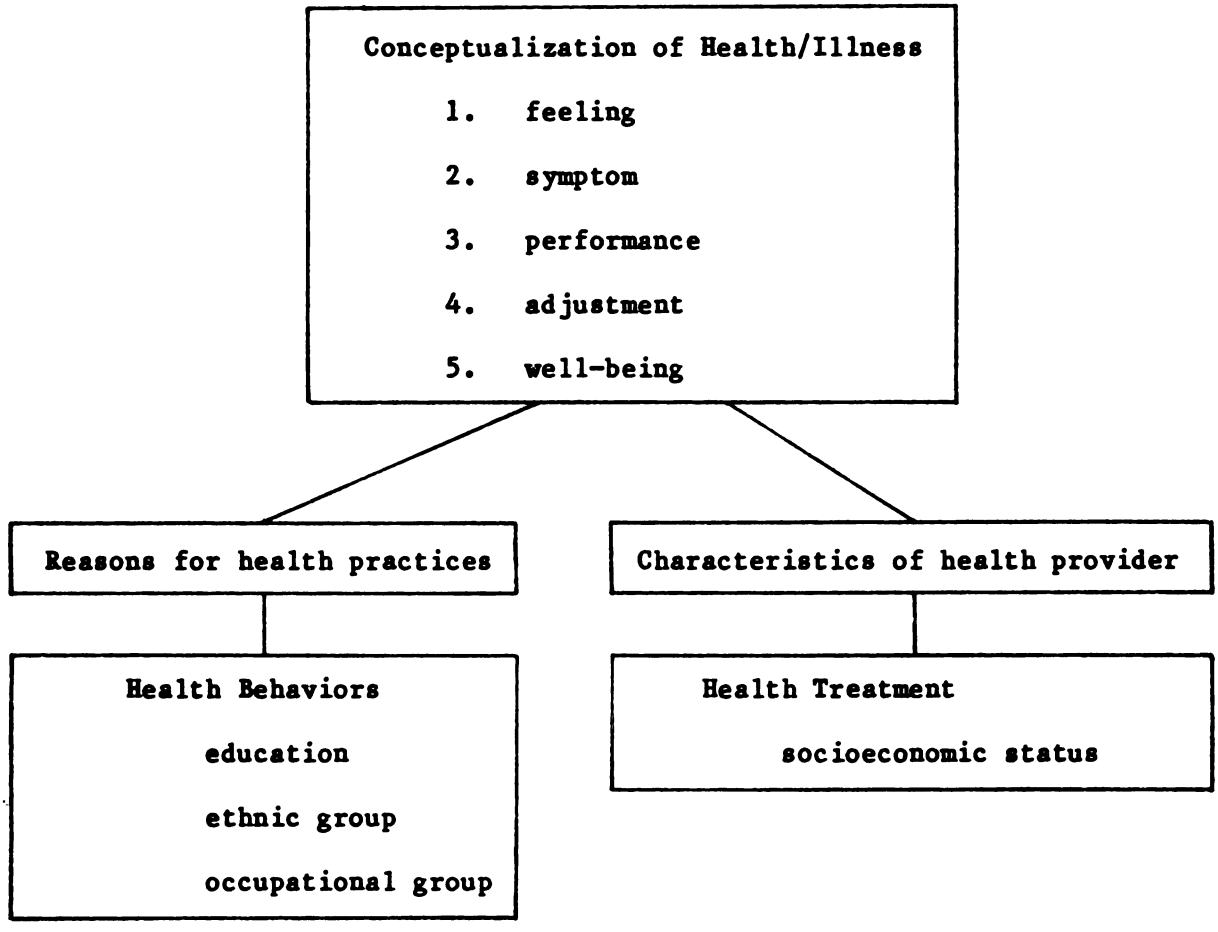

Figure 1. Internal and external relationships of health conceptualization (individualized according to life perspective).

Models used to understand how to predict health behaviors include (a) a causal model where disease detection, early diagnosis and

treatment are the object of preventive measures; (b) an individual's perceived susceptibility to an illness coupled with the individual's perception of the severity of the consequences of getting the disease leads to illness preventing behaviors; (c) health maintaining behaviors were practiced according to the enjoyment and pleasure derived from actions like relaxation and physical activity and the results of nutrition; (d) eight factors were outlined for motivating people who engage in health-promoting behaviors: importance of health, control, competence, self-awareness, self-esteem, definition of health, health status and perceived benefits of health promoting behaviors. Finally, the definition of health was seen not only to influence the extent to which an individual engaged in health behaviors, but also predicted the nature and course of action.

Significant aspects of models predicting health behavior can be summarized in a conceptual framework:

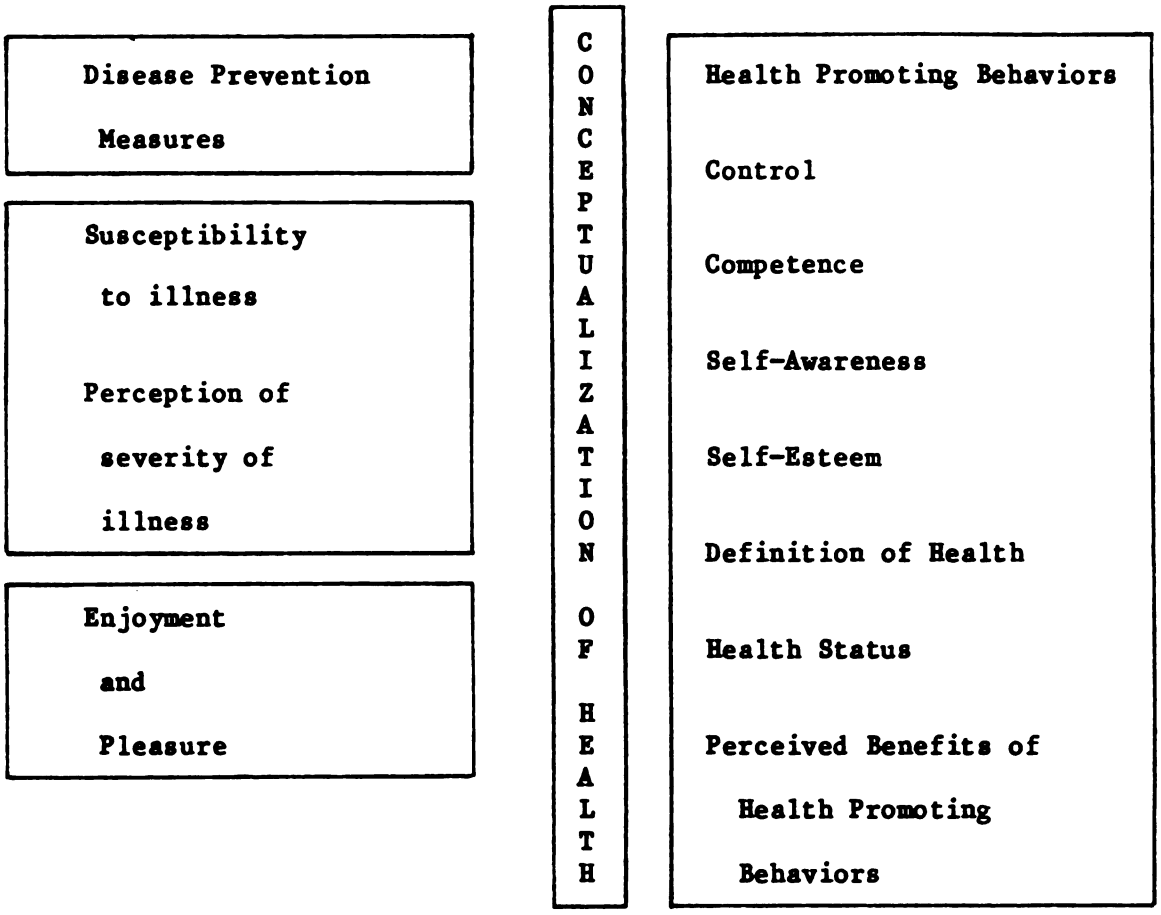

Figure 2. Predicting health behavior.

Historical Analysis of Arabic Health Knowledge and Actions

According to Foucault (1984), "There is no experience which is not a way of thinking, and which cannot be analyzed from the point of view of the history of thought . . . thought is understood as the very form of action" (p. 335). For Foucault, the transmission of knowledge is central to culture and this knowledge is expressed through language, in the spoken and written word. The constant comparative method, used in this inquiry, incorporates the historical word as comparable data which also provides validity (Strauss, 1984). Likewise, historical documents and other secondary sources enable an understanding of the situation in field methodology and dimensional analysis (Schatzman & Strauss, 1973).

Redfield (1971) stated that the great tradition of medical practice and theory of China, South Asia, and the Mediterranean belonged to the reflective few. In contrast, the little tradition belonged to the unreflective many, and maintained itself in the lives of the illiterate in their village communities. Those people who identified with the great tradition maintained an image of "highness" in contrast to "lowness." An historical account of Arabic health practices and knowledge follows:

Mesopotamia

According to Sigerist (1955), the origins of the great tradition of Arabic medicine can be traced to Mesopotamia. Propitiating the gods was thought to be the major way to avoid illness and restore health, and thus postpone death. No evidence existed to justify the notion of humoral theory, but the people did know that humors, air, and uncleanness contributed to the origin of disease. Natural forms of treatment such as massage, hot and cold applications, rest, special diet, and poultices were compatible with concepts of supernatural and magical causation.

Sigerist (1955) also spoke of the need for the individual to be reconciled with the supernatural. The soul-searching of the patients and the works of the physician had a profound effect. He described Mesopotamian medicine as "psychosomatic in all its aspects" (p. 490). There were three major types of priests who cared for the sick: (a) the seer, (b) the exorcist, and (c) the physician. The asu, as this physician was known, was considered to be representative of the healing God. The duties of the physician, either man or woman, were completely

devoted to the care of the sick. The barber (galluba) was an auxiliary to the physician and performed minor surgery.

Mettler (1947) stated that Egyptians had three theories for explaining nontraumatic disease. The first was the principle of contagion "in the magical sense." This included punishment by the gods. Gastroetiologic theory was a second cause and encompassed inevitable, excessive, or deficient diets. The third cause was meteorologic in nature, which saw a correlation of disease with weather, especially with seasonal and wind changes.

Physicians were taught to be kind and considerate, gentle but meticulous, and not to ridicule their patients. Note was made of the expression of the face, color of the eyes and skin, state of mind, memory, and consciousness, among other inspections and observations. The use of drugs and herbs was contained in an extensive list of materia medica (Basta, 1976).

Classical Greek Tradition

From its development through the Hippocratic school and modifications by Aristotle and others, Galen (131-201 B.C.) solidified the humoral concept into a more concrete and comprehensive theory. The Hippocratic School believed that an equilibrium should exist between the humors of dry, warm, moist, and cold. Galen proposed that external factors such as climate, seasons, and age would allow for dominance of one of the humors over the others. The use of diet, both as a prophylactic and therapeutic method followed from the humoral theory. Therapy was limited to practical measures such as emphasis upon proper types of food, a well-balanced diet, change of climate or the use of massage (Mettler, 1970).

Byzantine Period

The Byzantine period began with the early centuries of our era. Castigliani (1941) stated that the period saw a return to magic and mysticism largely because of the effect of large-scale epidemics and the influence of the Catholic church. Known methods of cures were useless and as a result confidence in doctors declined and desperate conditions allowed for the rise in superstitions. The Christian ideal gave a different concept of equality and charity which imposed on all the faithful the most severe sacrifices in order to lessen the sufferings of others, for example, "Under the influence and domination of Christianity, it becomes dogmatic medicine, of which faith is the first article. Its essential aim is assistance of the sick, regarded as a work of human and divine pity." (p. 257).

Arabic Medicine

Arabic medicine was an amalgamation and outgrowth of Egyptian medicine, refashioned by the Greeks on one hand and the Latin medicine of Europe on the other. Particularly well known was Ibn Sina of Avicenna (980-1036) whose textbook coordinated and codified the various branches of medical knowledge. The first step in treatment was to try and restore health with diet and therapy. If diet alone did not prove successful, then drugs would be tried. Contribution to surgery and innovations in ophthalmology were also introduced at this time. Doctors continued to attend to the psychic and spiritual aspects of their patients as well as their physical conditions, for example, "They cared for man as a whole with a view to the religious connotation and reverence bestowed upon him as 'the crown of God's creation'" (Hamarneh, 1972, p. 67).

Although Koranic verses and sayings of the Prophet Mohammed do not present a well-defined system of medicine, they had an influence on the manner in which Islamic medicine came to be practiced. Elgood (1934) referred to the Tibb-al-Nabi of a Persian named Mohamed Abbas Arzani which claimed to be the words of the prophet on concerns related to health and disease. Many of the teachings corresponded to those found in the Galenic tradition. According to Redfield (1971), the teachings of Galen were reinterpreted by the peasantry in local terms.

Health Care in the Middle-East

Shiloh (1961) offers a framework for understanding the philosophical concept of medicine in the Middle-East and considered its interaction with 'Western' medicine. Illnesses and injuries came about as a result of the omission or commission of certain acts and are caused by someone or something possessed of a power. The concepts used to express this philosophy are animism and animatism, terms that related to the fact that all objects, animate or inanimate, have consciousness. In a more holistic sense, animism may be seen as the natural way our imaginations express ideas about origins, without paying much regard to the difference between cause and effect (Huxley, 1974).

Shiloh (1968) stated that the attempt by the 'Western' medical systems to reach an accurate diagnosis based on the germ theory of disease vs. the attempt by the 'Middle-Eastern' medical system to ascertain the cause based upon the concept of evil eye or evil spirit should not be viewed as an apparent conflict. Rather, he believed the two systems are dealing with different phenomena, but that they are not mutually antagonistic, for example:

> The Middle Eastern preoccupation with preventing the activities of the evil eye or evil spirit is complemented by the Western preoccupation with preventing the activities of germs. A patient or practitioner anxious to maintain a given state of health sees, and should see, no necessary conflict in practices designed to prevent both evils (p. 382).

Illness Causation

Roberts (1976) concluded that belief in the evil eye originated in the Middle East with the evolution of complex peasant-urban cultures and diffused from there. Evidence suggested that belief in the evil eye preexisted the universalistic religions represented in the Middle East. The basis of the concept of the evil eye is that certain individuals have a power, whether voluntary or involuntary, to cast a spell upon animate or inanimate objects. The belief in the evil eye is frequently associated with envy or jealousy. Westermack (1926) stated that anyone who is afraid of the evil eye is automatically more vulnerable to it. This coincides with the belief that fear is the cause of misfortune. Moss and Cappannari (1976) paraphrased W. I. Thomas: "If men believe a thing is real and act in accordance with that belief, the consequences of their actions are real."

Practices

Preventive measures against the evil eye include amulets, charms and relics. Curative practices include fumigation, melted lead, charms, prayers, and exerting gentle pressure over the head and reciting a prayer while holding a bowl containing a liquid (Harfouche, 1965).

Smith, et al. (1969) commented on the fact that some Christians in Lebanon wore amulets containing the pictures of saints to protect them from disease and accidents. The concept of preventive medicine is alien to many Lebanese and medical treatment is sought only when the disease

has reached an advanced stage. In an article about health rituals at a Lebanese shrine, Howell (1970) stated that the rituals of folk medicine may sometimes relieve physical conditions, and they invariably have an important contribution to make in alleviating stress. The religious aspect of ritual relieves the anxiety of the mother by giving her the assurance that the welfare of her child has been transferred to a higher power.

Practitioners

Indigenous practitioners include (a) the barber, who is skilled at pulling teeth and treating small wounds, (b) the traditional midwife (daya), (c) the wise woman who dispenses "food-medicine" and has a special knowledge of cures, (d) herbalists and cuppers, who practice a procedure assumed to withdraw irritants from an affected part of the body, (e) bonesetters who treat fractures, (f) folk opthalmologists, and (g) holy people who are believed to possess supernatural healing powers and cure or offer protection against various types of misfortunes and illness (Pillsbury, 1978).

Arab Americans in the Health Care System

The literature concerning the health perceptions of Arab Americans was limited. However, the work of Meleis (1978, 1981, 1983) either alone or with other authors, provided a comprehensive overview of what to expect in the clinical setting from a Middle Easterner. She claimed that, while the Middle East has many different ethnic groups and individual Arab clients must not be stereotyped according to cultural background, guidelines for the health care provider do exist that derive from shared values and behavior (Meleis, 1981).

The need for affiliation is strong and a social network is seen as required if an Arab person is to cope with everyday events. In the event of a crisis, the Arab relies on other people to help and to give advice. Arabs resist disclosing detailed information about themselves and their families to strangers, therefore a trusting relationship must be established with the health provider before they give personal information.

Family members should be involved in discussions. Although an approach that combines expertise and authority with personal warmth can enhance the interpersonal relationship, sex role stereotypes can interfere with the professional relationship. For example, a young professional woman can have difficulty in maintaining an authorative position in dealing with Arab men (Lipson & Meleis, 1983). Trust is enhanced by the Arab respect for education and authority. Trust and compliance are likely to be undermined by any action considered insensitive or invasive (Meleis, 1981).

Lipson and Meleis (1983) offer some insights into health behavior:

> Often Middle Easterners express vague symptoms, giving generalized and global descriptions of their health status. Vague physical symptoms substitute for anxiety or depression because Middle Easterners lack concepts that distinguish mental states from physical states, and their experience does not permit them to carefully describe signs and symptoms as they are associated with different parts of the body. (p. 858)

Coupled with socially expected behaviors, such as bargaining, demands, and freely expressed emotions, the increased effectiveness of having a constant care giver proved beneficial. Personalized care might include expectations to engage in the social life of the patient and family, which could be intensely draining and exhausting.

Meleis and Sorrell (1981) gave some relevant aspects of health care pertaining to Arabs' social network. The Arab male might be perceived as having excessive control over his wife and family because of his demands for involvement in all aspects of health care. Children are expected to be a part of events that affect the family in any way. A women's power derives from her management of household affairs. When the extended family and the husband are unwilling to engage in household tasks, isolation may add to the stress of the Arab American woman. The woman is expected to be bashful, diffident and shy when acting with men and with strangers:

> The Arab women's status is improved and her acceptance by her father's family enhanced when she bears male children. The wife who has borne only female children is considered almost as worthless, socially, as the woman who has no children at all. (Meleis & Sorrell, 1981, p. 174).

Summary

Although a literature search gives an understanding of the origins of health and illness perceptions and health care, little knowledge exists about actual health conceptualizations, the factor which is thought to pertain most closely to actual expected health practices. No literature was available about Lebanese Americans' health conceptualizations in particular. The literature search justified an exploratory study into the health conceptions of Lebanese Americans as a significant group of people using the American health care system, as well as an informal nonprofessional system embodied mainly in family and traditional culture.

Following is an attempt at a composite picture of the essential features of the history of Arab health knowledge.

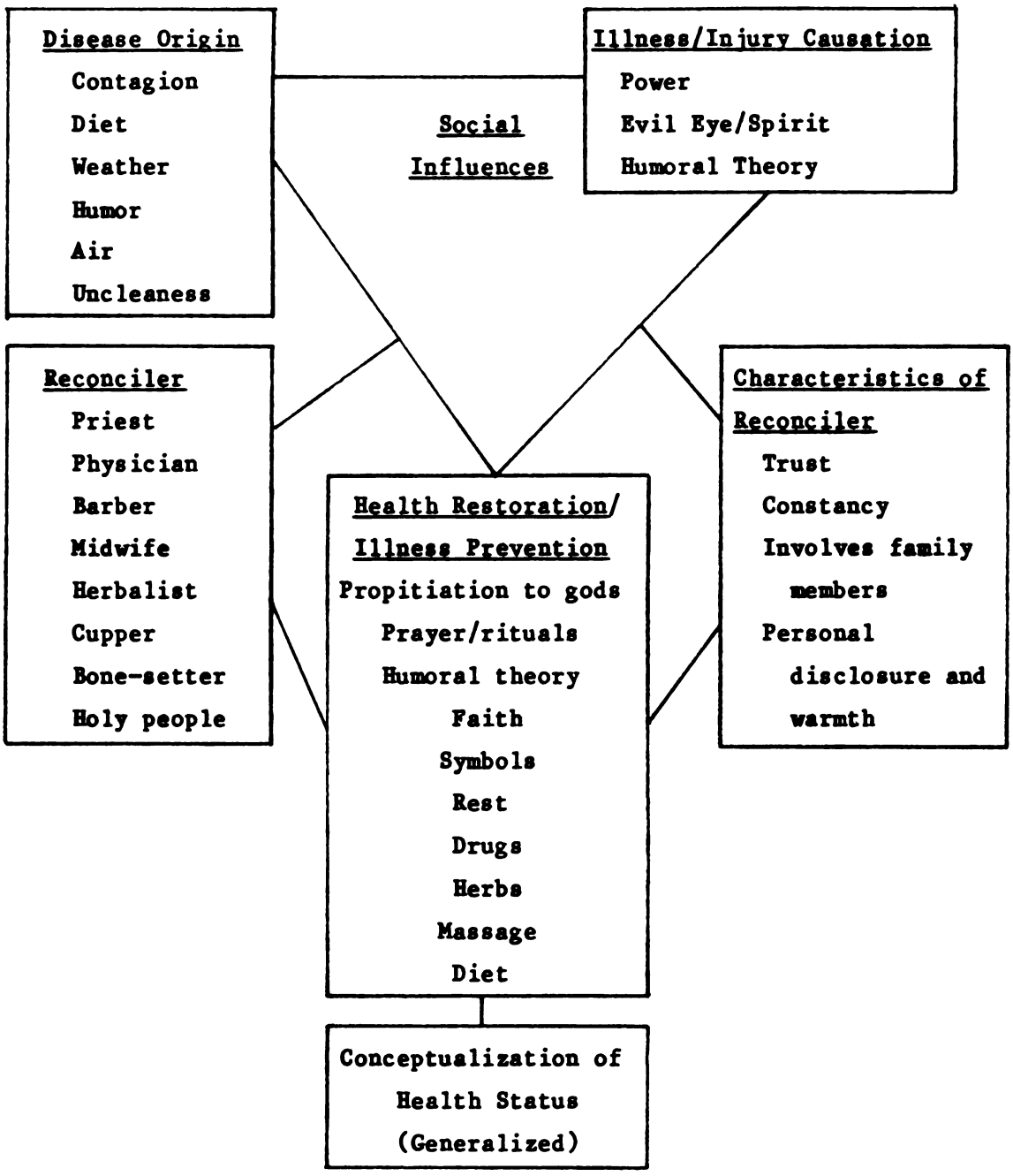

Figure 3. Features of Arab health knowledge

Historical and analytical approaches to the concept of health have been reviewed and health behavior models have been described. Some of the literature focused on the biomedical approach to health, illness, and disease, while other emphasized psycho-social or socio-cultural

aspects of health. Health was seen to be multidimensional, consisting of many aspects. The vagueness of the concept of health was illustrated by many studies that were labelled health research, but which dealt with disease and illness (Pender, 1982).

A literature review in health science research indicated that the majority of health studies followed the medical or clinical model and focused primarily on the physical health of large population groups. The historical search of the literature in order to understand the origins of health knowledge in the Arab world only highlighted the fact that there was no current and relevant research available concerning the health conceptions of Lebanese Americans.

Conceptual Framework

According to Schatzman and Strauss (1973), the discovery process need not be related to any prior theory. The inquirer does not necessarily wish to test or explore the limits of the usefulness of a theory. Any pertinent theories or assumptions are nevertheless pertinent to the substantive focus. The theoretical perspective for raising relevant questions arises from the inquirer's experience or knowledge acquired from the literature. This way of going about the process of inquiry, relinquishes a measure of control over the study, but makes the relation to it more flexible and enables the discovery of knowledge to generate theory.

A conceptual framework has been constructed from the review of the literature.

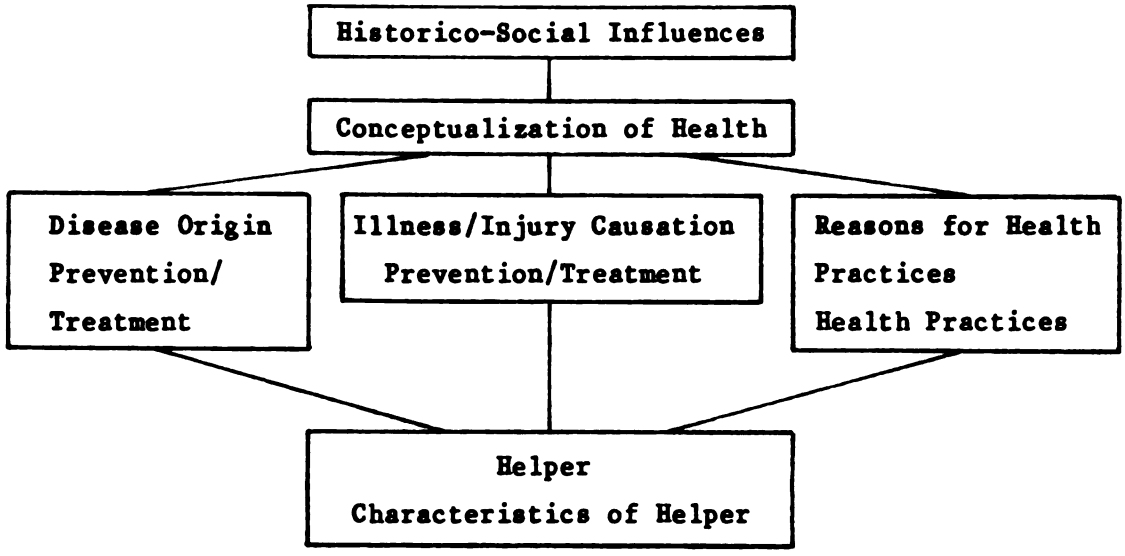

Figure 4. Health conceptualizations, predictors for health behavior and features of Arab health knowledge.

The conceptualization of health was formed from the historico-social context which invoked ideas about causes of disease, illness, and injury. Reasons for health practices were related to actual health practices. The helper or health care provider was assumed to possess certain characteristics. Major ideas influencing the conceptualization of health permitted the inquirer to pursue a social method of inquiry and with the use of open-ended questions to discover the generalized "health" focus among Lebanese Americans.

CHAPTER III

Methodology

Chapter III describes the research design, the process of inquiry, sample selection, and techniques. Assumptions and limitations of the study are also described.

Design

An exploratory, descriptive design, using field methodology to discover the conceptualizations of health for a group of Lebanese Americans was utilized. Qualitative methods were recommended for the exploration of unstudied phenomena because they allow the researcher systematic observation and explicit description of a phenomenon, which are the basic steps in the discovery of new knowledge (Ryan, 1983). Description of phenomena is, however, never finished, but always in progress. Although there are ample opportunities to identify phenomena that could be studied, the inquirer focuses on those concepts that contribute to a growing knowledge of the area actually under investigation (Glaser, 1978).

In general, this study was formed by grounded theory (Glaser & Strauss, 1967), a form of qualitative comparative analysis (Stern, 1980). The focus for grounded theory is not on collecting or ordering data but on organizing ideas which emerge from analysis of the data.

Setting

The San Francisco Bay Area was the chosen setting for the current study primarily due to convenience limitations, finances, and mobility in this area. Entry was gained through an introduction to a local Eastern Orthodox Church for participant observation. Many casual verbal encounters with Lebanese Americans occurred over a nine-month period.

Size and Sample Selection Criteria

Selective sampling for formal interviewing provided a population of 10 Lebanese Americans with the following characteristics: (a) Eastern Orthodox Christians; (b) 21-40 years; (c) English speaking; (d) from three generations; and (e) both sexes. Sampling was shaped by the time available and by developing interests and restrictions placed upon availability of interviews with respondents (Schatzman & Strauss, 1973). Informants introduced other members of their group, a form known as snowball sampling (Honigman, 1982).

Sample

Human Subjects Assurance

The committee on human research approved the request to waive the use of a written consent form because of a cultural aversion to signing forms and a respect for verbal agreements (Meleis & Sorell, 1981). The purpose of the study was explained and the concerns about confidentiality were expressed prior to the participant's identification. A written information sheet that summarized the protection of human rights was given to each participant. Results were coded alphabetically so that the participant could not be directly identified. Results were locked in a file box for which only this researcher had a key. These results were destroyed upon completion of the study. Participants were informed that they could refuse to participate, not answer particular questions, and/or withdraw at any time from the interview. For those who requested it, a tape recorder was used. These tapes were erased after transcription.

Participants were not financially compensated but measures were taken to maximize comfort and convenience. The setting for interviewing was mutually agreed upon by both the participant and myself.

Data Collection Process

Davis (1980) stated that individual interviews must be combined with other methods of data collection in order to verify the interpretations and possible distortions of what a group values are, especially in terms of rules and symbols. Thus participant observation allowed observation of group values and norms. Participant observation was carried out for 9 months prior to any formal interviewing.

Participant Observation

According to Lipson and Meleis (1983), the building of a personal relationship is essential for the development of interpersonal trust, for example, "Middle Easterners may be offended by the American proclivity to immediately talk about the business at hand instead of taking the time to establish a relationship." (p. 856). Middle Easterners, like others, seek also to understand events in the context of circumstances in which they occur. Consequently, it was considered appropriate to spend time interacting with this group of people prior to interviewing.

Actual Procedure

Data were gathered through attendance at church and celebrations and at informal meetings after the service each Sunday. I chose the "participant-as-observer" variation of the participant observer role, where the researcher and the researched are aware that their relationships stem from the study (Golde, 1970).

The actual field methodology was planned according to the strategies demonstrated by Schatzman and Strauss (1973). The church served as an entry point to meet people and to observe a particular social setting. Notes were taken immediately after the visits and the method of recording followed the guidelines of Schatzman and Strauss (1973):

1. ONs: Observation notes are the who, what, when, where, and how of a human activity and it tells who said or did what, under stated circumstances. ONs are statements written verbatim or as close as possible to it and other statements were descriptions of what was observed.
2. TNs: Theoretical notes represented interpretive statements of the recorder-researcher. Concepts are developed in this process: observations and interpretations are linked to each other.
3. MNs: Methodological notes are self-reflections on the ways of working, thinking, and feeling of the researcher.

Since "reality" can be presumed to be multi-dimensional, the field method of research enabled me to encompass multiple aspects of my substantive interest. The resulting findings and understanding were not so much dealt with in terms of testable truth, but rather in terms of the usefulness of emerging ideas. Validity was assured in faithful recording, in internal comparisons, and in analytic integration.

I was at first beset with doubts about my ability as a field worker and this affected my morale for a few weeks. I was helped through this period by my committee members and was able to continue the data collection and simultaneous analysis. On the whole, I approached the study with timidity, which I prefer to think arose out of a respect for

another's territory and customs. According to Gans (1982), participant observation is the most personal of all sociological research methods, and little can or should be done to eliminate the personal element.

Being marginal and trying to maintain neutrality created a constant strain. My natural inclination to form likes and dislikes, usually based on friendliness, varied the involvement I had with this group of people. Jarvie (1982, p. 70) illustrated this dilemma well: "The path between the Scylla of unreasonable ethnocentric prejudice and the Charybdis of university charity is very difficult to steer, and the woolly notion of cultural relativity does not map the currents and submerged rocks." I experienced, a certain enjoyment in being involved, but the obligation to participate in other social situations arising from this personal involvement became a burden and I often had feelings of hesitation and guilt (Lipson & Meleis, 1983).

The extent to which my personal characteristics influenced roles, relationships, and data also concerned me. The influence of sex, age, and gender was an issue but did not become more evident to me until the time of interviewing (Golde, 1970).

Interviews

Procedure

I identified myself as a nurse/researcher studying ideas about health among Lebanese Americans. I usually informed people of my prior experience, interest, and concern.

1. The interview technique was piloted during participant observation (see Appendix A).
2. Although I met each participant for a single interview, I sometimes followed up with a telephone call to clarify points.

3. The duration of the interview ranged from one to two hours;
4. Participants answered questions concerning their general ideas about health.
5. Demographic data was collected during the interview process (see Appendix B).
6. Anonymous others were referred to, in order to clarify contextual differences.
7. The interviews were either tape recorded or written, according to each participant's wish, or interviewer convenience.
8. Since the idea of the study was to operationalize the concept of health, ambiguous terms, such as sickness and wellness, and value laden terms such as good and bad, were avoided.
9. Since health has been defined in the literatures sometimes as "absence of illness," knowledge about health was elicited. The hope was to avoid defining health as "the opposite of what I described as illness."
10. An attempt to maximize directive questioning was made as much as feasible, until the participant focused upon a particular issue and indicated personal perspectives and subtleties.

Benefits of the Procedure:

1. The interview process allowed for open-ended questioning and provided the opportunity for a person to reveal unique ideas.
2. The opportunities were provided to clarify and facilitate perceptions as well as select generative questions which stimulated the line of investigation (Strauss, 1984).

3. Factors pertaining to interpersonal needs of establishing a relationship with a Middle Easterner, so necessary for revealing relevant communication, was enhanced (Lipson & Meleis, 1983).

Limitations of the Procedure:

1. In contrast to the questionnaire, anonymity was not possible. Direct questions could have inhibited responses or created "response sets."
2. As Schatzman and Strauss (1973) stated, "Interviews are [social] situations in their own right; therefore, what persons report in either case often better reflects those situations than the referential ones which the techniques were designed to ascertain. (p. 24)."

An appropriate introduction and the assurance of confidentiality helped to minimize limitations and enhance benefits. Respondent comfort was provided by means of selecting a mutually agreed-upon place.

Instruments

Participant Observation

Participation on the part of the inquirer allowed the researcher to obtain an understanding of selected aspects, thoughts, and acts of the people studied. Although the Chicago School of Sociology developed an interest in field research and field methods and considered that an anthropological approach could be used, investigators have been not explicit about their methodology. Traditional field methods in the form of observation and unstructured interviews have been complemented by life history documents.

The task of the participant observer is well summarized by Becker and Geer:

> The participant observer gathers data by participating in the daily life of the group or organization he studies. He watches the people he is studying to see what situations they ordinarily meet and how they behave in them. He enters into conversation with some or all of the participants in these situations and discovers their interpretations of the events he has observed (Becker & Geer, 1958, p. 652).

Interview

An interview focus was used to insure that each person had the opportunity to contribute individual ideas about the concept of health in general. According to Davis (1980) the interview is used to elicit information or expressions from another person or persons. From empirical evidence, the unstructured, nonstandardized interview is the best approach used for exploratory studies. This is called the focused interview in which certain types of information are elicited from all respondents but the particular phrasing of questions is directed to fit the characteristics of the particular respondent. Two assumptions underlie this type of interview: (a) questions are formulated in a way familiar to the person interviewed, and (b) there is no fixed sequence of questions, because each question is determined by the respondents readiness and willingness to take up a topic as it comes up.

Validity, Reliability, and Utility

Glaser & Strauss (1967) address the issue of plausibility rather than validity when talking about the credibility of grounded theory. The criteria for judgement is based on the actual strategies for collecting, coding, analyzing, and presenting data when generating theory, and on the way in which people read the theory.

Credibility

It is worthwhile quoting Schatzman and Strauss (1973) for a comprehensive understanding in regard to credibility of the area of field research:

> As a methodological pragmatist, the field researcher concerns himself less with whether his techniques are 'scientific' than with what specific operations might yield the most meaningful information. He already assumes his own honesty, rationality, and scientific attitude; therefore, he is not ready to concede in advance the superiority of certain types of "instrumentation" over his own abilities to see and to make sense of what he sees. He is certainly aware of selectivity in human perception and of the probability of bias, but he does not view "objective" or "consensually validated" techniques as being free of these limitations either.

I addressed the issue of content validity of the actual guide used by discussing it with one sociologist familiar with the form of the study and a nursing professor whose main area of expertise was "health." I had members of the Mideast SIHA (Mideast Study of Immigrant, Health, and Adjustment*) group critique me and the style I used. Additionally, they provided feedback in regard to actually capturing the interpretation of much of the data. These were some of the standards applied to address the issue of validity suggested by Reason and Rowan (1981).

Reliability

Internal consistency was addressed by stopping data collection at the point where "sufficient" substantive and conceptual complexity had been developed. I asked other nurses familiar with this population to

*The Mideast SIHA project was established at the University of California, San Francisco in 1982, to increase understanding of cultural variability between the American public and the health needs of Middle Eastern immigrants.

read examples from the transcripts and their dimensions, in fact, correlated closely with my own. I also used the availability of most participants to clarify data and interpretations with me by calling personally or via the telephone.

Utility

By being an active participant in both data collection and analysis, I capitalized on what is commonly regarded as a limitation in experimentally oriented research (Lipson, 1984). I was able to confront complex dimensions observed in the social nexus and generate useful questions concerning the human point of view in the situation (Aamodt, 1982).

Analytic Procedures

Dimensional analysis was the procedure used to discover the health conceptualization and practice of the respondents. It is a qualitative research perspective and procedure currently being developed by Drs. Schatzman and Strauss at the University of California, San Francisco, School of Nursing. As a method of analysis applied to interview studies such as this one, it dimensionalizes respondent verbalization, that is, renders what respondents say into distinct aspects or dimensions pertinent to any given substantive area. Within these aspects, the analyst discerns the properties of the situation experienced by the respondent and "assigns" these properties to other components in the cognitive process, according to whether they are context, condition, action, or consequence of action as experienced by the respondent. In this way, it is believed respondent logic is ascertained and the construction of respondent reality revealed.

Dimensional analysis as a method is seen as an expansion and elaboration of ordinary human analysis, naturally performed in everyday life. Its premise is that common human intelligence dimensionalizes experience, and naturally constructs, analyses, and defines situations dimensionally, and according to the components or structures indicated earlier. Thus, in analysis, whether performed by lay persons or by experts, there is a specification, differentiation, and subsequent integration of the dimensions and properties of things (or events and ideas) as experienced. The difference between research and lay analysis lies in the number and kinds of dimensions noted, not in the process itself except that in research analysis, the process is likely to be more self-conscious and systematic.

Dimensional analysis seeks out the structure and processes embedded in the data and this process goes on simultaneously with the gathering of data. Each respondent protocol reveals dimensions or aspects of thought which enhance the analyses of succeeding interviews. If and when later interviews reveal new dimensions of experience, earlier protocols are reanalyzed for evidence of these, or early respondents may be questioned again on these. Such analysis demands the conscious realization of the analytic process. The researcher utilizes theoretical sampling until dimensions are "saturated"; that is, until no new dimensions of experience are encountered.

CHAPTER IV

Findings and Discussion

The purpose of this study, to find out how a group of Lebanese Americans conceptualizes health and the pertinent influences upon these conceptualizations, has been fulfilled by the creation of a dimensional matrix. This dimensional matrix has been abstracted from an analysis of the data and suggests a way of approaching health care for Lebanese Americans by using the framework as a basis for action.

Dimensions created from the researcher's abstractions are considered as findings. These findings arise out of the context of the whole study and therefore the interrelationships between the parts are examined together, the discussion being an integral part of the process of analysis. This process began with a period of participant observation involving numerous Lebanese Americans, followed by formal interviewing with 10 Lebanese Americans. These successive periods are discussed sequentially so that the purpose of both procedures can be elucidated.

As Dewey (1938) stated, there is an existential matrix to any inquiry which grows out of the social relations of fellow beings to one another and develops in the course of living and the transmission of culture. The participant observation period allowed for a time to discover the cultural milieu within which health conceptions occur and the intensive interviewing permitted time to focus upon the health perceptions of a group of Lebanese Americans.

The essential social-cultural component of this study suggested, at the very start certain general, overarching dimensions to help with the

organization of my thinking.* The following dimensions helped me anticipate and order my observations and inquiries:

1. There is a phenomenological dimension in most or all human experience. Indeed, experience is a human process of interpreting, analyzing, or defining events as they are perceived; also defining self, and one's actions, with respect to these events. The phenomenological aspect, therefore, pertains to the way(s) people construct their reality, and what they "make of it" as it affects them, e.g., health and illness events and inquiries into their interpretation and meaning.

2. An active or interactive dimension: It is assumed, reasonably, that peoples' actions directly reflect the ways they interpret or define situations pertinent to themselves. People interact with events and with other people about these events; these interactions often serve to restructure interpretations which leads to still other actions and interactions, e.g., direct observations of actions and interactions and analytic interpretations of what people say and do about health and illness.

3. A contextual dimension: It can be assumed that events are defined and acted upon in some temporal-spatial context or situation which both affect and are affected by the phenomenological and interactive aspects. Context, here, includes the structural aspects of action: in what kind of setting the person is, the kinds and number of other persons present, and so on. In addition, certain structural aspects such as the gender, age, and marital status of persons can be thought of as context for action. Thus, the specific and concrete situation must be taken into account in order to understand the thought

* From discussion with Dr. Schatzman, Sociologist, University of California, San Francisco.

and actions of persons; its properties must be described and dealt with as important conditions for thought and action.

Observations and Interpretations

Early Findings from Field Study

Apart from descriptive observations, I conversed with many different Lebanese Americans over the course of 9 months. The most obvious dimensions elicited during that time of participant observation in and around the church setting were (a) ritual, (b) family relationships, (c) gender role differentiation, (d) physical and mental health, and (e) the immigration experience. Those dimensions can be expressed diagrammatically:

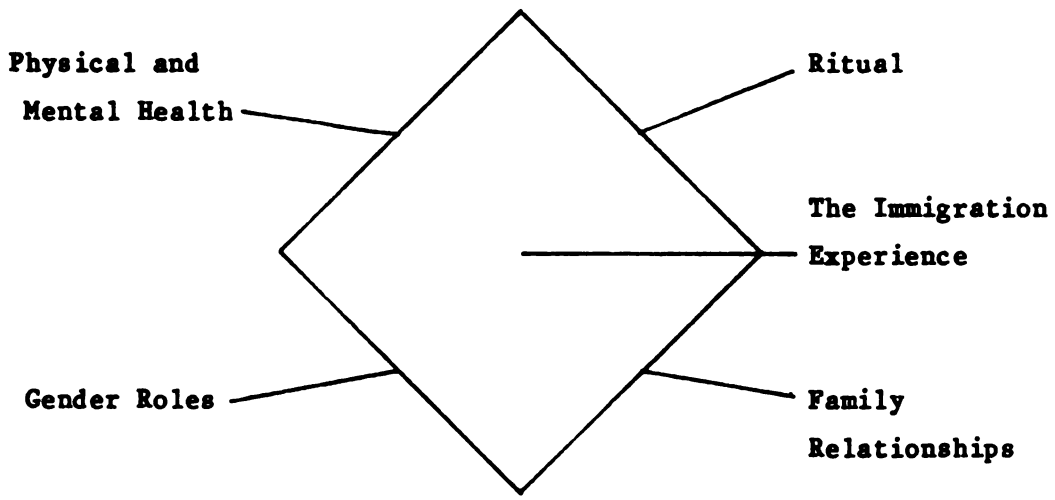

Figure 5. Preliminary Dimensional Matrix

The salient dimensions constructed during the field study were pertinent to the interviewing process which followed because they provided a matrix and guide for interaction in which to discuss health conceptions.

One of the significant observations about any church service is the amount of ritual present. In the Eastern Orthodox service, the behaviors of the congregation were highly ritualized for many life events. For example, the engagement of a couple was symbolized by the presentation of crowns, gold for men and silver for women, silver being considered an inferior color or metal. The ritual among family members and the strict role differentiation was even more apparent during the customary socialization following the service.

The congregation was made up of a core of steady attenders and transient people who came to celebrate an anniversary, such as the death of a cousin. Sunday was one day of the week when all of the extended family members were likely to come together. People arrived as family groups, sat in the service as a family, and departed as a family.

Children's socialization to ritual began at an early age; the central role of faith was apparent together with a strong ideological commitment to religious laws. A hierarchical structure existed within each family, with the eldest man having the most authority and all men having authority over women. Gender role differentiation was marked, especially in behavior and dress. Men tended to speak to or touch only other men and women to speak to or touch only other women. Although it is common to see women in a Westernized church service dressed in a variety of ways, there was a feminine stereotyped way of dress noticeable among the women. Women wore blouses and skirts or full length dresses, and used highly colored make-up, jewelry and high heeled shoes.

Just as ritual courtesies and role differentiations were obvious, so physical conditions, such as blindness and cerebral palsy were obvious. Compared with the general population, there were relatively few obese

children or adults, as well as relatively few people wearing glasses. Teeth were either heavily inlaid with gold or in an obviously deteriorating condition.

Introductions were generally followed by an explanation of my presence and this frequently opened up discussion about health concerns. Most of the references to health were made in terms of physical and/or mental health. There was an emphasis upon diet prepared in the traditional Lebanese manner, upon having sufficient sleep and rest, and exercise. Mental health was frequently commented upon in relation to the stress accompanying the immigration experience and resulting personal and social changes. Isolation of elderly women was frequently mentioned as a concern, mainly because many elderly men were no longer living. Family members tended to be working and women in this age group did not speak English well; French is the second language after Arabic for this age group.

Another aspect of mental health had to do with occasional lack of family cohesion, on one level between husbands and wives and on the other level between generations. Husbands and wives were more inclined to live apart from each other in the United States for several reasons: increased social tolerance of separation or divorce; decreasing family size and therefore less pressure to remain together; and increased support from grown children who were educated here. While the children were at school, there was concern over the conflict experienced between peer mores and traditional customs; for example, of dating outside of the ethnic group, especially for girls. An equally important stressful issue arose out of differential schooling in that it fostered a change in power structure between parents and children, exemplified by the following

remark: "Kids become interpreters of American culture for parents and this gives teenagers power to interpret to their own advantage."

As a result of the immigration experience, reversal in power structure in the family was often accompanied by impaired morale because of physical separation of family members, whereas morale was improved by being together and sharing the culture. For example, the main contributions towards morale came from socialization with other family members and speaking in Arabic, eating Lebanese food and listening to Arabic music. On the other hand, many people referred to the absence of family members either still living in war-torn Lebanon or living in another country, with feelings of sadness or anxiety.

Findings from Interviews

Interviews were conducted over a period of 9 months. The perspective taken in the analysis of the interview data is drawn largely from the pragmatic tradition developed by John Dewey (1917, 1929, 1938). Dewey (1938) makes the point that phenomena such as health and illness are not isolated from other aspects of living, so health phenomena are not isolated but rather fit into the larger context of life itself.

Dimensions from the matrix are evaluated and interpreted with regard to their implications for interaction between the Lebanese Americans who participated in the study and health care providers. Validity of the conclusions are substantiated by the data and the literature. The framework, which is a model of the major influences affecting health conceptions of Lebanese Americans, contributes to nursing by providing a context for nursing action, which focuses upon health and health care.

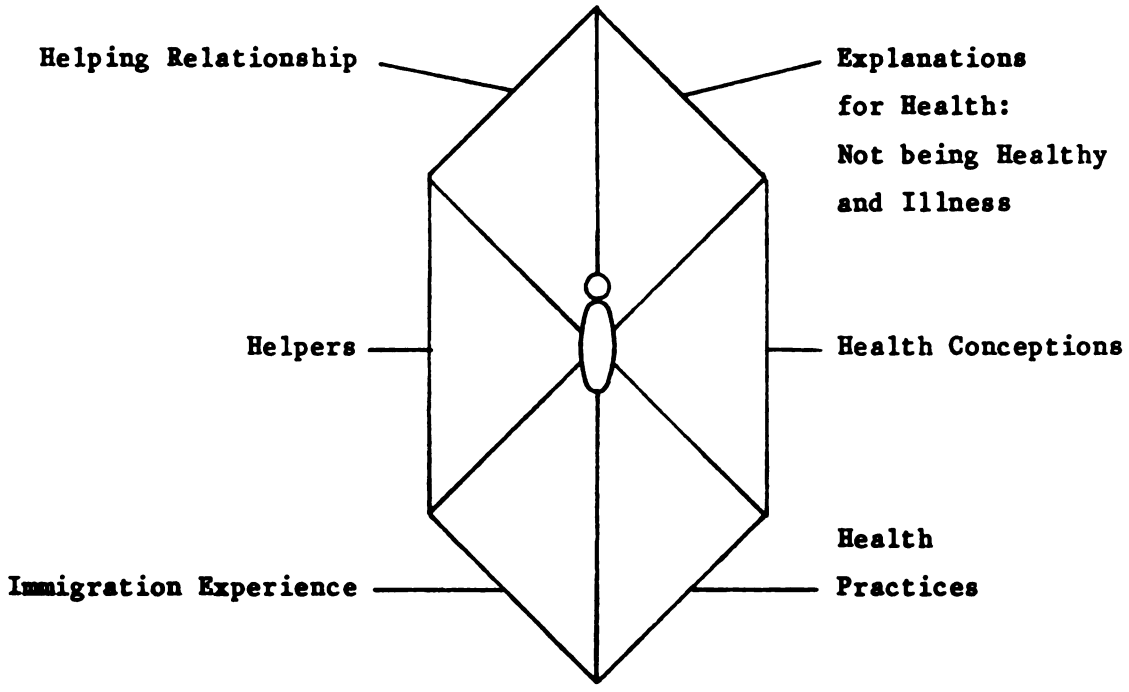

Figure 6. Dimensional matrix.

An explanation of the dimensions are discussed within the context of the data, emphasizing consequences pertinent to health care practice. Each salient dimension constitutes a heading and subdimensions are recognized by subheadings. Any other category that is worthy of attention, because of reasons given in the appropriate place, are also indicated by a subheading. Each heading or dimension follows with an explanation of the section to guide the reader.

Explanations for Health: Not Being Healthy, and Illness

Explanations for health, for not being healthy, and illness, can be subdimensionalized into categories of lack of explanation or unknown

cause, belief in the evil eye, God's divine power, and extremes of hot and cold. The important factor about these reasons for health and illness is that they have been accepted without much critical reflection. A perceptual ideology has reigned, but the Lebanese American's exposure to different ways of understanding health and illness and actually seeing how people can and do affect their health and illness status in this country, has given many of them a new sense of control and led them to question traditional beliefs.

Explanations for health were referred to much more frequently than explanations for not being healthy. These were preferred to using explanations for illness and disease, which were simply not mentioned. A historical basis for many of these explanations of health and illness has been provided in the Review of the Literature, giving a basis for understanding how these ideas of health have been formed and maintained. People usually did not know the basis for beliefs and did not question them readily.

Lack of explanation or unknown cause. Typical responses to questions about health beliefs and illness causation were, "There is no base for it, it's our belief," or,

> My belief is kind of changing. If good things or bad things happen that is from God, that is how I would feel if I were in Lebanon. Now that I am here, I don't believe that. I think bad things happen because I cannot explain why it happens.

These findings were substantiated in a study by Blaxter (1983) in Aberdeen, Scotland, who found the most notable features of conversation, when discussing the causes of disease, were the salience of knowing about cause and the strain towards rational explanation. Bury and Wood (1979) also stated that the disturbing reality of disease experience gave rise

to the questions "why me?" and "why now?" The offering of a diagnosis or label was not enough, and anxiety was alleviated only if some indication was given about how a situation might have arisen. Apple (1960) commented on the uncertainty or ambiguity of illness which gave added incentive to consulting a doctor. These common findings across cultures reveal the importance of supplying a reasonable explanation for concerns about health and illness.

Reasons given for health and illness need to be incorporated by the health provider, with an understanding of the prevalent explanations for health and illness. As Sigerist (1955) found, these explanations, for Arab people, often belong to a higher power, for example God, or some supernatural or psychic force considered beyond people's control. We may note the central importance of the concept of the evil eye as it manifested in the interviews.

Belief in the "evil eye." Although belief in the "evil eye" as a source of illness is not readily acknowledged by many Lebanese Americans for fear of shame and embarrassment, it is still a prevalent belief.* One person graphically portrayed the reality of the evil eye in the following way:

> We used to have this cow, a really good, good cow. Every day he gives milk. This lady came to my grandmother's house and just said, oh, well you see you are supposed to say 'Smullah,' an expression that means you don't give the evil eye. This lady didn't say Smullah. The same day the lady left and the cow dropped dead.
>
> You would be meaning something bad to the other person. Even in the bible isn't it said somewhere, do not look at someone else's

* The belief that the gaze of the human eye can bring misfortune to people and their property is referred to as the evil eye phenomenon.

> things, and wish it were yours! I think its one of the ten commandments. So this is why you look at something and you are so jealous to the point that you wish it was yours. That's when something bad happens. Everybody believes in the evil eye.

This person brings out the relativity of belief systems when she refers to one possible explanation for the evil eye coming from the Bible. Moslems quote the Koran to explain the origin of the evil eye (Kearney, 1984). However, belief in the evil eye can be grounded in a variety of sources; in fact it transcends religions and is a common belief in many cultures (Roberts, 1976).

According to Kearney (1984), belief in the evil eye is a specific cultural interpretation of the universal fact of jealousy, which is substantiated by the following quotations from people interviewed.

One person stated:

> People here, like the Jews, help each other. Back home, if they see you becoming better, you become like their enemy. And they won't associate with you anymore. Here, you can pursue whatever you want. Back there it is more difficult. They see someone getting better, they will wish it was them.

Many people referred to the following saying as the Arabic canon for interpersonal relations: "It was me against my brother; me and my brother against our father; my family against my cousins and the clan; the clan against the tribe; and the tribe against the infidel." Conflict has been viewed as an essential part of life and it is through the ability to prove oneself worthy through conflict that status and esteem are gained, even though this conflict is a consequence of jealousy, the raison d'etre of belief in the evil eye.

The influence of the effect of the evil eye can be prevented through the use of prayer and talismans. Likewise the effect of God's divine power or wrath can be subdued through prayer and practices to help keep the faith, the practice of charity, and self-sacrifice.

God's divine power. One person summarized the belief in the supremacy of God's power with the following words:

> God is the creator. Mind is prior to humankind. There is a universal mind which in humans is called instinct. Mind operates us. I don't think that I contribute. Each person operates differently; it depends on the information it gets fed. The program makes us unhealthy or healthy. Your basic being has basic programming for food, survival, protection from injury, reaction to pain, being aware of people.

The primacy of faith in God, for this group of Lebanese Americans acted as a motivating force for sacrificing their own self-interests to benefit others. For example, one person stated:

> I had a huge sacrifice to make because of financial matters. Really what I was fighting for was my husband's vision of his growth and the future and what affect that might have on his psychological well-being, which directly relates to mine and the children's.

The primary ideas relating to belief in God and the fixed relations existing between them are thought to be beyond a person's control and a manifestation of a Divine Power. This ideology is virtually unquestioned. However, one woman interviewed offered the following comments with some apprehension, perhaps typifying the reluctance of this group of people to control any inquiry into an area of life considered to be sacred:

> I don't know if I am so strong religiously because of me or what was told me. Nothing in this world is more powerful than God. It is my belief. There are lots of days when that's the only thing that gets me through. If someone tried to make me think that God really didn't exist I think that my health would disappear.

This reliance on just accepting beliefs within the culture was exemplified in reference to extremes in temperature shifts as causative of illness.

Extremes of hot and cold. Lebanese Americans seemed to have a preference for considering the significance of explanations for health and illness as more important than assuming any control they might have over health and illness. For example, the change from hot to cold or vice-versa, in foods or weather, was considered to be a significant factor in producing illness. This hot/cold explanation is all-pervasive, not exclusive of other explanations for health and illness. For example, one person stated that she had been taught to use a herb tea for a common cold, but that the tea had to be hot in temperature because "this was the belief."

Dewey (1929) noted that fruitful science began when inquirers neglected the immediate qualities of sense events, for example, wet and dry, hot and cold. Likewise, the immediate perceptual experience rather than the objectified reflection upon that experience is prevalent in health conceptualizations by Lebanese Americans.

Health Conceptions. Distinctions between phenomena are made by analytic thought, which, according to Dewey (1917) consists of several stages of inquiry. The first three stages of inquiry which were used by the Lebanese Americans in the study to conceptualize health fall into three major subdimensions designated by "a feeling state," which is representative of the first stage of inquiry; descriptions of the health experience into the differentiation of "physical and mental health," representative of the second stage of inquiry, and the meaning given to

health through apprehending "suffering," representative of the third stage of inquiry.

A feeling state. The primacy of sensory meanings belongs in this first stage of logical inquiry, which demands no reflection, for example, "It is a feeling at gut level," "you feel good," "It's a feeling of happiness" and "you can tell by whether you are in a good mood or a bad mood, whether you have a sense of humor or bad humor." There was a preference for using this category of a feeling state of health over other major categories reviewed in the literature, for example, the absence of symptoms, orientation towards performance, adjustment to the environment, and a state of well-being (Baumann, 1961; Smith, 1983).

Mental and physical health. The second stage, or empiric stage of inquiry which describes the immediate experience was used to identify categories of health, for example, "It's body and mind working in proper order," "being mentally and physically fit," "mentally and physically a whole person," "health is the condition of my body and my mind. If it's good health then everything is working in proper order." However, rather than the differentiation of physical and mental being considered as separate there were references to one affecting the other, for example, "I can be physically healthy but not feel very well" and another example, "The physical has an influence on the nonphysical." Therefore, the differentiation into categories of health was used to explain health in a wholistic sense where parts are interrelated. This wholistic way of viewing health is a relatively recent phenomenon in the Western world (Dossey, 1984; Flynn, 1980; Pelletier, 1979).

Only one person spoke of health by referring to its opposite, for example "as not being sick," which contrasts with the point of view of the Anglo-Americans studied by Zola (1980).

Suffering. The reflective stage of conceptualization was represented by the following examples which point to the value of suffering and self-sacrifice, not only to life but to the appreciation of both health and illness. For example, one person said,

> I think those days come, that's the pain that having got through the day and the emotional drain of it, allows you to see something you never saw before. There isn't life without pain and there is no growth without sacrifice.

Another person said, "People can't appreciate good health without the bad times. You won't appreciate it if its smooth. The families who have tragedy have the happiest lives." Newman (1983) saw health as a synthesis of disease and nondisease where disease is seen as the integrating factor necessary for personal transformation in the life process.

Just as suffering is seen in some Western societies as an aspect of life to be avoided or transcended in the ego's striving for self-actualization and well-being (Hillman, 1983) so the experiential way of describing and valuing health is relegated to an inferior or neglected position, in preference for using more complex and abstract descriptions (Kelman, 1975). There is a possibility that both Lebanese Americans and health workers in the United States can contribute to each other in a discussion about health. Lebanese Americans can share the importance of keeping in touch with the experience of health including the value of suffering and we can share the importance of abstraction, both essential components of knowing about health.

One other important fact arising from an analysis of the data is that rather than health practices being linked directly to health conceptions, which Laffrey (1982) found in her study, health practices for Lebanese Americans are more closely related to explanations for health. This discrepancy is probably related to the way of conceptualizing health as a feeling state and the perceived lack of control over health status, health practices being more naturally linked to a perceptual ideology which demands that certain actions be taken.

Health practices. The two major subdimensions of health practices carried out by the Lebanese Americans in the study were illness prevention measures and health maintenance practices. There were Western models of illness prevention, for example, the model described by Leavell and Clark (1965) and the Health Maintenance Model of Harris and Guten (1977), have been outlined in the literature review.

For Lebanese Americans, illness prevention measures concentrate on traditional practices like prayers, blessings and the wearing of talismans or practices like a special saying or ritual to prevent the influence of the evil eye, as well as other more subtle practices like keeping beliefs and remaining in touch with one's instincts and intuition.

Health maintenance procedures like diet, adequate rest, relaxation and exercise were often cited as examples. These practices enhanced the sensations of the bodily experience and are preferable to more abstract or complex procedures like biofeedback or Rolfing.

One important practice that the people themselves practice in Lebanon but are no longer able to practice here without going to a doctor and receiving a prescription, is that of taking medications in the form

of pharmaceutical drugs (Basta, 1976; Hamarneh, 1972; Meleis, 1981). Some people offered descriptive accounts regarding the obtainability of drugs in Lebanon, for example, "Lebanese society has reached a state of unhealth, taking Valium and sleeping pills. The bourgeoisie took drugs over the counter. Prescription drugs were not really prescription drugs in Beirut." Another person stated:

> Always it's home cures, never asking what is wrong. You have to have a 42 degrees temperature before going to a doctor. My mother had a saying, 'Doctors should have to ask her advice because she knows.' She knows every drug for each ailment and the name. She goes to Western medicine but she was young when penicillin was discovered. Therefore antibiotics can cure you of everything. You only have to know the symptoms of infection. You need no prescription. There is a wide abuse of antibiotics. Why go to doctors? He opens our mouth to see a sore throat and gives drugs. I can do that.

Illness prevention. Traditional illness prevention activities such as practicing faith through maintaining belief in God and the practice of prayer, were frequently cited preventative measures (Howell, 1970). For example, one person stated:

> You don't learn faith here [referring to church], this is the academic explanation. You learn it from life. Through the practical application. Faith is a feeling about yourself. If you don't feel good about yourself. See it in the context of believing and not worrying.

Another person said:

> To me I think God is someone I can talk to. Someone that could comfort me and someone that is always there for me whenever I need him. It's a power that I cannot explain, not visualize, but I know exists. I put myself in direct contact by praying and stuff. It's really important that I can rely on and reach to in any kind of trouble, that's my base, that's were I start from.

Another supernatural relationship to the cause of illness, the evil eye belief, already explained in the literature reviews as an explanation for illness, has certain prescribed rituals for preventing its influence. For example, on person said, "You see you are supposed to say Smullah,

short for Bismallah, before you compliment someone" and another person said, "Especially babies are taken to these special people, so that nothing will happen to them. They say a certain prayer to cast the evil away. You know who to go to." (Migliore, 1983; Pasquale, 1984).

In relation to the humors or changes in extremes of climate or food, one person offered the following comment:

> Change of water affects my digestive system, the wrong kinds of foods, change in the weather, probably the altitude also. I should diet and stop eating for two days to help my system fall back in order. I haven't done it properly and I am trying not to feel guilty about it.

The practices appear to be subtly infused into a way of life and may not be consciously performed by many people (Harwood, 1981).

Observing beliefs was another health action. Some examples follow from the fields notes:

> She then actually knocked on wood and said 'Of course I'm superstitious. I strongly believe there is a way to do things. Do the right thing and you are on the right path. Superstitions are part of it. We make choices all of the time. Each time you are entering a new reality. You do not have power over the final state.'

Some proverbs which were quoted as part of the belief system and were abided by in practice, were: "If you eat well you will be healthy," "Not fighting yourself is equivalent to happiness," "Don't pretend you're sick, because you will really end up sick, and then you will die." Many sayings were directed towards taboos for women, as for example, "Females shouldn't sit on the pavement. You could die of whatever;" "You shouldn't eat tomatoes or sour things when you have your periods;" "Bathing during your periods was bad of course;" "Girls were taught that you don't touch yourself, that's bad."

People often referred to keeping in touch with one's instincts or intuitive sense. One person described instinct as follows:

> Instinct is different. It is food, to eat and feed your body, to get your body in shape. All babies, when they are first born, they cry. They want to eat, to protect yourself from injuries, to react to pain. It's all basic instincts, to be aware of people. The first time they touch fire it hurts, that's instinct, if it hurts they won't touch it again. They are basics. Their pains, their human instincts, their tortures of life, their awareness of what hurts and what is pleasant, what hurts is painful. These are basics that you are born with, because of your formation and your basic being.

Health maintenance practices. The Health Maintenance Model of Harris and Guten (1979) appeared to fit conceptually with Lebanese Americans more than any other model reviewed in the literature. One person actually stated that "Health is taken for granted. We are maintainers."

Diet, exercise and relaxation measures were frequently discussed, while personal routine and environmental hazard avoidance were specifically mentioned as maintenance practices. One person pointed to diet: "A well balanced diet, you cook from scratch. You get the raw material. Even the uneducated know they need to eat fresh food, have variety and cook it yourself." Another person said, "Exercise is very important because at least I become conscious of my physical body and I develop more admiration of how it functions. It's time for yourself."

One person's comments on a relaxation method, learned in preparation for childbirth follows:

> The only way I can deal with it is to mentally get myself back into the situation I was in, to change my perspective on it. I use Lamaze breathing, constant deep breaths in and out; stretching the ribs in and out; stare at something and close my eyes, listen for something. Just calmly think about the breaths. Get my body involved in that. Get a focal point to look at. That works marvellous for me. I used the breathing during labor with both of my kids.

The domain of health practices belonged to the people themselves, a fact which many authors pointed out has been common to all societies (Idler, 1979; Kleinman, Eisenberg & Good, 1978; Stacey, 1984). Health practices among this group of Lebanese Americans related to ideologies and traditional belief systems about health and illness. However, those beliefs were often confronted after the transition of immigration because the people saw new practices and did not have the social pressure to conform to old customs. Guilt and the fear of punishment were strong influences that prevented some Lebanese Americans from changing or being able to listen and actually consider change. Many people commented that in order to take on new ways of practice, they needed careful explanation to test whether a different practice was viable for them. Consequently, the choice of helper was pertinent to them, the doctor being more frequently considered in the United States as a health provider then in Lebanon where traditional healers were more available and social pressures to use other methods were stronger.

Helpers

God, the individuals themselves, traditional healers, and doctors were considered to be helpers, quoted in that order of frequency. Lebanese Americans preferred to refer to health workers as 'helpers' and rarely used the concept 'health professionals' and rarely referred to the nurse as a helper.

Probably the most important factor in regard to seeking help outside of the family arises out of feelings of loss of control (Smith, et al., 1968). For example, in relation to a question about why people wait until an event is out of control before calling a doctor, one person replied:

> Its mainly mostly because at home, your mother for example, has the home remedies. When you have like a stomach ache or something, a cold, we used to boil herb, mint, and make it like tea and drink it for stomach pain and stuff like that. Most people relied on those types of remedy.

The mother was not only used to having control over medications within the family situation but also over herbal remedies which were often used.

God. One person spoke about the plan God has as the primary helper in people's lives, which was echoed by the majority of these Eastern Orthodox participants:

> Its up to God to cure, each individual's God. We all worship the same God whether we know it or not. Our own power derives from the strength of our creator. We need to exercise our faith . . . you have your own mind, you have your own knowledge and your own desires and that's your own God who forms you, who makes you whatever you are now, when you are alone and left in space, you have only your own God . . . The ultimate decision in you is your God's, because that decides whatever it is . . . We cannot understand God's decision.

As this person indicates the self is a vehicle of God's power. The power is acknowledged as coming from God, but it is up to each individual to find ways of knowing and being in touch with God.

Self. Although the mother frequently functioned as the unpaid health worker in all societies (Graham, 1979; Stacey, 1984), Lebanese American mothers perceive that their culture puts a special obligation upon them. Khalaf (1971) stated that family honor, and the care often taken not to blemish or taint the family's name or integrity, were expressions of a pervasive value orientation of loyalty. One mother stated:

> It is my responsibility to defend their medical rights. I do a lot of diagnosis of my own kids, a mother has to and I've developed the skills and I don't know if this is ethnic or not but parents put themselves and their own desires below that of the child. My mother is very overweight and is not taking care of herself yet she's insisted that we take care of ourselves. Certainly my background, more than other backgrounds, tells me that the responsibility of a

> mother, meeting all my kids needs to the ultimate, is higher than my responsibility to myself.

One person, in regard to her own personal self-care, explained:

> I think its very good for my health. I think it kind of relieves me, like one day I don't feel good, I am very unsettled, uptight and nervous so I just sit down for a few seconds maybe, that's what I do most of the time, say the Lord's prayer. I think that's a lot healthier than visiting a psychologist or a psychiatrist. So I think talking my problem outward with God is very healthy for me, it helps me a lot. That's the way I try to raise my kids, too.

People practice other methods of self-care, such as that indicated by the following person:

> I do exercise to help myself. I become conscious of my physical body and I develop more admiration for how it functions. Moving in exercise demands something that you do not get from ordinary, physical movement. Its time for yourself.

There are some health issues that require the assistance of another person, especially when an accidental injury to the bone structure occurs, such as a dislocation.

Traditional healers. The kind of practitioners mentioned in Pillsbury (1978), for example, the bonesetter, were used in Lebanon.

> You know when you dislocate the bone, there used to be the really, really good people. There was this really old man, old women too, they do something and they put it back. The younger generation here don't know how and even the doctors, they only go by the book and what they learn.

Experience and skill are valued, and perhaps alternative health care providers such as the physical therapist and chiropractor may be preferable practitioners in appropriate circumstances.

There are many reasons why doctors are not used until traditional ways of coping have been tried, but doctors are more often consulted in the United States because healers are not readily available.

Doctors. Reliance upon other helpers rather than the doctor is exemplified in the following example. One person said, "My parents

believe they get hurt from the evil eye so they don't go to the doctor."

Another person responded:

> If controllable the family would look after her. I know a family with five doctors and a politician. Their only aunt was in this country alone, not mentally stable. She lives with them. If they don't look after her they would feel guilty. They would believe God might punish them. They would be afraid. They feel they should. They are the same flesh and blood. There are different kinds of feelings towards our families. People in this country say "I'm not responsible."

Some experiences people have had with doctors in the United States follow: "I had these back pains and no doctor would believe me that something was really the matter. They said it was psychosomatic."

Another person stated:

> I let things go too long. I had this terrible pain and I went to this doctor who did a urinalysis. He gave me pills and nothing was getting better. I rang him again when I was vomiting and almost fainted and he said, "I told you there's nothing wrong with you."

One woman talked of her experience with a gynaecologist:

> A girl in Lebanon does not go to a gynaecologist before she is married. It was a shock for me to have to go to get a health certificate to get married. I was so nervous I almost passed out and couldn't let that doctor touch me.

One person summed up the attitude of many of the respondents by saying, "It doesn't matter what the doctors say, you want it or you don't want it and that's the ultimate resolution. Helpers are there to help you to say "I have it."

The characteristics of the helper, no matter who the helper was, were considered to be the important factors that facilitated "helping." These helping characteristics can be broadly classified under the terminology used in nursing and other helping professions, as "caring" qualities (Leininger, 1981; Watson, 1979) and are expected from any helping relationship.

Expectations from the helping relationship. Although many people in the Western health care system are accustomed to specialist treatment, Lebanese Americans looked for someone who cared for them in a more holistic sense, caring for both the physical and mental aspects of health (Hamarneh, 1972). One person stated:

> I shifted from the gynaecologist who was only concerned about the reproductive system. I was having back problems and I talked to him about it and not only got no sympathy and got no response. I wanted someone who was going to deal with my whole being, who was concerned if I was going to emotionally break down, if I was happy. How other parts of me were functioning. I'd had back surgery. How was the back? Are you anemic? Do you want to have more children? What is your family structure? What is your lifestyle? These were questions that I wanted asked.

Fagerhaugh and Strauss (1977) stated that the patient, as a central actor in the analysis of illness and treatment regimes, was one whose actions and values were as crucial as those of trained health care workers. Stacey (1984) also stated that it was a matter of patient and professional working together on the health issue, however there must be an understanding that an issue existed in the first place. The other significant expectation from the helping relationship was that of receiving an adequate explanation, of being able to benefit from new knowledge and to be able to make choices based on understanding and meaning.

Caring. One person summed up the characteristic expected from a helper by saying, "An individual who cares about others in general and is there to help you say 'I have it.' A person who has the art of survival." Some expectations from this caring relationship included the helper's ability to listen, to be friendly, to comfort and believe in the other. For example, one person stated the following in regard to expectations from a nurse:

What do you expect from a nurse?

Just smile.

Even though you are feeling sad?

Yes, sometimes a decent attitude. They think that if you have a question, it's a silly question. So I think it helps a lot if what you are saying, you are saying, not to be mean or you want the attention only to yourself. You are saying it because you are really suffering from something. And when they make fun of you, they laugh or smile. They think you are very demanding and I don't think that's the idea, especially in a hospital. It's not demanding, it's just because I need something. I need that help, just some emotional support, someone to be able to talk to freely and you know they are listening to you. You know they are not in a rush. They just want to leave you to take care of something else.

Adequate explanations. One of the outstanding points made by many Lebanese Americans was that of receiving an adequate explanation for care. People said things like, "Someone who gives information," "Educates about the health problem" and, "They give reasons why."

One person outlined the process which enables decision making by suggesting that an explanation provides understanding which leads to the ability to be able to make a judgment and then to make the final decision. Hayes-Bautista (1978) found, in a study with Chicano patients and medical practitioners concerning lay-professional interaction, that the issue of knowledge was at the base of perceptions about illness and consequent management and that sometimes many questions needed to be asked and answered in order for the other person to make sense of an episode so that an appropriate line of action could be taken.

Arney and Bergen (1984) remarked that knowledge discrepancy, where it existed, was related to issues of power and control and was used in the Western health care system as a technique for surveillance over stresses that might threaten the social order. Taussig (1980) also noted

that knowledge must not be used to manipulate, but that it should be used to enhance the effectiveness of choice available between alternative actions.

Some of the differences between expectations from the helping relationship, use of helpers, health conceptions, health care practices, and explanations for health and illness, became explicit through Lebanese Americans telling of their immigration experiences and confronting health care systems.

The Immigration Experience

Starr (1978) commented that Lebanese Christians occupied a somewhat higher economic position than other groups in Lebanon and also that Eastern Orthodox members tended to study in English medium institutions. Beirut was the hub of the business sector and virtually a Christian citadel from where most immigrants originated, both to Australia and America (Khalidi, 1983). The majority of the country's schools were in private hands, run by Americans, French, British, Italians and Germans. Americans controlled one of the best universities in Beirut (Gilmour, 1984).

Kasl and Berkman (1983) commented that countries differed on the level of organization of health care and the consequent sensitivity to health care status. Indicators to such differences as health care status became salient methodological concerns in evaluating the health impact of immigration. Ideas of Lebanese Americans about expectations of health care and ideas about health status often contrasted with those familiar expectations and ideas held by residents in the United States whose families have been here for several generations. Attitudes about change were revealed within the storytelling.

The major subdimension dealing with the immigration experience and its relationship to health care and health status was that of change, particularly discovering those resistances to change which are necessary to know before health care management can proceed in a compliant manner. According to Kotter and Schlesinger (1983) one of the reasons change does not occur is due to human resistance. Resistance can be categorized by levels of parochial self-interest, misunderstanding and lack of trust, different assessments, and limitations in ability to change.

Ability to change. Some actual experiences resulting from immigration were contrasted with previous experiences in Lebanon. For example, one person said,

> They believe that whatever happens to you, you have nothing to do with it; it is from God. If someone really got sick, it's from God and you can't do anything to prevent it. Since I have been in this country I know what I can do to take care of certain things, to take care of your health. I really thank a million times I am in a country where these things can be taken care of.

This person expressed appreciation for having the opportunities in this country which staying in Lebanon might possibly not have brought, and also shows a willingness to change.

Misunderstanding and lack of trust. Another person referred to the prejudice and social pressure that is not conducive to mental health:

> It's so hard in this country to be mentally healthy. You could be easily depressed, for example by the work environment. There is a lot of discrimination. You need power behind you, for example, community support. The Arab community isn't powerful. The Spanish are. There is a lack of interpreters. Someone who is Chinese is likely to find someone to interpret easily. Many Arab women are floundering because they don't have English.

These comments indicated a lack of trust because of the social situation, and contained the key to helping overcome that mistrust through support and consideration.

Different assessments. The idea of going to a mental health professional was foreign to some people, unless the person concerned was actually thought to be mentally ill, although second and third generation Lebanese Americans were less likely to have that opinion. One first generation Lebanese American stated:

> People go to a psychiatrist because they can't handle it. You should know your own path, your improvement. You have to have your own power. No one knows your mind except you. Most of the people don't know their own strength. I think they know it. We help our children all we can. I don't know if they really need it [referring to Americans going to psychiatrists]. If you know anything and its not appropriate to them, they say, go and see a psychiatrist. You are crazy, go see a psychiatrist for anything little that can be wrong. We don't. The psychologist and psychiatrist are really for very disturbed people. Its for everything here. This brings inferiority on them that they are not mentally competent, capable. Their ideas are wrong. This then creates a problem and someone's eventually going to believe it. Its out of line to say you are crazy. It will affect the person eventually and the person will not believe in himself. The psychiatrist needs a business too. The next thing you know its forever.

Obviously this person felt that something of value would be lost by visiting a mental health professional for concerns about personal growth, namely, self-esteem.

These examples of experiences and expectations from Lebanese Americans about the effects of the immigration experience upon their health and health care, revealed attitudes that underly conceptions and actions. Differences about ideas and practices were discernible through relating to stories about happenings before and after immigration and can help the health care provider gauge a person's capacity for change, particularly through becoming aware of resistances.

Summary

The dimensions that have been discussed and which result from the analysis of the data can be summed up in an integrative statement

exemplifying the significance of the analysis. These dimensions are those of the Lebanese American people and indicative of quite a different perspective from that of the health professional who is accustomed to viewing health conceptions within a specific socio-cultural context.

Health conceptions of Lebanese Americans can be interpreted in relation to actual experiences and the understanding of health and health care practices. Health conceptions are likely to be expressed in a feeling manner incorporating both the physical and mental aspects of health, recognizing the value of suffering, in some instances. Explanations for health and illness directly relate to health practices, such as prayer and diet. The helper or health care provider is not only chosen because of a certain area of expertise, but because of particular characteristics and expectations involving the caring relationship, such as believing in the person and having the capacity to negotiate, particularly through giving adequate explanations. Telling about health experiences both before and after immigration can be a helpful way for the health care provider to gauge one's ability and willingness to change, through becoming aware of attitudes evoked and resistances held.

Guilt in relation to family obligations and a fear of God's punishment may delay people seeking assistance. When a situation is thought to be out of control, the need to find some plausible reason for the health issue is sought. Decrease in family support and the lack of availability of traditional healers is likely to lead the Lebanese American to seek help from the doctor more readily. Health care providers need to build upon traditional explanations for health and attend to the caring attitude expected from the relationship, the key factor for maintaining practices arising from meaningful explanations.

The outstanding feature about health conceptualizations, and the context in which these conceptions are formulated, lies in the experiential mode Lebanese Americans use to express themselves and is a reflection not only of their way of thinking but also of acting. Dewey (1971, 1929, 1938) has given us some understanding into the correlation between the experiential stages of inquiry and the lack of control people are likely to experience in their lives, which for Lebanese Americans often belongs to God or some other supernatural influence.

In a time in history when Lebanese Americans are suffering huge losses both personally and collectively, health care providers have an opportunity to bring about change in beliefs and attitudes about health and health care thereby influencing changes in health conceptions and health practices. Based on knowledge, understanding, and a compassionate concern for fellow human beings, through open negotiation and the ability to incorporate cultural mores into their practice, health care providers can create a new form of community among the Lebanese American population, where health is a prerogative rather than a blessing.

Limitations

Because of the limited resources of the inquirer, the selected population of a group of Eastern Orthodox Christians and the number of 10 people formally interviewed, no generalizations can be made. The knowledge discovered, however, contributes to increased understanding and to the literature of nursing science.

The selected group of English-speaking Eastern Orthodox Christians was largely upper-middle-class, educated in either American or French schools. Although this narrowed the perspective of the aggregate, the

data may act as a comparison for another group of Lebanese Americans, or a like group in another country, (e.g., Australia).

The gender, marital status, and age of the inquirer affected the accessibility for interviewing men and consequently accessibility to women in the family. However, these factors possibly enhanced reciprocity among single, divorced, and middle-aged women.

Kluckhohn (1949) and Maquet (1964) stated that any person studying the culture of another attempts to follow the paths of one's own reasoning process, which may be very different from the one used by the person in that different culture. Although this can be seen as a limitation, the study in fact acknowledges this bias and because of it, reveals the uniqueness of my own interpretation, which is the manner of the methodology.

Maruyama (1963) outlined the basic elements for misunderstandings in interpersonal interactions, for example, the aspect involving communication such as culturally institutionalized or individually internalized elements. While being aware that different communication modes exist and often have different meanings in different cultures, the inquiry was subject to misinterpretation because I was unable, at times, to differentiate between what was a cultural expression and what was a personal expression.

Pertinent especially to data analysis, the categories used to dimensionalize arose chiefly from my own knowledge base. There was also the concern that I could have inadequate conception of the dimensions salient to the Arab's conception of health, nor would I know how extensively any dimension might be plumbed (Hahn, 1973).

Implications for Nursing Care

This exploratory study identified a dimensional matrix which could be used to approach the health care requirements of a group of Lebanese Americans belonging to the Eastern Orthodox religion. Although these dimensions were common for this group, the findings cannot precisely be generalized to others.

Parse (1981) stated that nursing's focus is the human being as a living unity. The responsibility of nursing in its practice is, "Guiding the choosing of possibilities in the changing health process . . . through intersubjective participation with persons and their families." (p. 81). The perceptions of health are recognized as unique to the person at the same time that they are being cocreated through the person's relationships with others. The fundamental place of personal and cultural values in determining one's health is clearly stated; "Health is man's style of living chosen ideals . . . a synthesis of man's values in open energy interchanges with the environment." (p. 31).

Since one's perspective of health care can be known only through personal description, the nurse is able to guide its sharing in the intersubjective relationship with the person and family. The emphasis on nursing activity is communication; communication to explore the possibilities of a situation in order to choose a preferred way of being and becoming, with openness to change valued. There are, consequently, numerous hypothetical implications for nursing practice that can be drawn from the dimensional matrix taking into account Parse's (1981) nursing focus:

1. The study findings reflected that the majority of people described health in terms of personal experience and assessment, e.g., of feeling happy or content. The definition was described as being "mentally and physically fit" in the context of either "good" or "bad" health. This way of expressing health challenges nurses to ask about health in terms of feeling or in metaphors, rather than by use of concise theoretical modes of inquiry.

2. The experience of pain is seen as a vehicle for growth and, although accepted as part of the life process, may delay a person's readiness for seeking professional help. The nurse should be aware of the necessity for the Lebanese American to be in control of his or her own health and that the self-care concept, prevalent in the United States nursing scene, may be appropriate. However, it is essential that information be given concerning the possible reasons for not being "in good health." This kind of explanation allows the person to have some understanding with which to make judgments and decisions.

3. The Lebanese American is likely to seek help from a professional only when in dire need. This indicates that any expression of pain or emotion, perhaps hidden in the form of a "demand," should be taken seriously and the person given recognition for some need. Lack of someone's presence could be seen as abandonment to an evil influence.

4. The nurse, seldom mentioned by the participants, is not seen to have authority to act as an informant. This is especially so for men, who belong not only to the patriarchal world, but to a milieu where the gender stereotypes are pronounced. The independent single woman who is a nurse may require the support of a male nurse or, preferably, that of a doctor.

5. Most help-seeking comes from the mother for her child. Due to family, social, and religious expectations, it is imperative that the mother be given information at all stages of health care and be allowed access to her child during periods of professional care.

6. Because of the traditional taboos associated with modesty in women, Lebanese American women, particularly those who are single, need respectful and considerate care. This particular care is directly relevant to the obstetric and gynecological and family planning clinics.

7. Traditional practices by the family or by traditional health givers should be encouraged due to their possible placebo effect, providing they enhance health. Special respect should be given to the "hot/cold" application of health practice, particularly to climate and foods.

8. Traditional healers and other practitioners frequently sought to dispel the influence of the "evil eye" are essential to those who so believe in it. Any rite or symbolic act or practice used to prevent or treat the evil effect is more likely to enhance healing than inhibit it. It should be remembered that the Lebanese American may not admit to this belief because of the fear of losing face and a feeling of shame and stupidity.

9. Particularly in the case of accidental injury to the bones, an alternative mode of treatment may be acceptable, or even preferable. A specialized practitioner traditionally dealt with manipulation of dislocations.

10. The nurse needs to spend time with the Lebanese American in a personal way, to establish a trusting relationship before taking formal assessments. There is little likelihood of receiving relevant

information if the patient does not trust or believe in the health care provider. A closer spatial proximity than normally experienced among Americans and the use of touch, together with the use of words denoting feeling, sense, and intuition, may add to a believing and reciprocal relationship.

11. The nurse would be wiser to encourage "good health" rather than treatment of illness or rehabilitation. Advantage can also be taken from the dietary beliefs and cooking practices to enhance health potential.

12. The nurse is expected to be loving and caring, to provide support in the form of listening and conversation and just being there as a presence, over the duration of time. The person, above all, wants to be believed in and expects a reason to be given for "bad" health. Meaning can be given through the explanation of methods used and the reasons why. Facilitating the sense of control over health should be of benefit to the patient, the relationship, and to health care.

13. A clinical nurse specialist in socio-cultural health would be an asset as a consultant and collaborator. In fact, any consultant conversant with Lebanese Americans would be able to collaborate with members of the health care team for the benefit of all concerned.

Implications for Further Study

This study investigated health conceptualizations of a group of Lebanese Americans belonging to the Eastern Orthodox religion. Some relevant implications for further inquiry arising from the study are:

1. In order to determine if the dimensions identified in this study are valid, a replication of this study with a larger sample population should be undertaken.

2. It is important to determine if the identified dimensions are unique to this specific group, or whether they apply to other religious groups representative of the Lebanese American population or whether these dimensions apply cross-culturally within the group, for example, in Australia.

3. Because the participants in the study hardly mentioned the nurse as a health provider, a study could ask the same kinds of questions but focused on nurses and nursing care rather than health care.

4. A study to identify the realistic expectations for nurses in a particular nursing care situation, e.g., community health or maternal and child health, would be important, so that some specific guidelines could be reached in regard to entry, approach, and the dynamics conducive to providing quality nursing care for the Lebanese American.

5. A study using a man and a woman as co-inquirers with representatives, both a man and a woman, from the Lebanese American community, to carry out a like study, would be a more successful way of exploring dimensions of health care for a sample of diverse age groups, both men and women, and families.

6. A study to specify the effects that an American nurse, particularly a single woman, has upon the receptivity of nursing care for the man, woman, and family of the Lebanese American population would be invaluable information to the understanding of the dynamics necessary for nursing care.

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Appendix A

Interview Guide

1. What do you think health is?
2. How do you define health?
3. How do you know when you are healthy?
4. How do you recognize when others are healthy?
5. What influenced your ideas about health?
6. What do you do to be healthy?
7. What do you expect from a person who assists you with health concerns?
8. Has your idea of health changed since coming to the United States?

Appendix B

Demographic Indices

Age

Education - language

Occupation

Marital status

Number of children

Experience with health issues

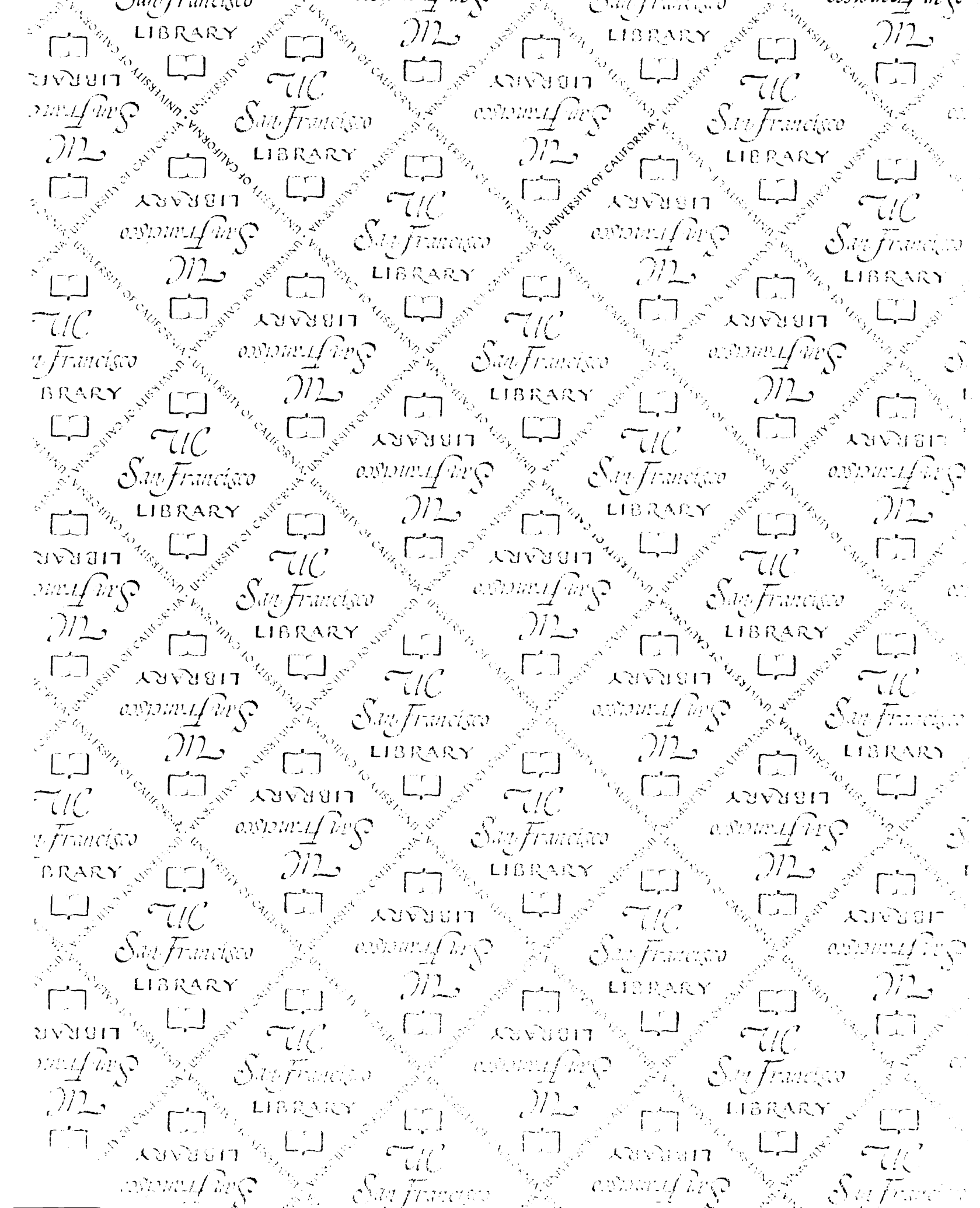
Use of health services

Genogram - parents, siblings, spouse, children

Time since immigration

Place of birth

Generation (1st, 2nd, or 3rd)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