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UNIVERSITY OF SAN DIEGO
Philip Y. Hahn School of Nursing
DOCTOR OF NURSING SCIENCE

CONCEPTUAL METAPHOR IN THE HEALTH CARE CULTURE

by

Cheryl D. Glennon, MS, RN

A dissertation presented to the
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Abstract

The conceptual metaphor has meaning only when understood within the cultural framework which gives rise to the conceptualization. The purpose of this study was to investigate the interaction of cognition (conceptual metaphor) and culture as manifest during intercultural communication in teaching-learning sessions between health care providers and patients. An ethnography of communication (Hymes, 1974; Saville-Troike, 1989) was the method employed to investigate the use of metaphor by patients, nurses and other health care professionals. Patients were viewed as a sojourner group in the health care culture; nurses and their health care partners were seen as a host group. Data were collected during a six month period using participant observation and key informant interviews with groups of sojourners/patients and a host/staff group consisting of six different health care specialties. The communication setting was an outpatient diabetic education program for those with a new diagnosis or whose condition had recently become unstable. The duration of the education program was six sessions, with variable participant attendance rates.

Ethnographic findings indicated that the communication of each of the two groups presented a variety of distinctive features, as well as shared features. The sojourner group communication events and acts included the creation of pre- and post-sessions, the creation of personal narratives, and the practice of stopping the communication. Hosts also generated distinct communication events and acts which were stand-alone sessions, the use of a lecture format, a minimized response to the sojourner narratives, as well as confrontation of non-adherent sojourners. They shared several constructs and meanings in the use of several metaphoric domains, as well as the use of the machine metaphor of

control (Ting-Toomey, 1987). Both groups also exhibited instances of parallel meanings in regard to the metaphor they used. The two groups shared many of the same source and target domains but some were incongruently interpreted by the groups

The findings have implications for future research into use of machine metaphors in health care communication, as well as implications for those health professionals who implement patient teaching to become more cognizant that their metaphors should be examined for effectiveness. Health communicators, who plan and implement programs, need to recognize that health communication may be more effective when they create a communication partnership toward encouraging the "voice" of patients in the process.

I would like to acknowledge the special people who have shared so much of themselves with me during this dissertation process. My committee chairperson, Dr. Patricia Roth, has been supportive and encouraging throughout the dissertation process as well as the entire doctoral study as my academic advisor. Dr. Jane Georges first greeted my proposal warmly and enthusiastically, which encouraged me since she had not previously been acquainted with my attraction to metaphor and culture. The special enthusiasm and caring in addition to sharing with me her anthropological knowledge has created a special place in my heart for Dr. Jackie Taylor, who shortly after her retirement agreed to re-enter academia and become a member of my dissertation committee.

I have been the grateful recipient of much assistance and encouragement from the research participants in this study who were cooperative and willing to share their thoughts and feelings with me for almost six months. Dr. Sharon Davids has helpfully facilitated many aspects in the research setting making so much of the study possible. My classmates have inspired me with their enthusiasm and interest in my research topic. Many of my faculty co-workers have offered support and encouragement throughout the years of doctoral study.

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CHAPTER ONE

Phenomenon of Interest

Effective communication in which there is shared understanding between nurse and client is crucial to the therapeutic relationship. Nurses have observed for years that client outcomes are more favorable when there is a shared understanding between nurses and clients regarding health and illness. Historically, nurses have sought to teach new concepts by engaging clients in various ways including formal educational programs as well as in informal conversations (Sundeen, Stuart, Rankin, and Cohen, 1994). During these interactions, nurses have employed accepted communication strategies and principles in an attempt to positively influence client outcomes. At times, nurses have been less than satisfied with some client outcomes such as adherence to mutually established plans for health care, for example. Subsequently, nurses have undertaken to improve and refine communication with clients, mainly focused on expressing themselves better and more clearly.

Recently, however, the focus of communication has been emerging as significantly more than the mere expression of ideas with others. The cognitive, rather than expressive aspect, of communications have emerged over the past two decades as important to an understanding of how people conceptualize the meanings they attempt to communicate (Lakoff & Johnson, 1980). As nurses continue to communicate effectively with clients, a

deeper understanding of how clients conceptualize nurses and health as well as how nurses conceptualize clients and health would enhance the quality of therapeutic relationships. The conceptualization of any reality, including health and illness, has been postulated by cognitive science researchers to be metaphoric by nature. Metaphoric means that one thing is conceptualized in terms of another quite different thing.

As a group, clients are often unfamiliar with the health care delivery system and as a result, need to learn how to communicate and understand the concepts and practices inherent in the system. Some are successful and others are not. Often, clients express their perception that health care is “another world” different from that of themselves and their families. This notion is manifest in the consumer movement which is well underway toward influencing health care to become more sensitive to clients. Frequently, health care has even been termed “the health care culture”. To enhance our understanding of the client experience, clients can be conceptualized as visitors or sojourners in the health care culture. In fact, many health care institutions have approached patients as “guests” using practices borrowed from the hospitality and tourist industries to try to improve patient satisfaction ratings (Douglass, 1992). The experience of sojourners in foreign cultures has been a focus of study by researchers in the field of intercultural communication.

The purpose of this study, then, was to investigate the interaction of cognition and culture as manifest during intercultural communication in teaching-learning sessions between health care providers and patients. An ethnography of communication was the method used to describe the culture-based use of a particular aspect of cognition called metaphoric conceptualization or metaphor. A cross-cultural analysis of metaphor

illuminated a culture-based way of thinking and learning used by clients and nurses.

Lines of Inquiry

Cognitive science is a multidisciplinary science including anthropology, psychology, artificial intelligence, and philosophy. Cognitive science researchers have studied cognition and their findings have indicated that cognition is metaphoric (Lakoff & Johnson, 1980). Metaphoric conceptualization of reality, shortened to metaphor, is a complex cognitive mapping process from one domain of experience to a new domain. The result is a new understanding of something. In this way, new conceptualization occurs (Lakoff, 1993). But the original domain of knowledge must be culturally relevant to the thinkers and speakers as they communicate. If the speakers are from disparate cultural backgrounds, the new conceptualization doesn't occur because the original domain of knowledge was not similarly known to both speakers. They were from different cultures and conceived of things differently.

Intercultural communication researchers have found that communication between groups from different cultures depends on many things. First, there is the setting of the intercultural communication: one group is a host culture and one is a sojourner (visiting), each has different characteristics, and each group interacts from a different perspective (Witte & Morrison in Wiseman, 1995). Secondly, characteristics of the sojourners (visitors in a host culture) such as their temporariness, willingness, expectations of the host culture, and their management of anxiety about the interaction with the host culture all impact the successfulness of the sojourner experience.

The broad research question, then, was how do patients/families and their health care providers involved in host/sojourner intercultural communication in health care settings use metaphors to construct and share their meanings? Inherent in this question were three broad constructs which informed this study, namely communication, culture and cognition. To arrive at an understanding about how people in these two cultures use metaphors in the health care context, three sub-questions seemed appropriate:

1. What kinds of metaphors are used by patient/or family members and health care provider (HCP) during a lengthy interaction period?
2. What meaning is given to the metaphors used by the patient/or family members and what meaning is given to the metaphors used by the health care provider?
3. What is the convergence among the metaphors used by the persons in these particular interactions?

Method

To pursue the study of these questions, a naturalistic approach to the inquiry was appropriate since the phenomenon of the cognitive metaphor as used in health care culture is not well articulated, much less understood. The naturalistic methods selected for this study were based on the assumption that reality is created by people in interaction with themselves (their historicity, values, beliefs and cultural schema), and with their social environment (Morse, 1994). An ethnography of communication (Hymes, 1974; Gumperz & Hymes, 1972; Hymes, 1996; Saville-Troike, 1986; Carbaugh, 1988) was employed to

describe and analyze the intercultural communications in which metaphors are used to verbally communicate and share meanings.

An outpatient education program provided a useful context for the ethnographic research because the interactions between nurse/staff and patient/family groups were stable enough to observe patterns of communication over time. Further, the researcher conducted semi-structured interviews with the persons involved to inquire about the subjective meanings they attribute to their metaphors. The initial analysis method was a variation of traditional content analysis. In this variation of the usual approach the themes included metaphoric themes and emerged from the data. An analysis of metaphor, based on relevant research findings in the field of cognitive science, was completed. Lastly, a comparison of the metaphors used by patients and nurses and their subjective meanings was undertaken to find the extent of convergence or congruence.

Bracketing

Bracketing is a qualitative research technique which originated and is most often associated with phenomenology (Munhall & Boyd, 1993; Lipson, 1991) but it has found its way into many discussions of qualitative research in general. For the ethnographic researcher, the use of self is a parallel and important concept with many of the same functions as phenomenological bracketing of assumptions to ensure more openness to the view of the research participant (Lipson, 1991). The self is important to the method since the researcher is the major instrument in the data collection (Lipson, 1991). In an ethnography of communication, Saville-Troike (1989) points out that the researcher must try to entertain no a priori assumptions about the findings upon beginning the ethnography

and the “voice” of the researcher (positionality, why are you able to do this study?) must be clearly heard throughout the rich description so necessary to ethnography. There is something of a paradox in these notions of setting aside the researcher’s preconceived ideas and yet identifying the self in the research. The best approach may be to remember to stay aware of one’s own biases and articulate them as needed in the research (Morse, 1994).

There were two fundamental notions set aside in this study. One, somewhat philosophical in nature, was the notion that metaphors are incongruent across the different cultures being studied. Different knowledge systems may in fact share similar constructs in this setting or at least share enough similarity of constructs to employ similar metaphors. The other notion set aside during data collection was that members of the two groups are able and willing to introspect sufficiently to reflect upon their understanding of each other’s communication. The psychological perspective of the researcher assumes that people can and will, if facilitated, introspect but it may not be the case in this data collection environment.

Significance of the Study

The significance of this study for nursing and health care research is that it introduces into the body of nursing research an approach to the analysis of the conceptual metaphor within an ethnography of communication. Metaphors are not new to nursing or health care research, but the metaphor analysis in this study with its focus on the cognitive components (domains) of the metaphor is novel, and it invites nursing researchers to analyze metaphors in various settings and with various patient populations. Additionally,

partnering the metaphor analysis with the study of the cultural framework, i.e. the Hymes (1974) model, asserts yet another dimension to ethnography in nursing research, which is the intercultural communication aspect. In conjunction, the two together (metaphor and culture) extend our knowledge about how health care providers and patients, as different groups, conceptualize health care and how they communicate those conceptualizations to each other. In this beginning process, research is directed toward the future goal of theory-building through a synthesis of the three constructs of communication, culture, and cognition (conceptual metaphor) which have informed and shaped this study.

CHAPTER TWO

Context of the Study

The research literature which is foundational to this study flows from the two disciplines of intercultural communication and cognitive science. Within both disciplines culture is a major context for theory development and research.

Intercultural Communication and Cognition

Intercultural communication research traces its formal beginnings to the post World War II period when communication on an international scale became a necessity for a war-torn world. The particularly relevant aspect of intercultural communication theory and research, for this study, was a type of intercultural communication called sojourner studies or transitions research, which investigates how sojourners successfully communicate and learn within a host culture. The concept of culture is the critical context for sojourner theory and research.

Within the discipline of intercultural communication, Anxiety/Uncertainty Reduction Theory (Gudykunst & Ting-Toomey, 1988) is a major theory, the focus of which is the sojourner, or visitor, to another culture. The other culture, known as the host culture, is central to Katriel's (1995) theoretical postulation that host cultures are more active with sojourners than previously thought. Burgoon's (1995) Expectancy Violation theory attempts to include both the sojourner and the host culture.

Cognitive science, a multidisciplinary science informed by anthropology, philosophy, linguistics, psychology, artificial intelligence, education, and others, has advanced both theory and research on the conceptual metaphor as a significant process of cognition. Communication within a cultural frame is the expression of the speakers' metaphoric conceptualization (Lakoff & Johnson, 1980; Albritton, 1995). Culture is highly significant for cognition and communication for several fundamental reasons. First, metaphoric conceptualization stems from the cultural experience of the body (Johnson, 1987; Markus & Kityama, 1991), and secondly, effective metaphoric conceptualization requires differentiated but culturally relevant concept domains for the metaphor to be understood as intended (Lakoff & Johnson, 1980).

The research within both disciplines, intercultural communication and cognitive science, can have significant relevance to health care providers who must communicate effectively with those client/families who sojourn briefly in the health care culture. The specific lines of inquiry focus on three constructs: culture, communication, and cognition, as well as their inter-relationships. They converge to inform basic issues in health care related to patients/clients who must, during their sojourn, temporarily learn and communicate in an unfamiliar health care or host culture.

Certain underlying concepts, then, shape the discourse about how patients/clients and health care providers conceptualize and communicate about health problems and solutions. The foundational relationships are those between culture and communication, and the relationship between culture and cognition.

Culture and Communication

Interestingly, the word culture is from the Latin word "cultus", which is a form of the verb "colere" which means to till, to nurture, to grow (American heritage dictionary, 1982). The image from the word's origins is one of growth, change, renewal and dynamism. How culture is perceived for research purposes has undergone an evolution. As the field of intercultural communication was developing in the post World War II period, the positivist paradigm was dominant and many early researchers conceived of culture as a static variable in research to be controlled or held constant experimentally. Only recently, as qualitative research paradigms have emerged in importance, has culture been studied not as a variable to be manipulated but also qualitatively as a context and as a dynamic natural phenomenon. As a result, a major developmental issue in intercultural communication research has become the disparate assumptions about the nature and role of culture. Such a fragmented notion of culture among intercultural communication researchers has reduced the comparability of culture as a concept across studies (Carbaugh, 1988). Although many recent researchers have tried to move away from the view of culture as static, others continue to operationalize culture in the traditional way.

In defining the term culture, Carbaugh (1988, p. 40) says culture must be "deeply felt, commonly intelligible, and widely accessible ", thus diverging from the positivist view of culture as a quantified variable. Still others refer to culture as dynamic, a communication- based community of meaning and a shared body of local knowledge (Gonzales, Houston, & Chen, 1994). Criticizing the assumption of culture as synonymous with a nation, S. Hall (1993) posits that culture is dynamic, ever changing and dependent

on the discourse of the period rather than a geographical location, suggesting that culture and communication are interdependent. Advocating for the importance of culture in intercultural communication research, Gudykunst (1991) recalled that E.T. Hall, an early and influential theorist who is enjoying a renaissance in this field, had suggested, simply yet profoundly, that culture is communication.

Although the above mentioned conceptualizations represent a sampling of the definitions of culture, a particularly apt definition has been put forth by the anthropologist Keesing, who views culture as a "system of shared knowledge" (Keesing, 1987, p 201). Knowledge can be viewed in this definition as a group's ways of knowing, such as knowing language, values, beliefs, self, others, relationships, roles, and much more (Keesing, 1997). Health care is a culture consisting of a highly complex system of knowledge and behaviors, most of which is based in western scientific traditions. Members of the health care culture are providers from various disciplines such as nursing, medicine, physical therapy, social work, psychology, and others, all of whom have been socialized by education and experience to a common origin of beliefs, values, behaviors, research traditions, and communication processes. Viewed as such, the health care system meets Keesing's criteria for culture.

Clients as a Culture

Clients, as a group, enter the health care provider culture, with a diversity of world views, value systems, and beliefs. However, there is a single significant unifying characteristic which clients share. Their sole purpose and function as clients is that they are all seekers and receivers of health care. They enter the health care provider culture

accompanied by their families and friends and together represent a separate and different culture, the client culture.

Sojourners

Sojourners are conceptualized in intercultural communication research as "strangers" who are adults socialized in one culture and temporarily located within a different culture in which they must function, and particularly, communicate with the host culture to some degree (Gudykunst & Y. Kim, 1984). When clients enter the health care system, they are similar to any other sojourner group. They enter a culture with which most are unfamiliar, in which they will remain for a time-limited period, and in which they will be expected to function and communicate effectively with health care providers. The health care system functions as the host culture which has a vested interest in helping the client group communicate about their personal and intimate experience, their treatment, their consent, their goals and plans, their cooperation, and many other private aspects of their lives. As with any intercultural interaction, the differences between the two cultures eventually become manifest, leading to high potential for a "collision of cultures" (Burgoon, 1995). Clients are members of an outsider group or sojourner group who experience intercultural contact with the health care providers, who are members of an insider group or the host culture. Although members of both cultures must interact effectively, the onus falls upon the sojourner or client group to interact and adapt to this new culture, justifiably or not (Berry, 1992).

Communication

Communication is an equally challenging construct for the interculturalists to

define. According to Gudykunst & Ting-Toomey (1988), communication is operationalized as a process, an accumulation of speech acts, language, verbal and non-verbal messages, a creator of culture, or culture itself. The function of culture and communication is often viewed as a linear relationship in that culture informs and controls communication, or that communication is an enactment of a culture (Carbaugh, 1988; Burgoon, 1995). By exploring differences in Eastern and Western cultural perspectives on communication (Kincaid, 1987), researchers have sought to find universal characteristics of communication which can be applied across cultures, but mainly find that while the phenomenon of communicating is constant across cultures, the universality of the methods, rules or values of certain kinds of communication is elusive.

Communication and Culture

The actual relationship between communication and culture, however, may be more of a dynamic in which communication and culture mutually inform and shape each other as they evolve over time, or as a consequence of exposure to other cultures, other communication processes, or in response to environmental factors.

This same dynamic connection between culture and communication appears valid for the health care provider and the client cultures, as well. For an example, client family members, or sojourners in the institutional health care system culture, generally prefer and initially expect to remain together, but in institutions, the health care provider host culture prefers pre-set visiting hours. Recently, however, through mutual communication the host culture has modified and relaxed the visiting hours rules to accommodate client families. Cultures seem to change as intercultural communication occurs (Berry, 1992), but why

this is so is unclear because contact between cultures alone is not sufficient for change (Hewstone & Brown, 1986).

Intercultural Communication Sojourner Theory

Intercultural communication research concerning the sojourner experience has resulted in two prominent theories to explain the sojourner experience. The role of sojourner anxiety and uncertainty in intercultural communication, and the notion of sojourner violation of expectancy are the two central tenets.

The Anxiety Uncertainty Management theory (AUM) (Gudykunst & Ting-Toomey, 1988; Gudykunst & Y. Kim, 1984; Gudykunst, 1991, 1995) of intercultural communication is informed by several important notions from psychology (anxiety as affective, behavioral and cognitive experience; categorization theory; awareness and ego defenses; attribution theory), anthropology (culture; cultural variations), sociology (ingroup-outgroup); and communication theory (expectation/violation; communication effectiveness; labeling, prejudice, and communication accommodation).

According to AUM theory (1995) new situations, such as sojourners encounter, create decreased security because outcomes and means to achieve goals related to the interaction are unknown, especially when cultural referents or cues are unclear or confusing, which is often the case for sojourners in the health care provider culture. Confusing referents or cues to sojourners may include unfamiliar ways of dressing, speaking and norms for addressing strangers. In an attempt to increase security, the theory posits that two behaviors occur. First, there is an attempt to seek information in order to reduce uncertainty and secondly, strategies to reduce tension are enacted to

lessen the anxiety level. AUM posits that the result of this is new understanding, one part of which is the ability to predict what the other party will perform.

Members of the health client group enact the anxiety and uncertainty reduction predictions of this theory by means of their anxiety signs and symptoms. During initial or mild levels of anxiety, there is an intensity of perception followed by decreased perception as anxiety levels increase (Taylor, 1994). During the initial anxiety levels patients or clients seek information in a variety of ways: ask questions, notice inconsistencies and noises from other clients and providers. At times, clients stretch their muscles, walk, or yawn in order to decrease tension. Decreasing tension can increase more accurate perception of the environment.

AUM would speculate that understanding ensues from these strategies to reduce anxiety, which means that clients are more able to predict behaviors of others in the provider/host culture. Prediction about others is primarily based on cultural or social categorization which is taking place throughout the intercultural interaction. Gudykunst (1995) points out that this type of prediction based on categories often leads to misunderstanding and false attribution because categories permit a wide range of errors in coding/decoding, language, and interpretation of beliefs systems overlap between the two parties who are interacting. There is not much specific information about the other, only categories of information.

The provider/host culture and the client/sojourner culture are in potentially high risk situations for this to occur, given the vast differences in language (provider jargon) and biotechnology (provider operated machinery), the limited time to develop trust, and

the inevitable categorization which occurs based on cultural and social referents. For example, providers assume trust by clients, they assume the purpose and function of bio-machinery is self-evident, and that clients subscribe to western scientific approaches such as direct cause and effect, or time orientations.

The theory rests many of its assumptions about cultural variations on Hofstede's work with dichotomous differentials such as individualistic versus collectivistic cultures, or high context-low context communication in cultures (Gudykunst, 1991). Although acknowledged as continua, not points, in practice cultures are categorized and labeled by these dichotomies as either/or type cultures. This can be counterproductive in research application. For example, health care providers might be considered high context by others (much information is coded in their communication), but low context (not much coded in their information) by ingroup members. As a theory, AUM is comprehensive and may resonate well with health care providers because of its psychological bases and its ready application to actual observations of anxious client communication behaviors.

Expectancy and Violations

Intercultural interactions, when coupled with high levels of ignorance about cultural differences among the interactants, lead to colliding expectancies or to violations of expectancies by each side as a starting premise of expectancy/violations theory (Burgoon, 1995). Violations can be positive or negative and this depends initially on cultural expectancies. If expectancies are violated and the violation is desirable and the communication is appraised as potentially rewarding, then the violation is considered positive. For example, an American businessperson might be expected by her Japanese

host to use direct speech (not indirect which is culturally desirable in Japan), and the American is more indirect than expected and includes other culturally appropriate behaviors such as bowing. The expectancy was violated, but positively violated.

Research by Burgoon and others (1995) has demonstrated that other factors are salient to success. Expectancy Violation Theory (EVT) predicts that there is a “net valence” (p.200) of violations which determines whether the overall intercultural interaction will be rewarding. Too many negative or positive violations lead to failures of the interaction between sojourner and host group. Desirable communicator characteristics are also an important variable. Burgoon has studied those characteristics which in the U.S. seem desirable, such as physical attractiveness, task expertise, familiarity, and status, among others. Desirable characteristics enhance the positive effect of violations. Nurses communicate more often with clients who have desirable characteristics (Olsen, 1993).

The intercultural interactions between the host/provider culture and the sojourner/client culture are replete with myriad expectancies often associated with minimal understanding of the intercultural differences. Providers encounter a large number of clients/families with limited time to develop understandings, and each group makes assumptions or creates expectancies based on the cultural categorization of each other. Clients often violate provider expectancies to communicate salient information about symptoms or risk factors. Providers often violate client expectancies for clear communications regarding diagnosis, prognosis, and treatment progress, and health education. Expectancy violations have significant effect on the sojourner/client group in the recovery or health status improvement which is mediated by the effectiveness of the

intercultural communication.

The characteristics of communicators, according to Burgoon (discussed previously) (1995), are highly relevant in expectancies within both host/provider and sojourner/client cultures. Clients who complain beyond expected levels are negatively appraised and communication is often avoided or ineffective. Clients who are perceived to be poorly competent in task expertise (self motivation, or self care, or poor communicators) often violate expectancies. Positive violations also exist and those members of the sojourner/client group are often appraised affirmatively.

Expectancy violation theory is helpful to understanding how sojourner/clients communication contributes to client satisfaction and reduced anxiety and uncertainty when they sojourn in the health care culture. A further advantage of this theory is that it provides a framework for future research into the sojourner experience with expectancies and positive expectations violation and its relationship to generating positive health outcomes.

Sojourner Experience

The nature of the sojourner experience in a new culture has been explained from many perspectives mostly in relation to sojourner adjustment or adaptation to the host culture. In a review of the relevant literature, Ady (1995) found the conceptualization and measurement of sojourner adjustment or adaptation has varied significantly and measured in many ways, such as general happiness or satisfaction, intention to remain/leave the host culture, met or unmet expectancies, physical and mental health consequences, willingness for intermarriage, and other measures. Operationalized as

such, sojourner adjustment is an outcome evaluation of the sojourner experience, and is valuable research. The limited focus on adjustment or adaptation probably derives from the practical need to have knowledge about sojourners within international programs, business, and government (Leeds-Hurwitz, 1990).

The actual process of sojourner experience, however, is often only dimly discernable from quantitative measurement of variables and outcomes. In contrast to earlier research, Chen (1994) has qualitatively researched sojourner subjective narratives and reported on a process consisting of three stages of sense-making by Chinese sojourners, who were studying at universities in the U.S. Midwest, as they tried to function effectively in their host culture. The sojourners' making-sense (of the host culture) was a cognitive process and, as such, required sojourners to first become aware of their own culture or system of knowledge, beliefs, values, and expectations. Usually, this happened as a result of a surprise or unexpected misunderstanding or event, which was followed by a new comprehension of how their own cultural systems interacted with the host culture systems. The interaction between the two cultures, of course, involved individual sojourners who employed personal attributes as they were communicating with other individuals in the host culture. In Chen's narratives, the personal effectiveness of the communicators was evident. However, the cultural influence of the sojourners was also obvious. Individual psychological characteristics, in addition to the culture-related characteristics, probably operated simultaneously to help the sojourner make sense of things. Making sense or understanding the intercultural differences happened via communication, of course, with other people, but that was not the whole story. In the

last stage of making sense, the sojourners used the new knowledge as aid for the next time they had to communicate and make sense of the new culture.

Consistent with the epistemologic tenets of the Interpretive approach, Chen's research was enriched by the investigator's clear positionality as a native speaker with a similar history to the sojourners. Analysis of narratives, a particularly useful research method within the interpretive or qualitative paradigm, was enhanced by a member check of the translations of the completed narratives, since Chen used sojourners' native language for the interviews. It is not clear whether she employed member checking for her analysis to determine whether it made sense to the sojourners, but that would have been valuable additional data in this study.

An extrapolation based on analysis of Chen's (1994) narrative research yields insights into those dimensions of the sojourner experience which are equally relevant to the Health Care cultures of interest in this study. The dimensions of particular interest are: the cognitive nature of the sojourner process, and the role of the host culture and the temporality and voluntariness of the sojourner experience. Each of these dimensions require further exploration with relationship to health care.

Cognitive Nature of Sojourner Process

Chen's participants illustrate that making sense of things is clearly a cognitive process mediated by communication. Members of the health care client culture also try sense-making, particularly regarding the strangeness of health care providers' technology, vocabulary, and rules for communication, such as asking your doctor about something (e.g. diagnosis) everyone else knows except the client or family. The latter, for example,

may come as a surprise to the client and, as such, trigger a process of awareness of the sojourner's own values and beliefs which is similar in process to the sojourners in Chen's narratives.

Host Culture

The role of the provider host culture is significant in the sojourner client experience in that providers (e.g. nurses) explain to clients the reasons for communication rules and how to communicate effectively in the health care culture. Effective communication is focal for both parties in this new interaction if a successful sojourn is to be realized.

The tourist encounter, as researched by Katriel (1995), is another source of understanding of the process of the sojourner experience, especially regarding the host culture. Katriel makes a sound proposal for the study of tourism encounters as a specific context for intercultural communication research, similar to that of trade or government service as a context. However, it is her views of the host culture that are most interesting. In intercultural communication research, the host culture is often assumed to be passive or resistant to outsiders. Within the tourism context, the host culture is expected to accommodate itself to the sojourner or tourist. In this context, the host culture is the culture which cultivates bicultural competence in language and tourists tastes, and seeks to develop goodwill among the tourists. Other unique features of the tourism-as-context approach are the celebration of cultural differences, not the assimilation of differences, and the value placed on authentic otherness. Trust/mistrust is the primary focus versus sojourner or tourist understanding/misunderstanding. The host culture characteristics

within the tourism context are particularly relevant to the health care cultures, both to the host and to sojourner. In order to be most effective in the provision of care to the sojourner, the host/provider culture attempts to develop competence in many ways, especially in communicating with the sojourner/clients; this is often referred to as therapeutic or professional communication. Today, the health care provider culture conducts “client satisfaction surveys”, and hires hospitality consultants to help promote positive “guest relations”. Katriel makes reference (1995, p.282) to the recent transition from the “game” metaphor (tourists bargaining for lower prices) as a conceptualization of the tourist marketplace to the “battlefield” metaphor (host cultures compete for tourist dollars) as a more appropriate one. This has relevance for the host/provider culture as well. Health care institutions openly compete for managed care contracts and other economic advantages in order to attract members of the sojourner/client culture.

Temporality and Voluntariness

Although Berry (1992) explained acculturation of sojourners in terms of individual level psychological factors, and the types of changes resulting from acculturation, he also illustrated that there are many different groups which engage in intercultural communication. Sojourners, who are dissimilar from immigrants, refugees, or colonized native peoples, are mobile, voluntary, and temporary, which is reflected in Chen’s participant groups as well as in the two health care cultures (provider/ host and client/sojourner). Thus, differences between sojourners and immigrants frequently impact on the intercultural communication and adjustment success in the host culture.

Clients enter the health care provider culture on a voluntary basis in that legal

permission is required from the client or guardian (if client is not competent to consent). However, given the nature of some health crises, there is a question about the notion of voluntariness when one's life or long term well-being is at risk. The length of stay in the provider culture is time-limited, whether the setting is institutional or community based, such as provider office, health clinic or even home health care. Even in long term care facilities residents may be considered sojourners in many instances, as when funds are depleted or level of care changes, and residents are relocated. The implications of voluntariness and temporality for health care sojourners is significant. It could be concluded that communication must be especially effective for the sojourner and the host culture, given limited time together and importance of compatible function.

Summary of Culture and Communication

Intercultural communication research provides a rich context for the examination of the patient/client experience. AUM theory uses tenets of the universal phenomenon of anxiety and uncertainty to explain how sojourners in a host culture try to manage anxiety by predicting the foreign behaviors of others using social or cultural categorization of others. The categorization process is a complex operation involving cognition in order to mediate uncertainty, but AUM does not explain what actually happens in that categorization process, only that it happens. Katriel's (1995) research with tourists behavior in host cultures suggests that health care providers, nurses in particular, may be naturally active in assisting the sojourner in a strange environment. Expectancies of the sojourner and those within the host culture are violated in positive or negative ways, according to Burgoon (1995) which promote or inhibit favorable experiences for the

sojourner. All these theories share a cognitive element with the experiential research by Chen (1994) regarding how the Chinese sojourners used sense-making strategies to succeed in their host culture.

Health care clients share similarity to sojourners in their voluntariness and temporality in the host culture. As sojourners, the communication which would be needed for effective functioning is different than if the sojourners were immigrants or refugees who are more permanent in a host culture. This idea has psychological implications for the nurses and clients who must relate to one another swiftly, effectively, and mutually and then separate from one another as clients are discharged and leave the host culture.

By synthesizing intercultural communication theory and cognitive science research on metaphor, this research aims to provide a foundation toward an innovative understanding about how clients and nurses, from backgrounds of disparate systems of knowledge, conceptualize each other, and how each group conceptualizes the clients' health and illness experience. With more understanding of the conceptual metaphors communicated by nurses and clients in this intercultural environment, the experience of the client will be better understood by nurses. Therefore, the relationships between culture and cognition are also significant.

Culture and Cognition

The study of culture and its relationship to cognition is largely the domain of cognitive science, and particularly cognitive anthropology, one of the constituent disciplines within cognitive science (Holland & Quinn, 1987). Within cognitive science, the conceptualization of reality is a cultural phenomenon. Recent research has

demonstrated that thinking, reasoning, and conceptualizing is a metaphoric process and perhaps it is a universal process. The conceptual domains in metaphoric thought, however, are clearly culture specific (Lakoff & Johnson, 1980; Keesing, 1987).

Cognitive Theories

Research into metaphoric conceptualization has been based on primarily four theories regarding metaphor, which are Assimilation, Similarity, Structuring, and Contemporary Theory. Assimilation Theory posits that metaphors function as advance organizers of new information which is then subsumed under old or previously known information (Evans & Evans, 1989). Therefore, with the "love is a journey" metaphor, knowledge about the concept of love is incorporated or assimilated under certain aspects of our knowledge of journey to make the metaphor work. A limitation with this theory has been the problem of a paradox that since new knowledge must fit into existing structures, how can we acquire truly new knowledge unless it is similar to the old (Pylyshyn, 1993). Many recent metaphor researchers do not use this theory because of the paradox and, further, the theory does little to explain much about how metaphors work. However, Assimilation Theory appears frequently in cognitive psychology-oriented research.

Similarity Theory proposes that metaphors conceptualize via shared, similar features or attributes between the two domains, and in this way metaphors are the same as similes but without the invitation word "like" involved i.e. "the man is an ox" and "the man is like an ox". This theory is also popular in the metaphor research data generated by psychologists. The Similarity Theory approach is also a linguistic approach to metaphors

(Ortony, 1993). However, Canac & Glucksberg (1984), Glucksberg (1995) and Tourangeau & Rips (1991), who are also in the field of psychology, found that similarity is not the way metaphors are cognitively processed. In fact, the more similarity between domains, the less apt or successful the metaphor. It is differences between the domains, not the similarity, which is necessary for sufficient metaphoric conceptualization. The concepts of love and journey are from sufficiently different domains and that makes an apt metaphor; love and honor are too similar and, whether true or not, "love is honor" does not function successfully as a metaphor. However, "love is a journey" is a sufficient metaphor.

Structuring Theory predicts that metaphors work by structuring an unknown domain from features of another well known domain via an interaction between and within the two concept domains (Evans & Evans, 1989; Tourangeau & Sternberg, 1981). The domains are stored in cognition as related systems. This is also called interaction theory and enjoyed support in the literature as it has evolved (Evans & Evans, 1989). The precise nature of the interaction referred to in the theory is not yet well explained however, and has actually been partially integrated into later theories.

Contemporary Theory of Metaphor

The Contemporary Theory of Metaphor, articulated most recently by Lakoff (1993), is a complex, general theory of metaphor which attempts to explicate and link many aspects of other concepts of metaphor. Contemporary Theory of Metaphor is comprised of many assumptions regarding the nature of metaphor, the structure of metaphor, and some special aspects of metaphor. The current formulation of the theory is

consistent with and extended from the joint work of Lakoff in collaboration with Johnson (1981), and Kovesces (1990), and Turner (1987), as well as solo work (Lakoff, 1987, 1993).

The assumptions of the Contemporary Theory of Metaphor (Lakoff, 1993) can be grouped as follows: metaphor is the main cognitive process for abstract concepts/reasoning; metaphor is how we comprehend much of scientific theory; fundamentally, metaphor is conceptual not linguistic; it is manifest in metaphorical language, and is grounded in non-metaphorical understanding (such as body experience).

The structure of metaphor is that metaphor is the mapping across (transformation of) conceptual domains; the mapping, which is asymmetrical and partial, is the result of the projection of the source domain (the concrete concept: journey) image schema onto the target domain (the abstract concept: love) in a way that is consistent with the inherent structure of the target domain; and finally, the mapping is not arbitrary but grounded in the body and in our everyday experience and knowledge. The domains of the metaphor, particularly the concrete domain, are culturally coherent in the cognition of the speakers (Lakoff & Johnson, 1980; Lakoff, 1993). Without the shared cultural experience, the mapping across the domains of the metaphor does not occur, that is , make sense. Sojourners (or others) from different cultures often do not understand the meanings of the metaphors used in the host culture because those domains schemas are culture specific.

The Contemporary Theory of Metaphor is widely referenced in the literature, and is a general theory to explain conceptual metaphor proposed to date. It appears to enjoy more acceptance in most of the disciplines within cognitive science (Holland & Quinn,

1987; Keesing, 1987; Allbritton, 1995, Martin, 1992) and is referred to somewhat less in psychology (Evans & Evans, 1989; Tourangeau & Rips, 1991; Glucksberg, 1995).

Criticisms of the Contemporary Theory of Metaphor are sparse in the literature. Glucksberg (1995) asserts that the way the theory describes metaphors as stored in memory after they are created is a problem of rigidity. He prefers the more flexible view that meanings of metaphors are created as they encountered, not as they are remembered from previous use. He prefers the emphasis on spontaneity of the mapping (still cognitive) rather than memory. Although Ortony (1993) offers little direct criticism of Contemporary Theory, he mentions that the macroscopic view (or general theory) is often less interesting than the study of the more microscopic or concrete viewpoints on the nature of metaphor such as the aptness, relevance, or rate of comprehension of a given metaphor or family of like metaphors.

Theoretical Studies

A noted cognitive anthropologist, Keesing (1987), has applied the Lakoff & Johnson view of conventional metaphors to examine the problems inherent in translations of theological and metaphysical concepts from non-western culture. He cautioned that if the conceptual metaphor is a cognitive and universal cultural phenomenon, as it seems to be, it may not be accurate to attribute qualities to another culture which are reflected in their metaphors. An alien investigator might assume we speakers in western science believe the sun moves relative to the earth when we say "the sun rises in the east" (p.206). He further reasoned that "dead" metaphors (sun rising) should not be discounted in a culture because the underlying schema may still be important to the culture. He concluded

that the researcher must also pursue understanding of one's own cultural metaphors. The Keesing concepts have direct relevance to an analysis of health care culture concepts as well, since awareness of nursing's own metaphors would help health care providers to understand how cared- for persons are perceived.

Another critical element in metaphor research is the work done on bodily experience as the basis for metaphoric thought/cognition. Image schema (Johnson, 1987; Lakoff, 1993; Allbritton, 1995) are defined as wholes of experience which are dynamic, flexible, recurrent patterns of ordering of things. Examples of image schema are: container, path, force, link, part-whole, and balance. These schema are differentiated from image-rich mental pictures of things, which are more specific and concrete. Image schema are general and abstract and relate to many different objects, events, activities, and bodily movements (Johnson, 1987). These schema are grounded in body experiences which humans extend from the body to other aspects of reality. For example, nurses talk about placing a tube "in" the body to provide nutrients; this in/out orientation reveals the conceptualizing of the body as a container into which things are put in/out, and contained or excluded. Other cultures (non health care cultures) may conceptualize the body less as a container and more of a garden, for example. In that case, the language might focus on "fertilize" the body with nutrients by putting things on the body. Image schema, which form the basis for conceptual metaphor, are culture specific (Johnson, 1987; Markus & Kityama, 1991).

General categories of metaphors have been identified from image schema.

Oriental metaphors are based also on bodily experience and refer to spatial metaphors

such as "I feel up today" as a metaphor for feeling good. Health is up. Ontological metaphors refer to the quantification of ideas into substances, as in "mind is a machine" metaphor. Structural metaphors use fairly concrete concepts to structure another domain, as in "argument is war" (Lakoff & Johnson, 1980).

Johnson's (1987) image schema and the general categories of metaphoric conceptualizations are necessarily culturally coherent in order to be understood and used (Lakoff & Johnson, 1980; Lakoff, 1993; Albritton, 1995). The conceptual connection between intercultural communication's sojourner research and cognitive science is culture. Sojourners are a separate group who interact and communicate with a host culture. Understanding the processes they use to communicate in a host culture and the host culture behavior is the domain of intercultural communication sojourner research. Understanding the cognitive means each cultural group employs to understand one another cross-culturally is the domain of cognitive science metaphoric conceptualization research.

Metaphor Aptness

Empiric studies of metaphor have often been quantitative studies focused on testing subjects' recognition response times to measure the quality or aptness of metaphors. Psychologists such as Tourangeau and several collaborators (Tourangeau & Sternberg, 1981 and 1982; Tourangeau & Rips, 1991) reported empirical findings indicating that the aptness (success) of metaphors was related to the unique interaction of the two concept domains, which play an asymmetrical role in the apt metaphor. However, their research focused on only low-aptness metaphors and omitted other factors which

may contribute to apt metaphor, such as culture.

Two cognitive psychologists (Camac & Glucksberg, 1984) reported an experimental study of response times which shows that successful (apt) metaphors create relationships instead of using existing associations, and that context is essential to apt metaphors as is directionality of meaning ("the surgeon is a butcher", but not the reverse). This finding regarding the importance of context represents a beginning effort to include context/culture in psychology studies. Their research showed that some metaphors are more apt than others but no indication about why this is so.

Much of the significant work in recent metaphor research is contained in a recent volume entitled "Metaphor and Thought", edited by a noted metaphor researcher (Ortony, 1993). The significance of this edited work is that Ortony presented a much needed developmental picture of modern metaphor research which reflects the full range of thought on the topic from several different viewpoints. The volume is evidence that the lines of inquiry on the subject are many and varied and still actively evolving. Some contributors adhere to a positivist view of the metaphor as a matter of words and language, but most seem to assume the cognitive priority. The emphasis in the title on "thought" is itself evidence of the trend away from a language-centered view of metaphor. This edition reflects research into the philosophical bases of metaphor, the technical functions of metaphors and testing of theories such as: similarity theory, concretizing theory, assimilation theory, and interactive domains theory, each of which predicts different empiric findings.

Within the field of cognitive science, research regarding artificial intelligence is

important as scientists seek to simulate the human thought process using computer programs. Martin (1992), a cognitive scientist in the area of artificial intelligence, used Lakoff & Johnson theories of metaphor to create a computer sub-program which recognizes, interprets and learns new metaphors during processing from both literal and metaphoric language. The work is preliminary but conceptually sound, based on recent theory, and in fact the program's logic, although it lacks elements of context/culture, was foundational to the metaphor data analysis process which was used in this qualitative study of health care and client metaphors.

Although western thought regarding the metaphor has continued for two millennia, the concepts which have been developed recently to explain the phenomenon of conceptual metaphors are dynamic and still in the process of unfolding. This study has investigated metaphors as they occur naturally in a setting of mixed cultures or mixed contexts, i.e. the health care culture and people interacting with the health care culture.

Metaphor Research in Health Care

The research regarding metaphors in health care has in many ways followed the development of the understanding of metaphor as more than an expressive, linguistic device into the phase of current research which views metaphor as conceptual and crucial to cognition. Many studies reflect a limited understanding of the conceptual metaphor.

Levels of Metaphor Research in Health Care

Research in cognitive science regarding the basic process of metaphoric conceptualization, as already presented, has provided a theoretical framework for exploring how metaphors are employed in health care literature. The value of researching

metaphors to help understand reality better has not gone unrecognized by researchers in health care, as well as in other related service disciplines. Some of the recent studies clearly reflect the researchers' appreciation of the metaphor as a conceptual process. Such research rests within a theoretic framework of metaphor as conceptual, rather than expressive or linguistic

Other studies reveal the researchers' neglect of the conceptual process of metaphor and focus on metaphor as an expressive or linguistic device and thus leading to the notion that metaphor is synonymous with 'theme' or 'symbol', or 'story'. This is a notion which predates the recent research on metaphor conceptualization, and essentially represents the archaic view that the metaphor is primarily expressive or linguistic in nature. However, the value associated with the latter studies, metaphor as expression, is that they point the way to fertile knowledge areas in which metaphor research has already begun. The disadvantage is that our knowledge is not advanced because the theoretical framework is insufficient and unarticulated in such studies. Thus, the meaning of the metaphors is confounded and essentially not clearly known.

Expressive Metaphor

Less modern views on metaphor often appear in the health care literature. Employing the metaphor as synonymous with "Theme", Huttlinger, et al (1992) set out to study the ways that Navajo (properly called the Dine') use metaphors to create their meanings for diabetes. Methodologically, the study is sound, except that more actual text, less summary, in the report would be more illustrative of native meanings. From the metaphor perspective, the use of the concept of metaphor is disappointing for such

anthropologically based researchers who reference Lakoff & Johnson (1980) and Sontag (1988) in their theoretical framework. Appropriately, the authors discuss the nature of metaphor but they deny that metaphor is conventional in thought and language, preferring the older assertion that metaphors are used when ordinary language is insufficient (p. 709), this is done in the same paragraph as they reference Lakoff & Johnson (1980) whose premise is that metaphors are conventional (everyday cognition) and not special language. Although domains of the metaphors are not delineated, the domains can be discerned by an informed reader; the section on the implications for practice wisely included the need for metaphors to be incorporated into patient teaching to increase meaningfulness. This recommendation is significant for nurse researchers.

In a brief paper, Smith (1993) provided insight into the workings of metaphors in nursing theory and explicitly defines metaphor from a dictionary source to be a figure of speech. She proceeded, however, to present certain metaphors (human being is a machine, is an organism, is an unfolding mystery, and homelessness is a storm at sea) as guiding thought and conception while avoiding further reference to any linguistic aspects. It appears that the author intuitively knows the cognitive and conceptual nature of metaphor but is not using the recent research on the nature of metaphor. Smith's emphasis on metaphor in theory is salutary but lacks the updated definition and concepts of recent metaphor research which would add clarity and precision. Similarly, Botha (1989) in her essay on nursing theory development, and Hodnicki, Homer, and Simmons (1993) in an inspirational discussion of nursing theory, have inaccurately used metaphor to mean 'themes' in nursing theory. Botha very usefully demonstrated how metaphors

govern interpretation of clinical data, and a study by Hodnicki, et al. (1993) confirmed that abstract ideas guide daily nursing practice, but both studies lack a modern treatment of the nature of metaphor.

Metaphor as “Symbol” is evident in Condon’s (1992) work which thoroughly explored the concept of caring ethics from a feminist perspective; near the end of her remarks, she asserted that caring is an appropriate and authentic metaphor for nursing in contrast to antiquated male metaphors such as religious calling, and duty in the battle against disease. If the author were able to identify the domains of the referent metaphor, or the emergent (or new meaning) created by the metaphor, she would add clarity to her analysis. As it is, the metaphor (“caring”) is probably used as a symbol for something else. There is nothing inappropriate about symbols, but it is not a metaphor.

In a report of the qualitative portion of their larger triangulated research methods project, Ferrell et al (1991) posit that cancer patients' "pain has a tremendous impact on family because it is perceived as a metaphor for progressive illness and death" (p. 1303). The findings include a statement that caregiver description of pain "could be viewed as a metaphor for the illness" (p. 1307), which indicated that the researchers interpreted pain to be a metaphor for illness based on an unclear idea of what is the nature of a metaphor. The metaphor was not described or analyzed as to concept domains nor what the emergent meaning might be. The literature review and conceptual framework included no mention of metaphor and neither did the respondent questionnaire mention any metaphors. It seems that “metaphor” was synonymous to “symbol” to the authors. Using one word as a symbol to present a concept is called metonymy, which is different from metaphor.

Certain health care research views the metaphor as a “story”. Cultural metaphors employed with Hispanic burn patients to manage pain were reported by deRios & Achauer (1991) as a therapeutic measure, which as they point out, is hardly new in mental health interventions. They identified metaphor as a figure of speech in which words are applied to things to imply a resemblance. They actually used agricultural analogies or stories to denote similarities of irrigation and blood flow, and eagles to connote power over injuries. The stories were told to the patients during a hypnotic state. The shared meaning, domain identification, and the new meanings, which are all composites of cognitive metaphors, were absent from their clinical descriptions. In this study symbols were not used as metaphors but analogies were. No reference was made relating to research on the nature of conceptual metaphor.

A nurse psychotherapist, Billings (1991), described clinical applications of therapeutic metaphors. Her work joined that of other mental health professionals, already mentioned (deRios & Achauer, 1991), who equate metaphor to stories, which is a view not supported by recent research in the psychology literature.

Interestingly, Hagey (1984), writing on biblical metaphors and nursing science, used the concept of metaphors appropriately as cognitive mechanisms. However, that work did not define metaphor and did not delineate concept domains or new meanings derived from metaphor.

Studies which view the metaphor as a figure of speech or as an expressive device of language limit the full appreciation of the powerful role of metaphor in forming and informing the experience of nurses and clients as they interact.

Conceptual Metaphor

In the literature related to the health care culture, the metaphor is emerging as a means to study health care providers and the client culture, as well. Beisecker & Beisecker's (1993) analysis is directly related to this study of convergent metaphors as they examined the doctor-patient relationship using the "divergent metaphors" of paternalism and consumerism. They concluded from their inquiry that incongruent metaphors result in relationship conflict, poor treatment outcomes, less mutual trust, and inefficient utilization of services. Although the authors cited Lakoff & Johnson (1980) as specific metaphor theorists, they did not identify the domains or structure or emergents of the metaphors that they associated with the concepts of paternalism and consumerism. However, their study is significant because they have put forward an understanding of at least two of medicine's guiding metaphors for the therapeutic relationship. One wonders about which metaphors guide nursing's practice and research and how unique are nursing metaphors to our conceptualization of our essence.

Chemically dependent persons in western society are scapegoated as they become "containers" for society's fears and guilt, according to Stein (1990). In his analysis, based on his long clinical experience and anthropological background, he identified the cultural metaphors of war and religion (war on drugs, combating alcoholism, drug offensives, crusade against drugs) as our conceptualization of the problem and the solution. These cultural metaphors for addiction treatment serve to divert attention away from the underlying problems of society and thus begin more meaningful addiction treatment.

Here, Stein illuminates how the society's metaphors create meanings about addictions and also direct society's actions to cope with the addiction situation.

"Illness and Its Metaphors" and AIDS and Its Metaphors" are two parts of a book by Sontag (1988) in which she shows how meaning is created by and from our cultural metaphors for illness. Sontag (1988) sought to demystify illness metaphors as she articulated how fear and lack of knowledge about a disease such as cancer (and previously tuberculosis) stimulated greater metaphorical conceptualization in our culture about illnesses. The militaristic cultural metaphors which dominate our world view of illness are prevalent when medical science cannot offer cures or understandings or clear-cut causes for illnesses. The danger, Sontag points out, is that the militaristic metaphors invite an excessive mobilization and an over-response to fearful and poorly understood illness processes. Consequently, people who live with these diseases also think metaphorically in terms of win/lose. Sontag identified insanity as also having strong metaphors which invite an over-response. Sontag cited the work of Lakoff & Johnson (1980), with whom she agrees, and asserted that since conceptualization of reality is metaphorical, humans act on these metaphors.

North American cultural metaphors for AIDS contain potent "political paranoia" (p. 106) which promotes distrust of others. According to Sontag, the metaphor of 'getting AIDS' means that AIDS comes from somewhere else such as from Africa to Haiti and then to high risk populations in San Francisco and New York City. Science fiction metaphors have been created for AIDS. 'Alien viruses attack' body's defenses. There are 'docking procedures' as viruses invade the host cell. The cell must 'combat the invader'.

Sontag articulates that effective AIDS prevention programs must be tailored to fit the metaphors of the culture. Throughout, Sontag's book accurately promotes understanding of the cultural use of metaphors as our perception of illnesses, even if this is detrimental, at times. The domain concepts, cultural coherence, and emergents of metaphors are intelligible and thus highly relevant.

The studies which view the metaphor as conceptual in nature offer a comprehensive picture of the metaphor as fundamental to human cognition about reality. Health and illness and the interaction of nurses and clients is one aspect of reality about which the conceptual metaphor can be expected to increase our understanding, as with Sontag's illness metaphors and as with Beisecker & Besiecker's physician-client relationship metaphors.

Metaphor Research in Related Disciplines

Several studies in disciplines other than health care contribute to increased understanding of metaphoric conceptualization as it relates to health care. Kuhnian notions of paradigms are thought to be metaphoric in nature (Kuhn, 1993). As Kuhn (1993) has indicated, metaphors shape what we think about and how we think about it. Heshusius (1991) asserts that metaphoric conceptualizations interact with brain-mind development as we grow up within a culture/context. He contends that the context for this development is also one's own consciousness which influences and is influenced by metaphoric thinking in the same way as paradigms influence brain-mind development.

Another understanding of meaning as created by metaphor involves domains of the metaphor, in that conceptual metaphors are comprised of concept domains which are

socially and politically meaningful within a culture or context. Altman (1990) explored how literary metaphors which are male gender-biased and create meanings about women as trivial by identifying women with figurative or rhetorical language which is often viewed as deceptive, changeable and unmanageable. Her example is Locke's metaphor that eloquence in rhetoric is like the "fair sex" which has such beauty that cannot be spoken against (p.497). Altman also illustrates how women can also sometimes be connected with literal language (as nature and earth) if an author seeks to extoll the value of figurative over literal language. The basic idea is that when the culture/context is male dominated, metaphors will order thinking about the feminine negatively. Her warning is to be careful about metaphors we live by.

A qualitative study of gender-biased metaphors in organizational life used content analysis of the interaction between male computer trainers and male and female employees (Wilson, 1992). She found that militaristic, and religious metaphors were used and well understood by the males. Women, however, preferred to convert their metaphors to relational (divorce, family) concepts to make computer program learning more meaningful to them. In Wilson's study, the researchers later interviewed the participants to discuss the meanings and comprehensibility of the genderized metaphors for the respondents; the methods approach has similarities to the methods for this study, although the precise qualitative methods were not reported and thus are not reproducible.

Metaphors also create meaning by governing value systems and world views (Holley, 1989). Holley (1989), in a philosophical analysis which addressed ethical considerations surrounding voluntary death, analyzed the metaphors that `life is a gift from

God' and the 'life is property' metaphor and contrasted the created meanings and new learning about life and voluntary death which derive from the metaphors. Viewed this way, the metaphors create additional meanings regarding advanced directives and decisions to refuse treatment and other ethical choices. Holley employed conceptual metaphors precisely, identifying domains and emergents which result from mapping across domains in the sense of Lakoff (1993), Johnson (1987), and Glucksberg (1995), and others.

Such studies from non-health care disciplines have relevance to nursing and health care in that issues of paradigms and gender are powerful issues of significance when considering how nurses perceive their own profession paradigmatically and how nurses perceive themselves within the health care culture in relationship to physicians and other colleagues.

Metaphor research in health care and related disciplines, therefore, presents varied approaches, which parallel the historical development of the understanding of the metaphor in human cognition. Previous to recent research metaphor was perceived as a convenient device of language when literal language was inadequate to express an idea. Currently, the modern theory of metaphor places metaphor as central to the process of cognition and new learning. Some research is dated and seriously limited as it concerns the use of the metaphor, such as that which equates metaphor with symbol, theme, or story. Other studies examine and explicate the conceptual nature of the metaphor, as Sontag's illness metaphors, the Beiseckers' relationship metaphors and Holley's meaning of life metaphors.

In the current study, the conceptual metaphor was foundational. Metaphor was

viewed as a means to illuminate the understandings which nurses and clients share with each other and the understandings which nurses and clients do not share.

Analysis and Critique

Intercultural communication research regarding the sojourner experience has explored the significance of the role of culture and communication as people try to communicate in a new culture. The relationship between culture and cognition as studied by cognitive scientists has directed researchers to look to metaphoric conceptualization, with its basis in bodily experience and culture, as a prime mechanism for cognition and new learning. A synthesis of these lines of inquiry may contribute to enhanced understanding of interactions between patients and nurses.

During the period while sojourners or clients temporarily reside in the health care host culture, processes similar to those predicted by sojourner theories and cognitive theories can be expected to occur. There is ample evidence that metaphor can be a powerful means to explore the reality of both those who are in the health care provider host culture and our patients or sojourners. As Sontag (1988) has mentioned, the health care culture has conceptualized AIDS and cancer as powerful killers; hence, the client culture views and acts upon the view that persons with AIDS or cancer are victims who are powerless and this may result in poor recovery and self care among those persons. Since the body of modern research on metaphor is in its early developmental stages in health care research, there is significant indication of the need for qualitative research to discern fundamental metaphors in nursing and health care.

Extant theory and research in non-health care disciplines have indicated how the

conceptual metaphor influences thought and behavior. There is also a body of research which explains how sojourners may understand and experience their host culture. In health care research, there are several studies which are prominent for employing metaphor as cognition, namely the Beisdecker and Beisdecker (1993) medical study on consumerism and paternalism, the Hodnicki, et al. (1993) nursing research regarding the “battle” metaphor among Dine’ people, and “the gift” metaphor work by biomedical ethicist, Holley (1989). The literature reviewed herein has indicated an awareness that metaphor is useful in health care treatment, in relationships with patients, and even in theory building and day-to-day practice. However, the current state of research manifests that there is little nursing or health care research which analyses the kinds, structure, and meanings of conceptual metaphors within a cultural setting in which nurses, other health care providers and patients communicate with each other cross-culturally.

This ethnographic study sought to contribute additional knowledge to the discourse on metaphor within the health care cultural context by addressing certain salient research questions. The questions were studied specially within the Hymes ethnography of communication (Hymes, 1974; Saville-Troike, 1989).

First, what are the metaphors health care providers, including nurses, and patients employ when interacting across their two cultures? This question was informed by the cognitive science theories regarding metaphoric conceptualization. Health care research is lacking basic inquiry into this type of culture-based conceptualization of reality, problems and problem-solving.

Secondly, what subjective meanings are attributed to the metaphors employed by

each of the two groups (sojourners and host)? The intercultural communication theories of Anxiety/Uncertainty Management (AUM) and Expectation Violation Theory (EVT) provided the context for this question in the sense that sojourners actively try to increase their understanding and shared meanings with the host culture by reducing anxiety and by meeting expectations.

Lastly, once identified, how congruent are the metaphors across the sojourner and host culture perspectives? The attempts by sojourners and hosts to understand each other better are inherent in the AUM and EVT theories of intercultural communication, and the cognitive theory of metaphor, all of which are foundational to a determination of the congruency of metaphor across the two cultures.

The resulting knowledge from this study was not expected at this point to generate new theory nor to validate existing theory. The goal was to illuminate and explain the cognitive aspects of the cross-cultural communication between health care providers and patients. The Hymes methodology (1974), as described in chapter three (3), provided the needed linkages among the three basic constructs of communication, culture, and cognition which informed this study.

CHAPTER THREE

Research Strategies

This study used an ethnographic design to address the three research questions regarding patients and health care professionals who were defined as two different cultural groups as they interacted in the general health care culture. The particular type of ethnography employed is called an ethnography of communication which is defined as the systematic description of the ways of communication within a culture or group, or cross-culturally.(Hymes, 1974).

Ethnography of Communication

The ethnography of communication, or Hymes method, is based on the two constructs of culture and communication (Hymes, 1974; Gumperz & Hymes, 1972; Saville-troike, 1989). A third construct in the study was cognition, represented as the conceptual metaphor (Lakoff, 1987). Metaphor is investigated within an ethnography of communication, as formulated by Hymes and his followers. in the analysis of the communication event known as instrumentalities, which refers to those aspects of communication which make the communication mutually intelligible to the members of the culture (Saville-Troike, 1989).

Foundational to the method created by Hymes and others is the notion that culture is the context of communication but for meaningful understanding of communication, culture itself is to be studied and understood concurrently with the study of

communication, since neither can be comprehended independently of the other.

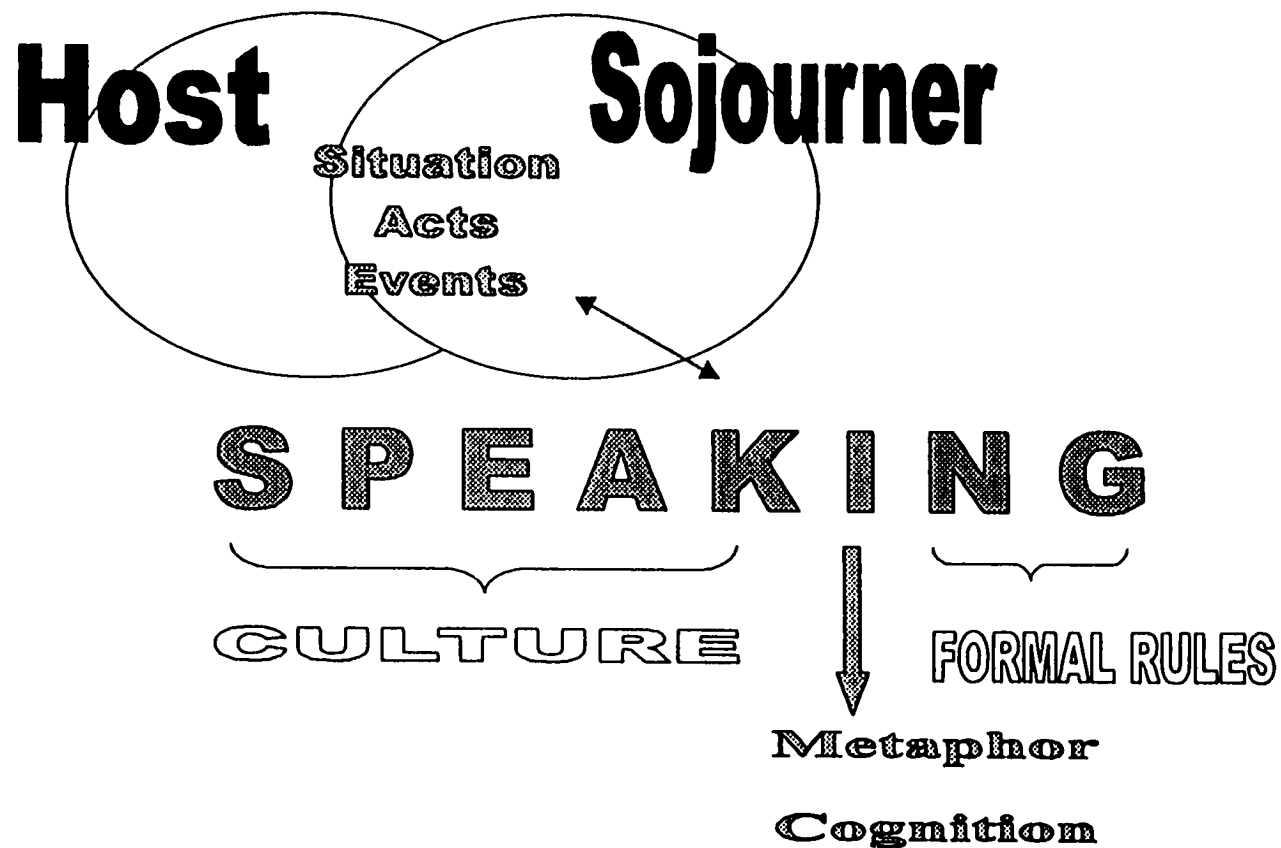
Communication informs culture and culture informs communication (Hymes, 1974). At times, however, intercultural communication researchers have mistakenly attempted to isolate and study culture apart from communication resulting in poor understanding of the relationship between the two (Carbaugh, 1992). Although ethnography of communications as a method is not frequently found in nursing research at present, it has been employed in intercultural communication research, anthropology, communications, sociocultural linguistics, education, and various other clinical areas, especially language disorders (Carbaugh, 1992; Duff, 1995; Toohey, 1995; Bredin, 1993; Rees & Gerber, 1992).

The method for the study of culture is ethnography. This study employed a specific type of focused ethnography called an ethnography of communication, which utilizes the classic ethnographic methods of participant observation and key informant interview as applied to communication. The incorporation within the ethnography of an in-depth study of the metaphors added yet further depth to the instrumentalities portion of the ethnography of communication.

As Figure 1 illustrates, the Hymes model includes the conceptual categories of culture, communication and cognition. The cultures were the host and sojourner groups whose intercultural communication was studied cross-culturally. As illustrated, within the overlap between the two cultures, the units of analysis were the communication situation, the communication acts, and finally, the communication events. Data was collected and analyzed for all components of the communication events. As part of the communication

Figure 1

Methods Model for the Ethnography of Communication



events, one particular component, called instrumentalities, the metaphor analysis was implemented.

The aim of an ethnography of communication is "to guide the collection and analysis of descriptive data about the ways in which social meaning is conveyed" (Saville-Troike, 1989, p.3). The focus of this method is the speech community which is not delineated by language but is a community of shared knowledge and purposes (Saville-Troike, 1989). Further, the metaphorical is particularly identified by both Hymes (1974) and Saville-Troike (1989) as constituting a major focus for the ethnographic description. But the significance of an ethnography of communication goes far beyond the mere cataloging of facts about communication or its metaphors; it contributes to the knowledge of cultural maintenance and change and may provide important cues to the history or evolution of a culture or a speech community (Saville-Troike, 1989).

Rationale for Use of the Method

In this study the researcher studied aspects of her own culture (health care), a process which has been debated within nursing by ethnographic researchers as to its advantages and limitations of objectivity (Field, 1991, Lipson, 1991, Morse, 1994). Lipson (1991) concluded that self awareness on the part of the researcher is required for successful ethnographic work of this kind, as well as training and experience in psychiatric nursing and the therapeutic use of self (in Morse, 1994, p.77). Saville-Troike (1989) and Hymes (1974; Gumpers & Hymes, 1972) concluded from discussions of the challenges of an ethnography of communication in one's own culture that the overarching advantage is that the researcher is able to make explicit what has been implicit, as well as functioning as

a source of rich data, information and interpretation and actually adds much to the validity of the study which is not otherwise available.

The rationale, then, for using an ethnography of communication in the current study was that this method is broad enough for cultural investigation and yet permitted a focused study of a specific aspect of cultures, i.e. human communication. Secondly, an ethnography of communication recognizes the cognitive aspects of communication which are created in social situations. Thirdly, this method requires an analysis in which the social and cultural aspects of interaction are essential. Lastly, this method, as an ethnographic approach, requires the close and systematic observation of the participants by a participant observer who may be very familiar with the host culture (Hymes, 1996).

Entre

Entre was achieved through a six week (6) process of personal contacts beginning at the Patient Educator Nurse level and proceeding upward in the organizational structure to the office of the Vice-President for Patient Care. When final approval for conducting the research was provided in writing, a contact person in the hospital system was identified to supervise the research within the institution. This person was a doctorally prepared nurse who coordinated diabetic education.

With entre assured, permission was requested from the Human Subjects Committee at the University of San Diego. Following approval from the university, the data collection commenced.

Ethical Considerations

Ethical reflections in qualitative research, and especially in this or any study

involving personal health related situations, invite the researcher to be aware of the possible dilemma between client advocacy and advancing knowledge (Munhall, 1993). The ethical issues around informed consent require particular attention, especially regarding the amount of information to be disclosed to the patients/families and their accurate comprehension of the research.

Prior to the interview of the sojourner group of research participants informational material was provided to each person (See Appendix A). The information was prepared congruent with guidelines articulated by Beauchamp & Childress (1994) to assure that the information is such that a reasonable person could comprehend.

Once any participant questions were answered, the sojourner group members who volunteered to be interviewed were given a Consent Form (see Appendix B) to be read and signed. There were two (2) potential participants who declined to consent.

Host group members were approached regarding the research which was discussed and the same information sheet was offered. According to hospital practice, any host group member may decline to be interviewed at any time, but were not to sign a separate consent form. All host members appeared to be enthusiastic and agreed to be interviewed, although some provided more interview time than others.

Data Collection Process

There were two phases of data collection, each guided by the Saville-Troike (1989) eight steps for data collection, which are required to produce an adequately rich description for a successful ethnography of communication. Phase one was guided by steps one through three (1-3) which were introspection, participant observation, and

observation. The remaining steps of interviewing, determining meaning, ethnosemantics, ethnomethodology, and philology were part of phase two data collection and organization of data.

Phase one

The first step is introspection in which the researcher tries to differentiate between the “ideal” and the “real” in a culture, especially in one’s own culture, health care in this case. This process involves self-awareness of values, beliefs, behaviors, patterns, expectations, and insights about one’s own culture. An advantage of the researcher was her experience as a psychiatric-mental health nurse, especially with therapeutic communication (Lipson, 1991).

Participant-observation is the second step in which the researcher frees the self, as much as humanly possible, from the filter of one’s own cultural experience, yet remains cognizant of one’s own cultural experience, as the researcher remains sensitive, aware, present with and interactive with the members of the cultures under study. Field notes were helpful during this process, but active listening was also essential. Participant observation in this study was made during all aspects of the teaching/learning sessions.

Observation is a third step and is rarely sufficient for data collection, but may be very helpful, such as when observing group dynamics as occurred in this research. Reporting observations should be done without making value judgements about the people involved or the meanings of behaviors without checking with members for verification.

In the study, a type of built-in member check was made during the key informant interviews with both groups and the nurse coordinator by writing their responses, as

spoken, on a chalk board. This was followed by a brief review at the end. At times, sojourner members changed or altered their responses. Host members rarely made changes during a verbal review of their responses.

In phase one, interactions between client/families and the health care providers were observed during sessions in which the researcher was a participant observer. In the earlier sessions, the researcher noted aspects of communication in several ways. Sojourner and host communications were written on either side of the stenographer paper to keep them easily separated. Changes and switching in topics, tone, energy levels, non-verbal actions, format, members' arrival and departures, and metaphoric language were signals to write details of the communications and carefully note what immediately followed.

Initially, there was some challenge in making the necessary notations on the process because the content information on diabetes was new and different to the researcher and seemed to be where attention was focused rather than the communication processes. This observation was discussed with the coordinator nurse and it was decided to just let that happen, at first, expecting that gradually the new and novel would diminish, which did occur. Then the changes and dynamics of the communication processes were more readily evident and noted.

Data were collected by also observing the nurse coordinator as she interacted with diabetic clients in inpatient and outpatient settings to evaluate them as potential future sojourner group members. These observations provided additional background information regarding how the sojourner member enters the group.

During the actual sojourner-host session classes, the researcher also identified and recorded on paper the metaphoric language (parsers) as the conversations occurred. It was anticipated correctly that this would be a cursory identification of spoken metaphors, but sufficient to stimulate the discussion in the structured key informant interviews which followed in the interviews.

Phase two

Interviewing is the fourth Saville-Troike (1989) step and, as expected, yielded a wide range of cultural information on many topics. Semi-structured interviews with key informants from the teaching/learning sessions were used in the research (See Appendix C). Questions were formulated as a result of what was heard by the researcher during the teaching/learning sessions. There was a general format such as “when you heard (my meds are working) what did you think of?” or “what did it mean to you?”

For the interviews, the researcher met with volunteer key informants from the sojourner group at the end of the sessions. At times, members of the host group and the sojourner groups were together but, most often, there were separate interviews with individuals from the host group. At that time, a semi-structured interview format was used (See Appendix A) to obtain data regarding the meaning of the metaphoric language used during the earlier teaching/learning episodes.

As expected, since the researcher is an experienced mental health educator and therapist with long experience in active listening and group facilitation, the skills required to identify spoken metaphors and stimulate group discussion did not present major obstacles to the collection of useful data. In fact, the data collection methods were

actually enhanced by the researcher's experience regarding group communication.

Meanings provided by participants during interviews were written by the researcher in the space allotted on the questionnaire guide. For each key informant interview, a different semi-structured guide was required. The reason was that different metaphors were used each time. Also, some repetition was incorporated for comparison purposes.

Ethnosemantics is the fifth in Saville-Troike's steps to data collection in an ethnography of communication and refers to "discovering how the groups' experience is categorized by eliciting terms in the informants' language at various levels of abstraction and analyzing their semantic organization, usually in a taxonomy or componential analysis" (Saville-Troike, 1989, p.129). This step was implemented in the study by an analysis of those metaphors used by the two groups. The specific method of analysis is explained in the subsequent section of "data analysis". Data collected in this step primarily addressed the first research question, i.e. what metaphors are used by each of the two cultural groups.

Ethnomethodology and Interactional Analysis is the final step, and one which seems to cross over into the process of data analysis. It deals with discerning the underlying meaning or interpretation which members of a speech community ascribe to the language they use. In this study the metaphoric language was the focus. Meaning is often discerned by ethnographers with difficulty because meanings change with situations, subsequent experiences, and cultural experience. During key informant interviews, respondents were asked directly to state their subjective meanings for their and others'

metaphors. This served to minimize erroneous interpretations by the researcher as filtered through a personal cultural lens, which is inevitable to some extent. Data collected in this step primarily addressed the second research question, i.e. what meanings are attached to the metaphors used.

Philology refers to the analysis of text and is hermeneutical in nature. In this study an interpretation of the use of metaphors as congruent or incongruent was made possible by a comparison of the source and target domains of the metaphors. Data collected and analyzed in this step primarily addressed the third research question, i.e. what is the level of congruency among the metaphors used by the groups.

In summary, the data was collected in two phases, both consistent with Saville-Troike's steps (1989). In phase one, the researcher used introspection to prepare to collect cultural data, and conducted participant-observations of the teaching/learning sessions. In phase two, interviews with key informants were used to determine meanings of the metaphors used in their cross-cultural communication.

Organization of Data

An ethnography requires that data collection and analysis occur concurrently in order to determine what to investigate next and when saturation of the categories of data has occurred (Schatzman (1973; Strauss, 1987; Hymes, 1974). This process of reaching saturation indicates when sampling of the data is near completion as well as when interviewing and observation is near completion. Hence, the concurrently evolving processes are complex and requires a simple yet sufficient method to track data for further collection and for analysis.

The researcher utilized the memo system recommended by Schatzman (1987) to organize, track, and analyze almost all the data which has been collected according to Hymes' framework. The metaphoric data was collected and analyzed without using the entire memo system since only the analytic notes (AN) memos were needed for the metaphor or text data .

According to Schatzman's method, which directs the researcher in the organization of data as opposed to Hymes method which directs what data to collect, four different types of memos were used. All memos contained information on the date, location, seating arrangement, participants, and the descriptions of communications of participants who were observed or interviewed leaving white space on the pages for line-by-line analysis at a subsequent time.

The observational notes (ON) memo recorded the who, what , where, when and how of the researcher's observations. These ON memos were generated, using written notes made during the sessions, immediately following the sessions or interviews in which data was collected. Approximately, forty (40) ON memos were generated ranging from one (1) to multiple pages for each.

Theoretical note (TN) memos were an analysis of the ON memos to discern meanings and patterns from the observations. These contained interpretations and new concepts related to the ON, as well as the relationships among the data within the ON. The TN memos were generated from analysis of the ON memos usually at a point in time after writing the ON memos. The TN memos became more numerous as the study progressed, of course, since there was an increasing amount of observational data to

analyze.

Methodological notes (MN) memos were the most prolific memos and consisted of reminders to self about whom to interview, which data to analyze next, and a critique of the methods used to date with suggestions about improvement and changes needed in future collection and analysis.

The last and most abstract of the memos were the analytic notes (AN) which elaborated on inferences, and explored ideas and interpretations in depth. The AN were generated mainly from the TN memos and continued to be generated even through creating the dissertation document. The AN memos formed the foundations of the Findings and Implications chapters of the dissertation document, as Schatzman predicted (1973).

Data Analysis

In order to describe and analyze the complexities of the groups' communication, there is a need for discrete units with recognizable boundaries, and Hymes (1974) and others (Saville-Troike, 1989) recommend three units of analysis: the communication situation, the communication event, and the communication act, the most basic of which is the communication event.

A communication situation is the context in which the communication occurs, although time or physical location may change. The situation or context remains constant although there may be diversity in the kinds of interactions which take place. For instance, in this study, the communication situation was the teaching/learning sessions within a diabetic education program.

Another unit of analysis is the communication act which may be a reference, a command, a question, a request, even a burp after a meal, or a period of silence (Saville-Troike, 1989). In this ethnography, the communication acts were yet to be discovered when the study first began, but were anticipated to be question-and-answer acts, or requests for assistance by the sojourner group.

A communication event is somewhat less clearly defined because the communication events totally emerge from the doing the ethnography itself. It is the change between events which most often defines the event, as when there is a clearly different way of speaking or sitting or a silence between events; although the situation and acts may remain the same, the events will change. Each event involves different ways of speaking and different rules for interaction. Saville-Troike (1989) provided examples of each of the units of analysis. A religious service would be a communication situation. This situation may include different communicative acts within discrete communicative events such as: call to worship, reading scriptures, prayer, announcements, sermon, and benediction. Within each event there may emerge particular conceptual metaphors unique to and defining that discrete event.

In order to analyze a communicative event within an ethnography of communication, Hymes (1974) and others (Gumperz & Hymes, 1972; Saville-Troike, 1989) recommend organizing data along the several cultural dimensions of a communicative event, in addition to a rich description of the overall cultural events under study (Saville-Troike, 1989). The cultural dimensions recommended are often identified by the use of the mnemonic SPEAKING in which the letters of the word signify the

specific cultural dimensions of interest in the communicative event (Gumperz & Hymes, 1972; Hymes, 1974). Those dimensions represented by the mnemonic are: settings, participants, ends (goals), acts sequences, keys, instrumentalities, norms, and genres. Each of these components within an ethnography of communication were used in the study to describe and analyze the communications between the two cultures being studied. These components serve as headings for the description of the communication events.

Settings

Diabetic teaching interactions were selected as the setting because these teachings occur with frequency in many health care settings, and the content is well defined. As such, there would be less ambiguity and an added element of clarity for the host culture. A commonly used body of knowledge would also enhance the generalizability of the study findings to other diabetic teaching groups.

It would have been possible to study any of a number of other cross-cultural interactions involving both host and sojourners such as cardiac, mental health, or child development/parenting teaching/learning experiences. The essential component for any choice would have been that a highly cognitive event was occurring which involved both sub-cultures, the client/sojourner culture and the staff/host culture. The setting could have been a formal classroom type or a more informal environment.

Participants

Members of the sojourner culture were defined as patients and/or their families who were receiving diabetic teachings from the host culture staff for the first time or for any subsequent number of times. Family members in the sojourner culture were not

required to be English-speakers but at least the one family member, who is receiving the diabetic teaching, needed to speak and understand English. The host culture member who was providing the instruction will also need to be speaking English for the research purposes of this study. As it turned out, all participants were English speakers.

Key informants who were interviewed following the teaching session were members of the same group of participants as in the teaching sessions, and all had previously consented to be part of the research. It was anticipated that participants were to be asked initially to complete a form anonymously which would ask for basic information such as age, national ethnicity, and gender, but this proved unnecessary as that demographic information about the members was already collected and available.

In a qualitative inquiry, especially an ethnography, sample size is determined by the quality of data required to respond to the questions effectively (Munhall & Boyd, 1993), unlike quantitative research for which, in order to use statistical tests, a specific sample size (n) is needed to meet the assumptions of inference. Another relevant point for this study is that metaphor research/data to date has indicated that metaphors are systematic (ubiquitous), and conventional (everyday usage) (Lakoff & Johnson, 1980). Therefore, dialog was expected to contain a great many metaphors, as indeed occurred.

It was anticipated that the discussions between patient/family and health care providers as key informants would be tape recorded and be limited to less than six group interviews in order to generate manageable volumes of recorded data for text analysis. The total time spent with the participants, however, was expected to exceed the hours of recorded data. As it happened, the client groups were small and tape recording was not

needed or used. The researcher and the facility contact person, the diabetic education nurse, anticipated that the presence of a recorder in such a small and close group would hamper, not promote natural communication.

The total number of sessions at which data were collected was thirty-six (36) over a five and one-half (5 ½) month period from June 25 through November 19, 1997. The sessions included twenty (20) classes, three (3) support groups, three (3) inpatient screenings, two (2) outpatient screenings, and eight (8) key informant group or individual interviews.

Ends

Ends are considered to be the purposes (Gumperz & Hymes, 1972; Hymes, 1974) for the interaction which in this case was the learning of new material or skills by the members of the sojourner culture from the presentation of such teachings by the member(s) of the host culture i.e. the health care professionals/educators. Ends or purposes were spoken in sessions and in interviews, and written in handouts and program literature by the host group. Thematic analysis as well as analysis of group structure, tasks and goals (Forsythe, 1983) were useful analytic tools.

Act Sequences

This component refers to the sequence of initiation/ response or summons/answer (Schegloff, 1972) cycles in a conversation. In this study the communication act sequence was expected to be a question/answer sequence alternating between the sojourner and the host culture members. An analysis of group dynamics (Forsythe, 1983) was particularly helpful, especially an analysis of the group dynamics of power (the ability to influence

others), and sociographic analysis (who talks to whom and who does not), and lastly, group cohesion (strength of the desire to work together). The researcher's familiarity with these analytic methods prompted their use, almost unconsciously at first, as the communication cycles between sojourner and host emerged as a dominant pattern.

Keys

Keys to the communication or interaction refers to the tone, manner, or spirit in which the verbal communication is made by the participants (Hymes, 1974). In this study the keys were expected to refer to the seriousness, informality or humorousness used by the participants. For metaphor data collection, in particular, it was expected to be important to analyze the tone or manner of the communication because metaphoric conceptualization may be couched in various tones or speaking manners which are often specific to the cognitive and cultural frame of the thinkers/speakers.

Instrumentalities

The instrumentalities component of the communication event was a major focus of this ethnography because the metaphoric analysis was studied within this framework. This component refers to the particularities of the language used by the participants; jargon is sometimes used as an example.

Hymes (1974) also referred to instrumentalities as codes, following from his socio-linguistic orientation. Codes are what makes the communication intelligible to the communicators. Since the 1970's when this method was first put forward as a focused type of ethnography, modern metaphor research, with its emphasis on the conceptual or cognitive origins and uses of metaphor to develop new understandings, was in its infancy.

However, Hymes (1974) referred to metaphors even then as a central focus for cultural codes to enhance intelligibility within cultures. In their edited volume, Gumperz & Hymes (1972) described the practice of “metaphor switching”, studied by Bloom & Gumperz (1986), as it occurs in Norway when communicators alternate between folk or native language and the formal or official language. Metaphors were viewed as codes which are understood within a cultural group as that mechanism which provided specific meanings for those who share the same culture.

The metaphoric conceptualization of the two cultural groups in this study, sojourners and hosts, was analyzed primarily within this component of the ethnography. A possible expectation was that switching of metaphors by participants from each culture might alternate between therapeutic communication (sojourner focused) and social communication (neither or both host and sojourner focused) as they interacted.

Parsers

Metaphor data was collected by recording on paper the metaphoric phrases as they were spoken by both host and sojourner culture members during sessions. Using a stenographer’s spiral pad which is divided vertically into two columns on a page, host and sojourner metaphoric parsers were written in one column or the other, along with a brief indication of what was happening at the moment in the communication process. Later, the parsers were copied onto notebook paper under a heading for each page.

Source Concept Identification

The headings for the parsers were determined to be those concepts which the speaker was using in order to convey a message. That concrete concept (for example, a

container) which one is using to convey information is otherwise known as a source domain of the metaphor. The source domains became the various headings under which the metaphoric parsers were subsumed. Eventually, thirty-four (34) source domains were identified and over twelve hundred (1200) metaphoric parsers were collected under those 34 source domains, to be used later for data analysis.

Source domains are often called schema or schemata in the literature (Johnson, 1987; Schwarz, 1997), which provided a rich offering of possible source domains, and was used to begin the organization of all the metaphoric parsers. Eventually, the extant literature provided all the possible source domains needed for the collected metaphor data. Table 1 presents the source domains from the literature.

Target Domain Identification

The process for identification of the target domains was found to be similar to the grounded theory methods proposed by Strauss (1987) involving a repeated line-by-line reading over time of the metaphoric parsers searching for the emergence of categories. The question asked of the sojourner data was “what are the data saying about ideas the sojourners are trying to understand?”. The same question was used for the hosts’ data. These questions were informed by the nature and role of target domains, as presented in the metaphor literature, that targets are the abstract concepts, which speakers are trying to understand, in order to conceptualize a new, novel, abstract thing (targets) by means of a more concrete, culturally familiar, embodied concept (source).

Eventually, the sojourners’ categories were abstracted into seven (7) target domains, which were as follows: control, problems, schedules, self-change, treatment,

Table 1

Schema (Source Domains) from the Literature Used to Organize Parsers

Johnson, 1987	Schwartz, 1997	
Balance	Breath	Right/Left
Blockage	Commodity	Sight Strength/Ability
Compulsion	*Container	Surface
*Container	Cut/Join	Take/Reject
Count	Debt/Payment	Up/Down
Counter force	Fire First Position	Word/Speech 12p
Feed	Floor/Ground	
Iteration (repetition)	Form	
Mechanical	Lot (chance)	
Near/Far	Mirror Image	
Path	Motion/Rest	
Up/Down	One/Many	
War	Parent	
	Pattern	
	Point/Show	

well-being, and feelings. Host target domains (8) were somewhat different and emerged as control, choice, self-responsibility, self-care issues, newest changes, how it all works, problems, and host help for sojourners.

At this stage in the data collection and analysis, there were data sufficient to answer the first research question guiding this study, which asked what are the metaphors used by the two groups. The source and target domains were available.

Once the metaphor source and target domains were revealed, approximately five percent (5%) of the original metaphoric parsers were selected. Each of these parsers and the associated source/target concept was then used in the key informant interviews to inquire about meanings. For example, “don’t leap into exercise” is the parser; the associated source/target was ‘treatment is a sudden movement’ (or should not be). Key informants were asked what this parser or phrase meant to them. If both host and sojourner attached similar meanings, the meanings were considered congruent.

In summary, all the 1200 metaphoric parsers which were collected could be placed under headings called schema, or source domains. Certain headings contained as few as 8-10 parsers, and others were associated with a many as 90-100 for each of the two groups. The organization of the participants’ metaphoric parsers in this manner permitted the subsequent analysis which produced the answers to the first research question about the kinds of metaphors used by the two groups.

Norms

Norms refer to verbal patterns in the interactions which emerged through the spoken thoughts of the participants. The research question in this study which refers to

congruency of conceptual metaphor within- and cross-culturally was examined and interpreted within this part of the ethnography. The norms were expected to include the frequency of the use of certain kinds of metaphor or no specific kinds of metaphor.

Genres

Genres can be said to refer to the style of the communication which may include poetry, myth, tale, proverbs, lecture, etc. A sermon would be a specific genre. In this study, the genre was a lecture, a discussion, or a media enhanced presentation by the member(s) of the host culture.

The data analysis methods, used consistently for all units of analysis, were traditional methods of ethnographic description; also used for several specific components of the units of analysis were group dynamics analysis (Forsyth, 1983), thematic analysis (Munhall, 1993), and in vivo coding (Strauss, 1987). Table 2 presents a summary of data collection and analysis of elements in the ethnography of communication.

Rigor

Guba & Lincoln, (1990) have advocated that issues of rigor in qualitative research design include trustworthiness, applicability, consistency and neutrality. Trustworthiness assures that the data and the analysis are close to the reality of the respondents (Creswell, 1994). In this study trustworthiness is manifest in the participant-observation mode (phase one) of data collection in a natural setting. By following up with key informants (phase two) who were present in phase one as well as the health care providers, the researcher and the participants can trust that all were talking about the same content. The interview questions in phase two served to validate findings in phase one and expand that data

Table 2
Summary of Data Collection and Analysis Procedures

Units of Analysis (Hymes)	Collection Method (Saville-Troike)	Analysis Process
Communication Situation	Observation (Ob) Interview (Int) Printed Material (PrMat) Internet Information (Web)	Ethnographic Description Memo system (Schatzman)
Communication Acts	Participant Observation (PrObs)	Description Pattern Recognition
Communication Events Setting	Ob, Int, PrMat, PrObs	Description Coding (Strauss)
Participants	Ob, Int, PrObs Departmental Attendance Record	Description Group Dynamics Analysis (Forsyth) (Structure)
Ends	Ob, Int, PrMat, PrObs,	Thematic Analysis (Munhall)
Acts	Ob, PrObs	Group Dynamics Analysis (Power, Sociogram, Cohesion)
Keys	Ob, PrObs	Description Pattern Recognition
Instrumentalities	Ob, PrObs, Key Informant Interview	Schema Synthesis (Johnson, Schwarz) Clustering of Parsers

Table 2 (continued)

		In vivo Coding (Strauss) Ethnosemantics (Saville-Troike) Philology (Saville-Troike) Interaction Analysis (Saville-Troike)
Norms	Ob, PrObs	Group Dynamics Analysis (Norms-Covert, Overt) Thematic Analysis
Genres	Ob, PrObs	Description Thematic Analysis

collection into a type of 'member check'. The subjectivity of the data was highly valued, as in all ethnographies.

Although other cultural settings will vary, it is the stability of the ethnography of communication methods which enhance the applicability of the ethnographic findings to other settings because the protocols can be repeatable anywhere. The seven steps of Saville-Troike (1989) for data collection, beginning with participant-observation of a natural interaction, and proceeding to interviews of the same persons about the earlier interaction, and subsequently comparing/matching of meanings and metaphors between individuals are methods which can be utilized in a variety of other health care settings.

Consistency across studies is less desirable for ethnographies because it is assumed that individual meanings are created in a culture and, since they are unique to each social and cultural situation, meanings can be expected to vary. However, the central research significance concerning culture, cognition, and communication are constructs which can be considered consistent, as well as assumptions about conceptual metaphors.

Neutrality was enhanced by extensive use of field notes, the memo system, repeated contact with the same informant/respondents and written semi-structured questionnaires in phase two, which was based on data collected in phase one. Each of these assisted the researcher in identifying bias, leading questions, and any "hidden agendas".

Summary

The data collection and analysis strategies were consistent with a model formulated originally by Hymes (1974) and refined by Saville-Troike (1989) and Gumperz

and Hymes (1972) and Hymes (1996). The model encompassed the three constructs which guided the study, including the conceptual metaphor, as Hymes placed metaphors, which was within the instrumentalities section of the communication events. The findings generated by this model were termed the ethnographic findings, as presented in the first part of chapter four.

CHAPTER FOUR

Findings

The findings presented in this chapter are organized relative to Hymes' (1974) ethnographic framework, and include a description of the communication situation, and the communication events. The communication situation is discussed first to provide a general context for the remaining communication findings. A rich description of the communication events follows and presents specific dimensions of the communication. The most detailed aspects of the communication events are the metaphor findings.

The Communication Situation

The general communication situation, which is defined as the context within which the communication occurs (Saville-Troike, 1989), occurred within a health care system which consisted of two acute care hospitals located approximately 16 miles apart within a large metropolitan area in the southwestern United States. The system has evolved over the past twenty (20) years to include, in addition to the hospitals' outpatient department, a home health care agency, a long term care facility/nursing home, and several wellness centers.

The outpatient department offered the community health teaching in several areas such as a cardiac rehabilitation program and a diabetic empowerment program. The diabetic empowerment program provided to those people with diabetes a range of self-care services, specifically, assessment, support, and education. Although the particular

communication which was studied was the education aspect of the empowerment program, the program is described briefly to enhance the context.

The Empowerment Program - Assessment and Support Aspects

The empowerment program was described briefly in a blue information card available throughout the hospital system. The purpose of the program was to assist diabetics in understanding their diagnosis and in providing their own self-care. The published philosophy of the program was that diabetic self-care, in conjunction with communication with the patient's physician, helps to prevent medical complications from poorly controlled diabetes. Generally speaking, diabetes is a very complex disease that affects all aspects of a person's health and well being.

The program was implemented under the direction of a coordinating nurse who was a doctorally prepared with the title of diabetic educator. This person concurrently held several other positions in the hospital system. She was the parish nursing coordinator and a faculty member within the family practice medical residency program. The nurse coordinator had an extensive background in collegiate education and clinical practice. Her role in the medical residency training program was to teach physicians about diabetes and the medical management of diabetes. Since she was a member of the research participant group, her role in the ethnography will be subsequently described with the other participants.

The first part of the empowerment program required diabetic patients to make an outpatient appointment to see the diabetes clinical nurse specialist or the medical dietitian. The referral process to the program was, ostensibly, to originate from the patients'

physician but, in fact, many other members of the host culture identified those patients in need of assessment, support or education. They made the suggestion to the physician, and a formal referral for assessment and preliminary education was made to the nurse or the medical dietitian, and the process would begin.

During the initial outpatient appointment, the nurse or dietitian would determine whether the patient would be a good candidate for the other aspects of the empowerment program, namely, the support or education classes. Those who already had sufficient knowledge of the disease process and self-care were generally offered the support groups. Those with need for beginning education or a need for additional or reinforcement of knowledge were offered the diabetic education classes.

The support group aspect of the empowerment program involved monthly meetings located at the main hospital or at the Wellness Center which was a storefront center in a new shopping mall. The meeting room at the hospital was located adjacent to the cafeteria to provide ready access, as did the mall location, for members of the community.

Family involvement was encouraged and often occurred during the initial interview with the nurse or the dietitian. Family involvement in the diabetic monthly support group was much greater, especially when the family member also had a medical problem of some type or a form of diabetes.

Many diabetic persons who attended the support group meetings had previously completed some amount of diabetic teaching at some point, others had not. During the support group meetings, both patients and families asked many questions. A physician in

the family practice residency program generally led the support group. Therefore, the focus was the medical diagnosis and medical treatment for complications. For example, one support group meeting focused on preventing complications of the eye. Another support group presented information about complications regarding foot problems. During both of the support group meetings the physicians circulated, for their inspection, and explained the actual use of several instruments for diagnosis, such as an ophthalmic scope or a tuning fork. One physician was adept at explaining the instrument and encouraged use by the sojourners, which generated a lot of excitement and interest. However, during another support group meeting, another physician simply passed the instrument around for people to look at without any explanation, which generated very little interest among the sojourner group.

The third aspect of the program consisted of the six diabetic education classes. The diabetic education program within the outpatient services of the main hospital was organizationally located within the hospital's patient care services administration, the vice president of which is also a nurse. The collaboration, which existed among the various departments that participated in the diabetic empowerment program, was a direct result of this organizational location, since all departments reported to the same vice president.

The diabetic education classes were repeated in an ongoing cycle throughout the year. The sequence of the six classes was organized as follows: medications, diet, stress reduction, monitoring your blood glucose, exercise, and medical complications. The six classes of the program were provided free of charge at the main hospital facility. The cost of providing services was underwritten by the hospital through the various department

personnel who participated as part of the host culture. A similar program at the newer hospital facility charged a small fee for the program and it is currently anticipated that a fee will be charged at some point in the future at the main hospital facility.

The coordinating nurse was present for each class although specialty members of the host culture conducted five of the six classes. The nurse was responsible for teaching the class on monitoring blood glucose. The nurse established and provided updates regarding the content for each of the six classes using materials synthesized from published diabetic education literature.

In summary, the broadly delineated communication situation was a typical large city hospital outpatient department which offered to people with diabetes a program called empowerment; the program offered a range of services from assessment, support groups, and education for self-care. The specific communication situation, occurring within the overall context, was the diabetic education component of the empowerment program.

Communication Events

Communication events are defined as a bounded entity containing a unified or similar set of components. Either a change in topic, or new rules of interaction, or use of ritualized phrases signals the boundaries of the communication events. Discovering what constitutes the communication events is the major part of doing this type of ethnography (Hymes, 1974; Seville-Troike, 1989). As summarized in Figure 2, Framework for Presentation of Findings in Communication Events, the communication events which emerged were: a pre-session, the planned session by the host group, and a post-session.

Figure 2**Framework for Presentation of Findings in Communication Events**

Events	Categories of Findings
◆ Communication Events	◆ Pre- and Post-Session, Planned Session
◆ Dimensions of Communication Events	◆ Setting
	◆ Participants and Cultures
	◆ Communication Ends or Purpose
◆ Acts Specific to Communication Events	◆ Personal Narratives
	◆ Sojourner Acts
	◆ Host Acts
◆ Key or Tone of Communication	
◆ Meaning Aspects of Communication to the Groups	◆ Kinds of Metaphors-Domains
	◆ Congruency of Metaphors
	◆ Interpretation of Metaphors

Several dimensions of these communication events are then discussed to provide in-depth insights into the cross-cultural communication.

Pre-session

The pre-session was a spontaneous communication event which occurred as sojourner members arrived for class, and it usually began with the arrival of the first member about twenty (20) minutes prior to the official time for class to begin. This event was sojourner initiated, sojourner dominated, and met the sojourner need for control for a part of the communication experience. The communication during this event primarily centered on personal stories of the preceding weeks' experience as a person with diabetes trying to cope with self-care. Occasionally, work, family, or physician stories were included but clearly were incidental to the diabetes self-care. The arrival of the host member and start of the class signaled the end of this event. Since the pre-session was not part of the formal class, the researcher became aware of its existence only gradually.

Planned session

The planned session was the official class on the topic for the day. In contrast, this event was controlled by the host group in that the topic, speaker, and class time was pre-set, of course. The only sojourner influence on the communication during this event was evident in the frequent interjection of personal narratives by the sojourners.

There was no review of the previous session, nor was there continuity from session to session by the host group. The nurse functioned as the sole connection between sessions and between the two cultural groups, although she was clearly a member of a host group. The machine metaphor which connotes parts and pieces as its focus can be

thought of as the guiding concept for discontinuity among the classes . The minimal integration of the classes with one another and therefore of the concepts which are essential for effective self-care may have, in fact, communicated a conflicted message to the sojourner group.

Post-session

The post-session was yet another spontaneous event shaped by and dominated by the sojourner group. Most often, the host member who was the speaker that day was not present, having departed the room, leaving the sojourner group and the nurse. Sojourners dominated this event again; they were intent on asking the nurse questions, seeking clarification about specific attempts at diet or blood testing or physicians.

The three emergent communication events contrasted in several ways. Of course, duration was one distinction; the planned session was the lengthiest event in that it was usually an hour long. The other two (pre- and post-session) were each about fifteen (15) to 30 minutes in duration, with the post-session as the longer of the two. Another difference was which culture dominated the communication. The pre- and post-sessions were exclusively dominated by the sojourner group since sojourners set the topics and duration, whether the nurse was present or not. Thirdly, there was a contrast in the level of intensity. The post-session was the most intense of all three events in that the communication was charged with the energy and emotions of the sojourners as they discussed their frustrations.

Dimensions of Communication Events

According to Hymes' model, the dimensions of a communication event should be

described in an orderly and systematic manner to enhance comparisons with other communication ethnographies. He recommended using elements of the S P E A K I N G mnemonic as headings for the description of findings to gradually create a mosaic of the culture's communication.

Communication Setting

The physical setting for all the communication events was a small classroom located in the cardiac rehabilitation unit, which was an outpatient area with ready access to the multi-level parking structure via a covered walking bridge. The one-hour diabetic education classes were held at 4 p.m. after the cardiac rehabilitation patients had gone home for the day.

The classroom was approximately 15 feet by 15 feet with a large table in the center of the room surrounded by eight fabric, sled-style chairs, two on a side. Approximately seven or eight chairs were also located on the periphery of the room, with a wall mounted white board at one end. There was also a TV monitor and a VCR on a movable cart, several small tables, and a bookshelf, which together created a crowded environment. The overhead lighting was adequate. There was often noise interference from the vacuum cleaner being used after hours in the cardiac rehabilitation area, or from staff conversations in the area, which necessitated closing the classroom door periodically.

The classroom was difficult to find for sojourners attending the first time because of its out-of-the-way location, and its location within another department (the "cardiac rehab" unit). The diabetic education classroom was not associated with a unique location identifier on the list at the front lobby information desk. Periodically, the nurse

coordinator was paged and exited the class to escort new arrivals from a lobby to the classroom.

Communication Participants.

Participants in the communication events included sojourners and host group members. Each group functioned as a cultural communication group.

The host culture. The host culture consisted of a group of professional health care staff which included a nurse, two pharmacists, a dietitian, three social workers, a family practice medical resident, and two exercise physiologists. All members of the host culture held college degrees and most held advanced degrees in their specialty area. Members of the host culture have been employed by the hospital system for various periods of time ranging from several months to several years. The family practice resident was an M.D. in a medical training program associated with the hospital system. The nurse member held a doctorate in education and was one of the faculty members for the family practice physician residency program. All members of the host culture provided health care services in both the inpatient and the outpatient areas of the hospital system.

The six different types of health care professionals in the host group presented classes in varying frequencies. There were two pharmacists, one of whom presented in class three different times during the study duration. Three (3) social workers were involved, one of whom presented twice. One medical dietitian did all of the diet presentations. Two exercise physiologists each presented once. A physician presented once. Lastly, the nurse presented a total of six times, which included her own sessions, once presenting in lieu of the medical resident, and twice presenting for staff who did not

appear for the class. Most group members were of European-American ethnicity, except for the one pharmacist who was originally from India; the dietitian was bilingual in Spanish.

The host group members smiled frequently, provided good eye contact, answered questions promptly, brought handouts to meetings, and came well prepared to present material on the topic. The host members seemed committed to participating in the diabetic education program. Since the class time period was scheduled from four to five p.m., the hosts had already worked a busy day; yet, they were prepared, interested, and enthusiastic. Several of the sojourners were known to many of the host group who had previously provided some sojourners with inpatient care as well as outpatient diabetic care.

All members of the host culture belonged to one of a number of departments within the hospital; those departments contributed one or more hours per week to the diabetic education program, which was under the coordination of the nurse. The various host members rotated into the diabetic education program on a regular periodic basis. The host members from the various departments involved in the program may or may not have been the same person for each class assigned for that department.

The within-group behaviors of the host group consisted of smiling, positive and complementary comments regarding the skill and abilities of others, expressions of gratitude for presenting information. As a group, they provided up-to-date diabetes information to this sojourner group. Members of the host group each wore the official hospital name tags, and introduced themselves and their professional role at the start of

their presentations.

They presented their content to the sojourners in an organized fashion following an outline originally provided by the nurse. Throughout the data collection period, only one host member did not show for class; they substituted for one another when necessary and the nurse said that she is always prepared to teach any class if necessary. In general, the host group members were supportive of one another and evidenced a positive attitude towards sojourners and seemed to believe it possible to experience successful living with diabetes. One of the pharmacists, as well as the nurse herself, had family members who have diabetes. The schedule of topics and speakers has been summarized (See Appendix D) to show actual topics discussed during the data collection period.

The nurse was the main bridge between the two cultural groups. She was the only real connection for new sojourner members since they usually had met her previously. The nurse addressed the sojourner members using surnames upon first meeting, used principles of adult learning such as active listening, asking sojourners what teaching was needed, and using a non-threatening approach. The nurse was the one host member most connected with the sojourner group. She was engaged with them and often taught in a personal way during the period called pre-session, and during the post-session when she worked with sojourners on a one-to-one basis. Prior to beginning these six diabetic education classes, the nurse interviewed potential members in the hospital before discharge, or in an outpatient setting. At that time, she would assess needs and taught the basics of self-care using adult learning principles.

The other members of the host group were equally positive and interested in the sojourners' welfare but did not address sojourners by name nor were they familiar in a general way with the background of the sojourner member unless the sojourner had previously been hospitalized in serious condition. Essentially, the host group members arrived for class, presented the material, were warm and friendly toward the sojourners in a general way, and would leave the classroom after the session ended. In several instances the host members would offer sojourners additional services by providing their work phone numbers and making themselves available to sojourners, if needed

The sojourner culture. The sojourner cultural group consisted of persons who had been diagnosed with diabetes mellitus and included several of their family members as well. The host group referred to these persons as “patients”. The sojourner group attended weekly diabetic education classes in order to learn about their diagnosis and their self-care.

Members of the sojourner group were adults who have recently received a new diagnosis of diabetes, or have been diagnosed as diabetics for quite some time, as much as 23 years in one case. Approximately one-half of the sojourner group was insulin dependent diabetics, and the rest used oral medications to control their diabetes, or a program of diet and exercise. Approximately two-thirds of the sojourner group were employed, several lived on disability or retirement income. Sixty percent of the sojourner group was female. The majority of the sojourner group lived within a short drive of the hospital outpatient department. No one walked to the facility. All members of the sojourner group lived in their own homes, not in an institutional setting. A total of

twenty-three (23) sojourners participated in a total of twenty (20) classroom sessions during the five and ½ months' duration of the data collection for the study. Thirteen were females. Nine members were insulin dependent, thirteen used oral medications, and one member was maintained on diet alone.

The ethnicity of the sojourner group consisted of five (5) Hispanic-Americans, one (1) African-American, one (1) Asian-American, and sixteen (16) European Americans. Ten (10) of the sojourner group attended fewer than 6 classes, four (4) attended more than six classes and seven (7) attended the required six classes.

From the descriptions of their own health experiences, the sojourner group members were feeling sick some or most of the time, as evidenced by the symptoms they described and worries they related. Several did not sleep through the night, getting up to take blood glucose readings or medication. Some believed they could not go out to restaurants or social gatherings to eat with friends and family because of their dietary restrictions. Some felt awkward inviting friends and family to their homes because of dietary and medication routines. When their blood glucose readings were out of range, or symptoms became prevalent, they experienced feelings of failure and low self-esteem. Their disease dominated almost this entire sojourner group as manifested by the ubiquitous demands of self-care and their worry about symptoms.

At times, some sojourner members were successful in their self-care as evidenced by the absence of symptoms, or acceptable ranges for blood glucose readings, or a positive report from the physician. At other times, the same sojourner group members considered themselves as unsuccessful, in that the diabetes was not well controlled as

evidenced by symptoms of fatigue, irritability, thirst, dietary problems, and blood glucose readings that were out of acceptable ranges. For the sojourner group, taken as a whole, their situation seemed to be a roller coaster experience with many ups and downs.

It should be mentioned that this sojourner group, or any similar illness-oriented learning group, is unique and different from other learners such as university students, hobbyists, or skills training groups. This is due to the prevalence of physical and emotional symptoms and to a self-care regimen which is complex, chronic and anxiety producing.

Sojourners described their level of control of their diabetes in various ways ranging from "I give up" to "well, I think I'm doing fine ". From their own characterization of their level of control it was determined that ten (10) of the sojourner group were in poor control of their diabetes, three (3) were considered to be in good control, and three (3) were considered to be in "OK" control. Eleven (11) of the total sojourner group consented to participate in key informant interviews during the latter part of data collection.

The relationships within the sojourner group and within the host group, as well as across groups provide additional insight into the nature of the two participant groups. The within-group sojourner relationships can be described as distant from each other. Members did not generally introduce themselves to each other when they were new to the group and often referred to another group member as "that lady" or "that man". There was some obvious initial discomfort by new members who were often experiencing symptoms of poorly controlled diabetes, as well as the usual social uncertainties of being

new in a group of people.

The sojourner group members did not wear nametags, nor in any other way were they identified to each other by name. Members of the sojourner group did evidence an interest in each other's medication, and diabetic status. They referred to each other as "the lady with the 300 blood sugar" or "that young guy who didn't talk much last week".

The only observed type of peer leadership occurred in connection with the sign-in notebook. Sojourners cued one another to sign-in, each one on their own sheet.

Each sojourner member had a private physician, or was seen by a family practice resident for medical supervision. The physicians were, of course, not present during the diabetic education classes, but they have a presence in the class in the sense that physicians were frequently referenced. Some sojourner members praised them or criticized their physician usually for not providing enough time and support during office visits. The host group members, although careful, were not averse to making strong recommendations regarding specific questions which sojourners should ask their physicians. These recommendations concerned adequate examination of feet, periodic lab tests, and new medications. During both the support group meetings and the one diabetic education class meeting in which a physician presented material, each physician referred to the nurse at least once for consultation regarding medical treatment.

Several sojourners returned for additional classes beyond the six, or for an additional cycle of classes in order to gain more information. One woman would drop into class on a random basis unaware and seemingly unconcerned which subject was the topic for the day. She seemed to need the connection and the information regardless of the

topic. The nurse welcomed her and sojourners appeared indifferent to her sporadic presence, since new members were often present and some did not return during their six (6) class cycle.

One sojourner member was a nurse with a master's degree in public health but whose diabetes was "out of control" when starting the program. In addition to learning more about self care, this sojourner member also attended to learn the diabetic education program, so as to duplicate the program in a Spanish speaking community. At times, this nurse/sojourner verbalized great frustration regarding various aspects of personal health status (diet, exercise, and stress). The coordinator nurse treated this sojourner as a colleague as well as a sojourner member. As a member of both host and sojourner group simultaneously, this sojourner repeatedly expressed gratitude to the coordinator nurse. .

Another sojourner member had been diagnosed with other health problems when first attending class following a new diagnosis of diabetes. Upon physician advice to do so, this person experienced pride about having recently lost about 40 pounds. His income was from disability; he was not employed, and had limited funds with which to purchase the blood glucose monitoring equipment. Consequently, he arrived early for class and visited the nurse in her office to have his weekly blood glucose checked. Other participant characteristics are delineated (See Appendix E).

Ethnographers have recently examined the role of the researcher as a participant observer within a cultural setting, especially when the researcher belongs to the culture being studied (Mundall, 1993; Gumperz & Hymes, 1972 Hymes, 1974; Saville-Troike, 1989). A conclusion is that it is unrealistic to view the researcher studying her own

culture as an objective outsider to the research process. In fact, this type of researcher is a participant as well as an observer and analyst and cannot be omitted as participant in the study.

As a participant observer nurse, the researcher was closer to holding membership in a host group rather than in the sojourner group and was accepted as a group member by the host group. Yet, since the researcher sat among the sojourner group, took notes, and did not present material to the sojourners during the class, the sojourner group accepted her as one of them as well. Sojourners would non-verbally include the researcher by making eye contact, nodding heads toward her, and frequently asked the researcher if she had to sign the sign-in book as well.

Sojourner identity. The identity of the sojourner members, both as individuals and as a group, was lost to other sojourners. Because they did not know or use one another's names nor introduce new or returning members, they were restricted from offering personalized support and consolation to one another. The lack of identity within a group, which has similar goals and tasks, is not conducive to a positive self-concept. Limited self-concept, which, in addition to coping with a difficult disease such as diabetes, may compromise positive learning experiences. The sojourners knew the name or identity of the host because the host introduced herself, but not the reverse.

Ends or Purpose

Ends refer to the purpose, the goals and the function of the communication events as well as the individual participants' interaction goals. The purpose of the communication for the sojourner group was to try to understand the information presented by the host

group and in this way to provide better self-care and prevent complications. Toward this end the sojourners used listening skills, some note taking, asked questions/clarification, and tried to relate the material presented to their own experience.

Some in the sojourner group achieved a degree of success during the six-week classes, but others did not. Success was measured by maintaining blood glucose readings within a certain range (80-140), according to the host group. Many in the sojourner group also said they wanted to achieve the more subjective measurement of success which was to feel less tired, and experience minimal problems with vision or numbness and tingling in the extremities. Some wanted verification from their physician that they were successful.

Another main purpose from the sojourner group perspective was to talk about food and diet regardless of the topic for the day, which they did even when they were in good control of their diet. One woman, whose diabetes was well managed, with an excellent knowledge about her food plan and her diet, consistently asked minor questions such as whether she could eat a whole graham cracker or a half graham cracker at bedtime.

The learning that was required for the sojourner to master was complicated since the overall management and treatment of this disease is very complex. People without an extensive scientific background (as they often suggested themselves) were expected to learn a measure of pathophysiology, principles of medication administration, nutrition concerning proteins, carbohydrates and fats, and stress reduction techniques which are based on fairly complex psychological principles (self-esteem, bio feedback, re-framing).

When the material being presented reached a certain level of complexity, the sojourners would interrupt the speaker with a "folk" story or personal narrative. This was not the only condition in which sojourners would use folk stories but the complexity of the material was frequently a trigger for this phenomenon.

Generally, the information being communicated during the formal session was not sojourner driven in that the host group members were the ones presenting the material and clearly wanted to finish the material which they had planned to teach. After a folk story interruption, a host member would frequently say "now to get back to the topic". It was only during the pre-session and the post-session that the sojourner group directed which information was to be shared. This was done by asking questions or stating a problem to the nurse.

The purpose of the host group was to impart the necessary information to the sojourner group so they could provide adequate self-care. Unlike the sojourner group which was trying hard to understand the communication of the host group, the host group was not trying to understand the sojourner group in this particular communication context. The information flow was generally unidirectional from host to sojourner during the sessions.

Acts Specific to Communication Events

This dimension of the communication events refers to those acts which are specific to these communication events and which signal a change or alteration in the focus and direction of the communication. These acts function as a type of signpost that some change in the interaction is occurring.

The most significant act in these communication events was the sojourners' personal narratives which were pervasive through all the speech events (pre-, planned, post-session,) and which included certain themes. Also, additional communication acts were found to be present across all the communication events, namely, note-taking, parrot-ing, and silence.

Personal Narratives and Themes

The personal narratives were not communications invited by the host group. The sojourners interjected their personal narratives during the planned sessions, as well as during the pre-session and post-session communications. The method of interjecting was to speak out directly, raise the hand, or raise a paper or say "yes, yes, me too." and then tell a story. The response of the host members varied but, in general, they listened patiently to the sojourner for a brief period of time, often with a nodding of the head, followed by the verbal response similar to "OK, now to get back to the topic". Although subtle and mild, this response of minimal interest by the host member did not deter the sojourner because another person would soon initiate yet another narrative.

Timing of the occurrence of the sojourner narratives was also significant. Although the narratives were expressed when the material being presented was mostly didactic, or when the language being used was highly technical or excessively scientific, at other points in the communication, unrelated to jargon or didactic lecturing, the personal narratives were interjected as well. In effect, the narratives were ubiquitous in the communication.

Themes of the sojourner personal narratives emerged over time in the

communication community. Such themes emerged from the experience of the sojourners during the communication, and conversely, these themes were also the prompts for the narratives to begin. In other words, as sojourners expressed their frustration, doubt, knowledge deficits, they told stories about those very concerns. These initial concerns became the themes of their stories or narratives, as shown in Figure 3, Sojourner Narrative Themes.

Frustration with learning or results. Specific themes of the sojourner narratives concerned the frustration with learning or results experienced by persons with diabetes surrounding the complexities of self care, mainly diet-related matters. Many were highly challenged to abandon the older ideas about the role of sugar as paramount in favor of carbohydrates in maintaining stable and adequate blood glucose levels. A close second in the frustrations was the necessity for blood testing and adjustment of insulin dosages and oral hypoglycemics, often twice daily, to correspond to the blood testing results. The need to incorporate the role of exercise and stress into the equation for maintaining glucose levels was, for many, too overwhelming.

Self-Doubt. Another theme of the sojourner personal narrative was the doubt about their own adequacy to handle self-care and, ultimately, the self-responsibility for medical complications if the disease was not well managed. Sojourners were defensive at times, and self-blaming at other times about failure or perceived failure in blood testing, medication and diet.

Economic Worries. The problem of finances was always a concern in sojourner stories in reference to the significant monthly costs for testing strips, which can reach fifty

Figure 3

Sojourner Narrative Themes

When Sojourners were prompted by
their experiences.....

.....>The sojourner response

was to

TELL A STORY.

|

|

THEMES

|

|

Frustration with learning or results

Self -Doubt

Economic worries

Knowledge deficits

Confident or Not Confident in own M.D

Significant disruption in own lifestyle



(\$50) dollars per month. The glucometers can be low cost through special offers from the manufacturers of the strips. The imminent Medicare coverage of strips and other self-care aids as a result of new federal legislation, effective January 1998, was often hailed by sojourners as very helpful for themselves as well as all persons with diabetes.

Knowledge deficits. Knowledge deficits and the perceived need to learn the latest information on medication, and treatment/cures also imbued much of their stories as they sought verification about a new cure or a simpler treatment on the horizon. For example, some sojourners were interested in herbal aids to increase healthy circulation and reduce the risk of kidney or eye disease.

Confidence in One's Physician. Another theme was the role of the physician providing medical management of their diabetes. Several were pleased with their doctor's level of knowledge and thoroughness of examination (skin, feet, eyesight), but others were far less confident. It was common to hear people compare doctors' names and ask host members for confirmation about physicians' reputations.

Lifestyle Disruptions. The last theme which emerged could be thought of as a composite theme in that many concerns were integrated into a general category of lifestyle disturbances as a result of the diabetes self-care. Family adjustments would be included in this theme as sojourners talked about changes in meals and eating habits formerly enjoyed with spouses and grown children. Some discussed how demands of their jobs affected the ability to plan snacks and healthy meals, go out to restaurants with friends and family, or enjoy family celebrations.

The target of the "folk stories" was meaningful in that the narratives were always

directed towards the host member and not toward peers in the sojourner group. It appeared that the sojourner group wanted to relate the material they were hearing in the classes to their own experience. When other sojourners would reinforce a personal narrative of another, their attention was focused on the host member as well. Most often the reinforcement of another's story was brief and limited to head nodding, or short phrases such as "yes, I know".

Functions of Narratives

The use of the personal narratives by the sojourners functioned in one of several ways. The stories created for the sojourners a type of ownership of the communication as opposed to being controlled exclusively by the host group. In this way, the sojourners re-focused on the concrete, the real, me. They personalized the communication. Consequently, they succeeded in controlling the communication in the formal sessions for brief periods of time.

Interestingly, the sojourner group did not generally discuss their serious health problems and yet some were seriously impaired by their diabetes and its sequelae. One woman was seriously depressed and was currently at the one-year anniversary following the death of her husband. This health problem seriously impaired her ability to learn about self-care. Her blood glucose readings were far above range; she seemed to understand very little about diet, exercise or stress management. She was not able to discuss her feelings about grief or inadequate self-care, attended only two meetings, and remained for less than 10 minutes of post-session communication. The researcher and the nurse discussed a referral to her physician for immediate assessment for medication.

The sojourner narratives also included non-diabetes related topics such as family matters, work situations, computers, the traffic and parking situation in the vicinity of the hospital, or an earlier hospitalization, or a pet who had died.

This ethnography of communication demonstrated a dynamic of shifting influence and an unequal partnership in this cross-cultural environment. Each culture dominated some parts of the communication. The personal narrative was the sojourner attempt to make the communication relevant to the group's own personal experience as persons with diabetes.

The sojourner personal narratives or folk stories were listened to but not discussed even when highly relevant material was being presented. Perhaps most members of the host culture did not feel qualified or did not feel there was sufficient time or did not feel it was necessary to explore the sojourners' personal narratives. In this way, however, the sojourner voice was minimized and not valued by the host group which was a genuinely committed, interested, group of professionals. Regardless of the host reaction, the sojourners were not deterred and continued to interrupt and insert personal narratives even more so when the information being presented was scientific or theoretical and which may have been interpreted by this sojourner group as too remote.

In summary, the phenomenon of sojourner personal narrative was an unexpected finding from the viewpoint of the frequency, persistence, and function of the stories. Themes within these narratives were mainly centered on personal challenges of self-care to the virtual exclusion of some of the serious physical and emotional health problems and complications which were causing pain and discomfort in daily life, such as depression,

vision deficits, hypoglycemic shock, and neuropathy. Despite minimal encouragement by most host members, the sojourner stories did not decrease in number or intensity.

Additional Communication Acts

Several additional communication acts were found to be prevalent across all the communication events, namely, note-taking, parrot-ing, silence and stopped communication. Sojourner written note-taking during classes was a communication act, which occurred more frequently when there were larger numbers of the sojourner's present, or when new members were present. When one or more sojourners started modeling this note-taking behavior, then several others did it also. If, as Hymes (1996) indicated, writing is not only a representation of what is spoken, but also a generative or creative communication in itself, then possibly the written note-taking by sojourners was a type of thinking more deeply and forming conclusions from the spoken communication.

There were two observable characteristics of those sojourners who were writing notes more frequently, and asking questions from their notes. They were attending the series of six (6) classes for the first time, and they finished the required six classes and did not return during the study period for any additional classes.

Another observed communication act could be called "parrot-ing", which can be described as the verbatim repetition by the sojourners of the spoken communication by the host group. During an interview with several key informant sojourners, when asked about the meaning of certain concepts such as "control" or "healthy eating ", the sojourners "parrot-ed" back ideas learned in class and they said it promptly. During an interview with the nurse following this particular sojourner key informant interview, for which the

coordinating nurse had been present, she promptly noted the behavior and coined the term “parrot-ing”. After a brief examination of what it might mean, she observed that a positive interpretation might be that perhaps the sojourner group had really integrated the phrases in question and that would be a desired outcome from the classes.

Sojourner silence was another notable communication act because it connoted an unspoken yet influential feeling or emotion within the group. One condition in which silence was used by the sojourners occurred during a class on stress management when the social worker encouraged introspection, but she also used much psychological jargon during the session. Other conditions during which sojourners were significantly silent during much of the session occurred when they attended classes irregularly, or when they were angry or frustrated regarding their inability to control their blood sugar levels.

Finally, the finding that some sojourners stopped communicating and how they did it is important. The less successful sojourners were found to stop communicating via several methods. First, some stopped attending classes. During the study period, there were a total of ten males attending the sessions. Two (2) were part way through the sessions. Four (4) of the men in the sojourner group all attended the requisite six (6) classes and one of those attended extra classes. However, four men attended twice or three times and then stopped. All those who stopped were having serious problems with maintaining diet and blood glucose levels. While attending, these men were minimally participative, three told many stories about their near death experiences from diabetes, two were quite physically ill during the period of attendance. Two of the four were knowledgeable about diabetes and self care. The other two were newly diagnosed.

Thirteen (13) females attended sessions and three (3) of those were continuing when the study period was ending. Of the remaining ten (10) women, three (3) attended two or three sessions and then stopped. They, also, were in serious physical and emotional health crises. Of the remaining seven (7), six attended the six (6) classes and four of them attended extra sessions. Another woman was a periodic visitor who was thought never to have completed the six sessions. More men than women prematurely stopped attending.

Secondly, some regularly attended but tried to justify their non-adherence to the self-care program citing their impossible circumstances and their unique condition as the reasons why diet, or exercise, or medication/dosages did not work for them. They seemed to experience a block of some type. Clearly, diabetic education based on self care did not work for all sojourner members.

Host acts were specific, as well. Members of the host group, in general, made little attempt to encourage silent members to speak or otherwise participate in the session, especially when the host was presenting content using a didactic format. Several aspects of the communication were rarely discussed by the host group, particularly sojourner feelings and emotional states. Perhaps the host group decided that the class on stress management would deal with feelings. However, stress management is a highly cognitive topic involving cognitive appraisal, re-framing, and planning future responses. There were feelings of grief and despair associated with one person with 23 years as a diabetic, who was out of control. Also, there was low self-esteem associated with a feeling of failure; and many other feelings and emotional states were evident in this ethnography and

possibly limited the sojourner learning, but none were addressed directly by the host group.

Tone and Style of the Communication

Tone and style, also called genre, refers to the manner and spirit of all of the communication acts; not the type of act but the manner in which the speech acts are delivered. The host style of presentation was primarily a lecture format following from a content outline, but not read from an outline. Although there was not a feeling of being rushed, clearly, the hosts intended to complete the information during the planned session. Rarely did the host members arrive early and engage in the pre-session communication, but some did remain five or ten minutes after the session, and thus became briefly part of the post-session communication event. When the sojourner interrupted or interjected with narratives during the presentation, the host members were polite and listened to sojourners for a brief time and then returned to the planned content. In order to complete their planned session, hosts were required to follow a communication pattern of alternating between the planned content and the sojourner-interjected narratives several times during the planned session

The general tone of the host communication was serious, but hopeful and positive, especially regarding new or innovative treatments and technology related to diabetes. Defensiveness by host members was rare when challenged or questioned by sojourners, but did occur even though the general style of most host members was quiet and accepting. When one sojourner member shared inaccurate information, the host member said, "well, I'm not so sure about that, but..."

The general tone of the sojourner communication was accepting, attentive, and rarely challenged the host member. The sojourner response to the presence of the researcher was also accepting and helpful as when a sojourner member would say "oh yes, I'd like to participate. I like to do anything to help improve communication about diabetes". The sojourner members who engaged in the key informant interview read the consent forms carefully first before signing.

The style of the communication refers to the manner of the communication. During the pre-session the communication style among the sojourners was informal and mainly concerned the difficulties involved in self-care such as diet restrictions, difficulties with doing enough exercise, as well as parking and traffic problems with getting to class. During this pre-session sojourners did not address each other by name but often evidenced adequate memory about each other in terms of elevated glucose monitoring readings or other health problems if significant.

The nurse arrived five or 10 minutes before the planned session was to begin and her first remarks would often be " how are you doing" or "what kind of week did you have?" Responding to this invitational style, sojourner members would again relate problems associated with self-care which they had been experiencing.

The signal for the class to begin started with the host member who would introduce herself and her topic for the day, at which point the sojourners would stop talking and become attentive to the speaker. The class would then proceed following a lecture style, interspersed with interruptions by sojourners with their folk narratives. The host member signaled that class was over by looking at the clock, saying "I see we're out

of time", or "any questions", or "well, that's it for today". Except for the larger support group meetings, there was no applause from this sojourner group and not usually a "thank you". Frequently, the host member would engage a sojourner member in follow-up with a question, or offered further services or assistance.

The sojourners began the post-session by referring a question to the nurse, or reminding another person to sign-in, or by sharing another personal narrative with the nurse, or with the researcher. During the post-session, the use of the scientific style of language by sojourners was fairly limited. They referred to "readings", "meters".

There were basically two styles of confrontation used by the host members. Confrontation was used when members of the sojourner group denied that they had any control over their blood sugar readings, diet, exercise, and stress. The nurse used what may be called a "soft" approach saying "how can I help you fix that", or "what can I do to help you?" or "do you remember what we talked about last week?" Another of the host group adopted a different approach, in a similar situation, saying "that is a choice you're making", or "that's your choice and it's not helping you", or "that's your decision".

Host teaching styles ranged from a strict lecture format including overhead transparencies with highly scientific language presented in a darkened room to better view the screen, to an extremely informal approach such as: "okay, ask me anything you want to". Most of the host members used a style somewhere between these two extremes. Although videos about self-care were used, they were not heavily relied upon as the only way to present content.

Record keeping by the host regarding the sojourners' progress was generally not

done, unless the client was being interviewed as an outpatient, on a one-to-one basis, for a fee. Class attendance was recorded via a sign-in book. Physicians were notified and sojourners who completed the required six classes were sent a certificate.

Meaning Aspects of the Communication

Instrumentalities, as a component of the communication events analysis, are especially important for this ethnography. The term refers to communication codes, one type of which is the metaphor, which are employed in the communication events to convey meaning, or understanding (Saville-Troike, 1989; Hymes, 1974,1996).

The three research questions which guided this study mainly inquired about the type of conceptual metaphors used; secondly, about the meaning as given by the research participants; and finally, about the cross-cultural or between-group congruency. Analysis indicated that the kinds of conceptual metaphors used by the cultural groups could be described by the type of source domains and target domains which constitute the metaphor.

Kinds of Metaphor

From the metaphor literature, conceptual metaphors are composed of source domains and target domains. Source domains are concepts that are generally concrete, readily known, and commonly understood within a culture because they derive from body experiences. These concrete concepts are used in a metaphor to explain something else that is abstract. The abstract domain, about which something new is to be explained, is called the target domain. In the literature, metaphors are frequently described according to their source domain (Lakoff and Johnson 1980; Johnson 1987; Schwartz 1997;

McConachie, 1993).

The 1200 or more parsers of metaphoric language which were collected in this study were found to have been employed by the sojourner and the host groups, suggesting, as expected, that each group used metaphors frequently in their communications. Almost all the collected metaphoric parsers fit within the approximately 30 source domains (also called schemas), which were synthesized from the relevant literature, in which other investigators, primarily Johnson (1987) and Schwartz (1997), reported their findings.

Source domains.

Source domains are important findings because they represent one-half of a metaphor, but also they tell which concepts the person thinks will best convey the ideas being conceptualized and communicated to others. Often the source domains are called the vehicle concept in metaphor research literature.

In this study, both the host and the sojourner groups shared several schemas or source domains in their metaphors. The source domains for each group in the study are summarized (See Appendix F). As the table indicates, of the more than thirty (30) schemas or source domains found in the study, some (17) were used by both groups, and some (14) were used exclusively by the host group. There were no schemas used exclusively by the sojourner group. The most prevalent of those schemas used by both groups were directionality (up/down), pathway (path) , and containment (container) schemas.

Directionality schemas refer to up/down, in which up is good (the head of the

body, the brain as center of control for the body), and down is bad (feet, dirt).

Confusingly for sojourners, blood glucose readings that were down were good, and up were bad. Up/down is also associated with the notion of polarity or the absence of a middle ground, something at the extremes. For the sojourners in this communication community, the polarity of up/down and good and bad results did not include much of a middle ground; readings over 140 level were bad and under 140 are good. Directionality schemas also are associated with linear thinking in that there is a straight line between up and down (Schwarz, 1997).

Path or pathway schemas also refer to linearity or one way to do things, wherein change means to go backwards, or get off track, or not be goal directed. Examples showing how pathway schemas were used in communication are:

Follow the diet

Start out with 70-30 insulin mix

Stress goes nowhere

There is no turning back with insulin

No stopping point with sweets

Sugars still run at 400

Containment schemas were also prevalent and involved limitations. To be "in" is proper and legitimate; "out" is improper and not desirable (Schwartz, 1997). McConachie (1993) believes that container metaphors, based on containment schemas, are defensive, protective, an emotional vessel for safety. Containment metaphors are ubiquitous in our culture (Lakoff and Johnson(1980), Johnson (1987). Both sojourners and hosts in this

speech community used containment metaphors in reference to diabetic self-care extensively, especially in conjunction with control metaphors as in:

in control

out of control

in the know about these things

out of it (in reference to symptoms and knowledge)

Further examples of how the two groups used directionality (up/down) and container schemas, the two most common schemas, are illustrated in Table 3, Example of Schemas as Used in Communication by Groups.

Certain other schemas were found to be shared by both groups but differ in the degree of preference according to group. These were sight, strength, take/reject, and war schemas. Although both groups used these schemas (See Appendix G), it is the frequency of use which seems important. Hosts used certain ones considerably more than the sojourner group.

According to Schwartz (1997) characteristics of the sight schema include the observation that since humans are predominantly visual in orientation, knowledge is often metaphorically interpreted as seeing. Examples of the use of these additional schemas and the factor of preference by the host group are also summarized. Schwartz (1997) also characterizes the strength schema as fundamental and basic to the capacity to act, thus informing our conceptualization of causality, change, power, work, and value. The host group used this schema five times as much as the sojourner group did (See Appendix, G).

The take/reject schema was used more than twice as much by hosts than it was by

Table 3

Examples of Schemas As Used in Communication by Groups

Host Group

Schema: Directionality (Up/Down)**Host Phrases**

Symptoms clear up

Glucose rises

Come up with goals

Set yourself up

Schema: Containment**Host Phrases:**

In healthy range

Glucose is out of control

Stress you out

Build it into your life

Out of Balance

Sojourner Group

Schema: Directionality**Sojourner Phrases:**

I got mixed up

My count is going down

He came up with pills

I got let down

Schema: Containment**Sojourner Phrases:**

Too much coming in for me

I bottomed out

I'm through today

I'll bring myself out of it

the sojourner group. Schwartz (1997) described this schema as taking in sensory data, assimilating knowledge, and manifesting a primitive grasp, or drawing to self, acquiring knowledge. Examples of this schema are also located in Appendix D

War metaphors connoting struggle, aggression, and conflict were used three (3) times more often by hosts than sojourners. Examples are also shown in Appendix D.

In summary, since source domains are important for what they indicate about how the person conceptualized an idea, the findings indicate that hosts and sojourners used many of the same source domains as indicated in the literature (approximately 30 different ones) and that while some were used or shared by both groups, some were unique to the host group and not used by the sojourner group. Further, of the ones shared by both groups, there was a considerable preference for hosts for several source domains such as sight, strength, take/reject, and war.

Source domains are only half the story, however. They evidence the concrete, culturally familiar concepts used to ground the metaphor. The other half of the metaphor is the idea about which the person is trying to explain, the target of the metaphor, called the target domain.

Target domains

Target domains, in this study, were derived directly from the data, that is from the 1200 parsers organized into approximately 30 source domains, by asking the data the basic question. The question asked of these data was "what is it that these groups were trying to understand?" To determine the answer to that question, a line by line analysis of each phrase or parser was performed in the grounded theory methods tradition (Strauss,

1987). The resulting conceptual categories yielded 13 target domains, seven of which related to the sojourner group and what they were trying to learn. The remaining six target domains related to the host group and what they were trying to explain. Analysis of the latter group of target domains indicated that the host group was not trying to understand these concepts but was trying to make them understandable to the sojourner group. The sojourner target domains were different from the host target domains, to varying degrees (See Appendix H). As can be seen in that Table, control and problems were two targets in which both groups were interested to understand or explain. The remaining concepts of interest to the groups were different between the groups. From the experience of data collection and analysis, one aspect of the sojourner target domains, schedule, was particularly strong. Throughout the sojourner communication there was a focus on time, the best time to eat, to sleep, to take medication, to exercise. There were many questions to the host group about time, which of course is difficult for the host group to specify. The best time for all these activities is such an individual matter and depends on so many factors such as: glucose readings, usual routine, dietary practices, stress and activity levels. The sojourner members, nevertheless, persisted in trying to determine the best times for activities.

Because conceptual metaphors consist of two parts, the source and target domains, each group's target domains were matched with the source domains for that group. The results of that analysis permitted a final description of the kinds of two-part metaphors used by each group. A summary of the final conceptual metaphors for the sojourner group is presented in Table 4, Summary of Sojourner Conceptual Metaphor.

Table 4

Summary of Sojourner Conceptual Metaphor

 Sojourner metaphors:

(Target/Abstract)	(Source/Concrete)
My Problems are:	Commodities, Motion/Rest/Path, Up/Down, Bind, War, Container
My Schedule is:	Motion/Rest/Path, Up/Down, and Container.
Self-Change is:	Up/Down, Bind, Take/Reject, and Compulsion
My treatment is:	Bind, Container, Count, Cut/Join/Split, Sight, Strength, Surface, Take/Reject, Up/Down, Commodity.
My Well-being is:	Bind Commodity Up/Down Word/Speech
My Feelings Are:	Up/Down

Those findings show that sojourners were interested in their problems, their schedules, their treatment, and their feelings, as well as their well-being and the process of self-change. Toward that end, they used some of the same source domains as the host, but only about half of the host source domains.

By contrast, the host group used more than thirty (30) source domains. This contrast seems logical in that the host group was teaching and would be expected to try to use as many concrete domains to help the sojourner group learn an abstract concept. The concepts to be learned by the sojourners (target domains), however, were mostly different than those which the host group was trying to teach. These findings are indicated by the final list of the two-part host metaphors, which contained different target domains and almost twice as many source domains, as indicated in Table 5, Summary of Host Conceptual Metaphor.

The metaphor literature revealed many metaphor studies of target domains such as: disease metaphors (Sontag, 1988; Stein, 1990; Huttlinger et al, 1992), politics metaphors (Lakoff, 1993), Gulf War (Mio & Lovrich, 1998); military/war, consumerism or business metaphors (Beisecker & Beisecker, 1993), agriculture (de Rios et al 1991), cosmos/planetary, music/art (Feinstein, 1996), animal world, gender (Wilson, 1992; Altman, 1990), legal (Winter, 1995), or body (Boers, 1997). As can be discerned from the findings shown in Table 4, Summary of Sojourner Metaphors, people were mainly concerned with medical problems and their treatment, self-care, and change.

In addition to findings related to source and target domains for each group, another feature of the metaphors used by respondents in the study was the dominance of

Table 5

Summary of Host Conceptual Metaphor

(Target/abstract)	(Source/concrete)
Your Choice is:	Surface
Your Responsibility is:	Balance, Container, Cut/Join, Mechanical, Motion/Rest, One/Many, Path, Pattern, Sight, Strength, Surface, Take/Reject, Up/Sown, War
Your Self-care Issues are:	Bind, Commodity, Container, Count, Floor/Ground, Iteration, Locked, Chemical, Mirror, Motion/Path, Point/Show, Right/Left, Site, Strength, Surface, Take/Reject, Up/Down, War
The Newest/Latest	
Information Is:	Container, Motion/Rest, Strength, Up/Down.
How All This Works:	Balance, Bind, Commodity, Container, Count, Force, Cut/Join, First Position, Floor/Ground, Mechanical, Mirror, Motion/Rest, Near/Far, One/Many,

Table 5 (Continued)

Summary of Host Conceptual Metaphor

	Path, Pattern, Right/Left, War, Strength, Surface, Take/Reject, Up/Down.
Problem Is:	Commodity, Container, Counterforce, Near/Far, Surface, Take/Reject.

the metaphors concerning control. This finding was ubiquitous and fit neatly nowhere in the domain framework for evaluating metaphors. Therefore, control metaphors were treated separately under the notion of root metaphor as a kind of metaphor.

Control as a Machine Metaphor

A significant metaphor finding, because it was the most foundational metaphor, concerned control. Ting-Toomey (1987), an intercultural communication theorist, posits that control is a machine metaphor, which is a "root" metaphor. A root metaphor is reflective of a particular worldview orientation. Such metaphors are differentiated as mechanistic (formistic) or organistic (context) metaphors. The root metaphors reflect the intellectual life of humans.

The machine metaphor concerns laws, rules, control from outside, routines, cause and effect, inflexible/non-responsive to the environment; in summary, this is an "outsider" mode; the concept of control is a machine metaphor (Ting-Toomey, 1987). Control was a core concept in this communication community as in:

control of blood sugar levels

controlling diabetes

controlling diet, stress, schedules, symptoms

insulin control

In her interpretation of control as a machine metaphor, Ting-Toomey (1987) aligns it with the mechanistic worldview, as opposed to the organistic worldview. The latter is associated with personal experience, internal influences, fluctuations, emergent outcomes, and flexible/responsive to the environment; in summary, this is an "insider" mode.

There is a tension, a conflict, a dialectic inherent in the common notion of the body as machine metaphor (food is fuel for the body) since the body is a living organ, not a machine. This tension may account for much of the difficulty some in the sojourner group experienced in trying to sustain effective self-care. Simply put, the messages may have been too mixed to be useful to some sojourners who were not as familiar with a medical model emphasis on parts.

The context/organic metaphors as used by sojourners in their narratives (stories/voice) stand in opposition to the machine/form metaphors inherent in the hosts' communication about diabetes. This can be seen in the sojourner narratives about unsuccessful friends or family members' experience with diabetes.

Yet sojourners also used the machine metaphors so favored by the host group. An important distinction would be whether the sojourner is imitating the host (metaphor performance) or is meaningfully using the metaphor cognitively (metaphor competency). Probably, given the host dominated communication setting, and communication situation, sojourners are more inclined to imitate host metaphors. Yet, if the machine metaphor makes immediate sense to the sojourner, they may become quickly competent in the use of the 'body as machine' metaphor to structure thinking and perception, as would be predicted by many metaphor researchers (Lakoff & Johnson, 1980; Lakoff, 1993; McConachie, 1993). The work of Hymes (1996) would predict that given this particular communication context, i.e. the sojourners' strong use of non- scientific personal narratives/stories which were usually minimized by the host group, perhaps the sojourner group was more imitative of the host metaphor of choice.

Control Metaphor

The host group articulated that the notion of balance and harmony in the complexity of diabetic self-care was essential, and yet the concepts of harmony and balance were discussed very rarely and only in a cursory fashion. The metaphoric analysis indicated a minimal use of balance and harmony concepts by the host group as they shared information with the sojourner group. Instead, there was a very high level of reliance on machine metaphors to try to explain to the sojourners how the body is impaired by diabetes, and how the sojourner group might effectively care for themselves. "Control", which was a concept so prevalent in this analysis of inter-cultural communication, is a machine metaphor (Ting-Toomy (1987)). Interpreted as such, machine indicates an underlying conflict within the host culture. The conflict centers around using a machine metaphor to organize their meaning while intending to convey to sojourners an understanding of diabetes as an organic activity. There is significant conflict in the conceptualization of the body as a machine, the essence of which are laws, rules, control from outside, routines, cause and effect, inflexibility, and an unresponsiveness to the environment. These concepts represent the "outsider" mode, according to Ting-Toomy (1987)

A machine can be thought of as an assembly of parts working together which is different from a pattern or harmony because, in the latter, the focus is not on the parts but on the whole. In stark contrast, the conceptualization of the body functioning as a harmony or balance or dynamic equilibrium is associated with notions of personal experience, internal control, fluctuations and variations, emergent characteristics,

flexibility, response-ability, or an "insider" mode.

An important question is whether or to what extent the sojourner group perceived the conflict. The evidence would be indirect at best. The persistent use of narratives interrupting the host speaker might indicate the presence of the conflict mentioned above. The scarcity of identification and interaction among sojourner members' within their own communication may be an indication of a conflict within their own understanding.

The cultural assimilation by sojourners into the host culture thought and language patterns was highly evident, especially in the parrot-ing phenomenon mentioned earlier but also by the pervasive use of the control metaphor by the sojourners. In a way, as the nurse pointed out, assimilation is desired by the host culture because it may reflect sojourner learning of critical concepts necessary to prevent complications of the disease. Within this speech community there was not a way to evaluate the actual learning nor a method to evaluate the effectiveness of the host language.

To summarize briefly, answers to the first research question concerning the kind of metaphors used by the two cultural groups indicate that sojourner metaphors focused on their self-change, schedules for self-care and treatments and well-being. The focus of the host metaphors centered on choice, responsibility, and the effects of diabetes in the body. They both used metaphors for problems. In addition they used the root metaphor of control pervasively.

Meanings of the metaphors to the groups

The second research question was about the meanings attributed by each group to the metaphors. Meaning is another component of the instrumentalities in the Hymes'

model. The data to answer the question of meaning were collected by means of separate interviews with key informants from both groups. Approximately 10 key informants volunteered from the sojourner group and 6 key informants from the host group. The six sojourner group interviews involved some sojourner members more than once in groups of two to five persons; five of the six host member interviews were done individually due to the convenience of the host members for a total of six host key informants.

The researcher selected forty-four (44) metaphoric phrases which had been used by either or both groups during the sessions. Due to the logistics of the key informant interviews, both groups provided their interpretations of the meaning of the phrases for twenty-three (23) metaphoric phrases; sojourners exclusively responded to fifteen (15) of the phrases; and the host members exclusively addressed six (6) phrases. The forty-four (44) metaphoric phrases represented approximately five percent of the 1260 metaphoric phrases recorded during the five and one-half months of data collection.

The method used to ask both groups of key informants about the metaphoric language was similar. Two questions were used. The first was "what does this phrase mean to you?" and the second question was "what is your interpretation of this phrase?"

In general, the meaning of any metaphor is culturally determined and the same can be expected for the two groups in this study. The meanings provided by the key informants can be perceived in several ways. Some of the meanings are clearly dichotomous in that the host interprets the metaphor from a scientific viewpoint and the sojourner from the non-scientific perspective (see Appendix I).

Another dichotomous interpretation is the host viewpoint of knowledge which is

given and the sojourner view of information as received. Again, because the host group is the teacher group and the sojourner group is the learner group, it may be reasonably understood that, within a traditional education setting, the teachers give and the learners receive information. The result is almost verbatim repetition by the sojourner of the host, as also seen in Appendix I.

One further dichotomy was prevalent. The theoretical/practical in which the host preferred the theoretical and the sojourners preferred the practical.

Not all meanings were dichotomous, however. Some meanings were explanatory in the sense that the meaning of the metaphor was interpreted simply as a clarification, not opposites. Another non-dichotomous interpretation was deprivation. Examples of both are found in Appendix J.

Congruency of conceptual metaphor

As reported throughout the discussion of kinds of metaphors used by each group, the findings related to the third research question regarding congruency indicate that approximately one half of the source domains were shared or congruent between both groups, although there were many which the sojourner group does not use at all. The target domains indicated still less overlap between topics which interested the sojourners and those which the host group was trying to explain, since only two (2) of the seven (7) sojourner and eight (8) host target domains were shared between the two groups.

Summary of Instrumentalities.

The kinds of metaphors used by the two groups have noticeable similarities and differences. The similarities existed primarily within the source domains and it was

suggested that the reason might be that the sojourners were imitating the hosts in the use of their concrete concepts in their attempts to understand the complex abstract concepts.

The differences appeared more noticeable between the target or abstract domains, indicating that the sojourners had somewhat different interests from the hosts, at times, in what they wanted to learn about. The congruency levels were appreciably far apart with respect to the target domains of the metaphors.

The meanings of the metaphors to each of the groups seemed to configure around dichotomies in which the hosts interpreted metaphors more scientifically than the sojourners, and more abstractly than the sojourners. There was some evidence that the hosts operated from a more external locus of control than did the sojourner group.

The findings concerning the original research questions about the kinds, meanings, and congruency levels of metaphors between the two groups seem to support the findings within the other components of the communication events (see SPEAKING mnemonic) as created by the participants in this speech community. The hosts dictated the kinds of source domain metaphors used by both groups, yet the sojourners asserted their own target domains or what they wanted to learn about. This assertion, partnered with the extensive use sojourners made of the personal narrative throughout the communication events, points to the sojourner attempts to influence the communication experience toward their own needs, regardless of the foreign setting or culture (a hospital outpatient department) naturally dominated by the host group.

Norms or Ways of Doing the Communication.

The host group evidenced certain norms of communication regarding avoidance,

the stand-alone sessions and their confrontational styles. Sojourners shared in the use of avoidance at times, but also elected to use stigma as a feature of social response to their condition.

The host group avoided an initial introduction of the sojourner members to each other, perhaps assuming that they all knew one another already. Sojourner name tags were not provided at the sessions to assist in mutual identification. The host members always introduced themselves and their job titles, or the nurse introduced them to the sojourner group by way of speaker introduction. Hosts wore their official employee name tags at all times.

The stand-alone nature of the planned sessions permitted the hosts a degree of flexibility and convenience. Host group members would substitute for each other in some circumstances. When class was canceled the day before July 4th, some sojourners appeared for class anyway and the staff exercise physiologist in the cardiac rehab department spontaneously presented the class on exercise. When the dietitian was unavoidably delayed at another facility, the nurse conducted the class on nutrition. Videotapes regarding diabetic self-care were used to introduce the topic and to structure the presentation. In general, the nurse employed a more interactive approach, to which the sojourner group responded positively and with much more involvement than to the lecture formats.

The sojourners also engaged in avoidance by not introducing themselves to each other. They showed no inclination to learn each others' names, although they reminded each other to sign the attendance page in the log notebook. It was not uncommon that

some sojourners would come to class and say " I give up" in reference to some aspect of self-care. The other sojourners would remain silent at these times and look toward the nurse for her response, which was generally compassionate and caring. The sojourners did not openly offer advice (except for the one "advice-giver", mentioned previously) nor solace to the discouraged member. This was left to the nurse to do, even when another host member was presenting the class.

The sojourner group evaluated the seriousness of the diabetes condition of other sojourners by the elevation of blood glucose levels, but especially so on those occasions when a relatively new member had not been testing their blood and agreed to be tested during class, or during the pre-session or post-session. They responded with alarm to severely elevated readings "oh my, that's too high" and " mine has never been that high". These remarks were more directed towards the nurse rather than toward the sojourner peer with the elevated glucose level. Otherwise, blood glucose readings were not generally shared within the group, but during a folk narrative might be mentioned.

Primarily this sojourner group mentioned the stigma associated with diabetes when members of the host group mentioned new or proposed legislation related to diabetic services. Either sojourners would point out personal experiences with the stigma associated with diabetes such as difficulty securing a driver's license, the non--Medicare covered glucose monitoring devices or syringe or blood testing strips. The strips are very expensive and are required for adequate self-monitoring. Another way sojourners mentioned stigma was "lots of people have diabetes or know somebody who has diabetes but it was not that way when I was first diagnosed". Some of the sojourner group had

mentioned the social stigma associated with their obesity in connection with diabetes even when diabetes is under good control

Confrontation was another finding of special significance. Understandably, the use of confrontation by the host members, however gentle or strong, was reserved for communication with sojourners who seemed to not adhere to diabetic self-care, or with those who seriously doubted that the self-care methods being presented could actually help them personally. However, "confrontation", as a communication mode, was dependent on the style of the host member, not dependent on the sojourner or their needs, as one might expect. The nurse gently confronted, using positive indirect methods such as "well, how could I help you test your blood for glucose more often?" Another host member said to another sojourner "that is your choice not to eat regularly and so the consequences of being sick are also your choice".

Summary

The communication situation consisted of diabetic education classes, as part of a larger outpatient program to empower diabetics for effective self-care, which was provided free of charge to pre-screened diabetic patients. The patients were temporary visitors in the health-care culture of a large hospital system. As sojourners in this larger culture, they interacted with a host group comprised of specially trained health-care professionals. The host group, who were very knowledgeable about the disease of diabetes, shared information with sojourners who were unfamiliar with the science of the disease and the self-care required to minimize complications from the disease. Within this context, the two groups created a speech community.

As Hymes (1996) has pointed out, an ethnographer seeks to develop insights about how a people do a thing, as well as search for connections. The ethnographic data in this cross-cultural study has yielded several insights important to an understanding of the communication between sojourner group and the host group. As shown in Figure 4, *Understanding Cross-Cultural Communication*, the communication of each of the two groups presented a variety of distinctive features, as well as shared features. The sojourner group communication events and acts included the creation of pre- and post-sessions, the creation of personal narratives and themes of the narratives, and the practice of stopping the communication.

Hosts also generated distinct communication events and acts. Their group employed the use of stand-alone sessions, the use of a lecture format, a minimized response to the sojourner narratives, as well as confrontation of non-adherent sojourners.

However, the two groups also shared several communication characteristics. They both used selective silence, a degree of avoidance of certain practices and issues, and lastly, they joined in a dynamic shifting of influence within their cross-communications. They shared several constructs and meanings in the use of several metaphoric domains, as well as the use of the machine metaphor of control. Both groups also exhibited instances of parallel meanings in regard to the metaphor they used. The meaning aspects of the communication, as evidenced by the metaphor findings, show the prevalence of the target domains but some were incongruently interpreted by the groups.

The findings from this ethnography of communication revealed that the two groups of participants were very different from one another in background, knowledge of

Figure 4

Understanding Cross-Cultural Communication

Sojourner Communication Events and Acts

- ◆ Create Pre- and Post Sessions
- ◆ Create Narratives to Gain Voice
- ◆ Stopped Communication

Host Communication Events and Acts

- ◆ Stand-Alone Sessions
- ◆ Lecture Format Preference
- ◆ Minimized Response to Sojourner Narratives
- ◆ Confronted Non-adherent Sojourners

Shared Communication Acts

- ◆ Selected Silences
- ◆ Avoidance
- ◆ Shifting Influence

Shared Constructs and Meanings

- ◆ Use of Metaphors
- ◆ Congruent Metaphor Domains
- ◆ Machine Metaphor of Control

diabetes, goals and desired outcomes, and the methods they used to communicate with machine metaphor of control by both groups to conceptualize self-care. The two groups shared many of the same source and one another. The host group was from a highly scientific background, yet the sojourner group had knowledge of diabetes from personal experience of their own bodies, which the host group did not and could not have without being diabetics themselves. The host group, without the personal body knowledge of living with a disease on a day-to-day basis, had the scientific/medical knowledge about diabetes. Mostly, the scientific knowledge took precedence over the experiential or embodied knowledge.

CHAPTER FIVE

Discussion of Findings

Findings in this research correspond to the intercultural communication and cognitive science research literature which are so closely associated with the main constructs which informed and guided this ethnography, namely, culture, communication and conceptual metaphor. Other findings in this study can be directly compared with studies in the health care literature.

Participants

The dynamic interplay between the two groups of participants is the focus of this discussion of the participants. Three aspects of particular importance in this category are first, the shifting influence between the participant groups, secondly, the acculturation of the sojourners to the host culture, and lastly, the sojourners identity.

Shifting of Influence

A shifting of influence in any cross-cultural communication event would not be an unusual finding. In this study, it refers to a dynamic give-and-take approach regarding which group of participants dominates the communication at any one time. However, the significance of this dynamic shift between the two groups is marked by its intensity, and the persistent, almost rigid manner in which the sojourners asserted themselves. This assertion was evident in that they created a pre-session and a post-session during which they dominated the communication and assured that their needs were met in the way they

most preferred. Although the pre-and post-sessions were never formalized, they were distinct communication events which the sojourner group created spontaneously.

The sojourners almost always remained in the classroom following the formal end of the session and in this way created the post-session communication event. The communication at this time was predominantly directed towards the nurse in a one-to-one type of interaction. Other sojourners "listened in" on such conversations and often interspersed a personal and relevant question or yet another of their personal narratives. The duration of this post session would vary from 10 minutes to 30 minutes. The eventual placement of the key informant interview with sojourners following the end of the planned session interfered with the usual post-session communication event. However, the post-session communication was important enough to the sojourners that it continued following the interview or was simultaneous with the interview, but conducted out in the hallway.

The planned sessions belonged to the host group in that they selected the content and the format of the communication to be employed. The sojourners were followers and the host group was the leader. A switch occurred in the pre-and post-sessions which the sojourners created. The content and format was selected by the sojourners by asking questions, and validating experience with the host group. Sojourners seemed to need a space and a time to speak informally and subjectively, and in this way created what they needed.

This shift in influence from the host to the sojourner provided a sojourner voice which the planned sessions did not naturally provide. Sojourners were suffering symptoms to some extent and wanted relief, which may have been a motivator toward asserting their

own voice during this time of stress.

In the traditional sense the host were teachers who gave information and the sojourners were learners who received information. This may have been too passive a position for people with serious health problems. The health-care culture, based on the western scientific model, however, is not conducive to shared, mutually developed knowledge with patients about care and cure. Experts (host) didn't suffer the symptoms; the non-experts (sojourners) directly experienced the symptoms on a daily basis. The tensions in such an environment are similar to any intercultural communication tensions.

To enhance the understanding of the sojourner experience, Katriel (1995) has suggested the tourist encounter might offer a framework or model for increasing the effectiveness of naturally occurring inter-group tensions. In her model, the host seeks to accommodate itself to the tourist (sojourners) while celebrating cultural differences between host and tourist/sojourner. Certain elements of the host/tourist relationship in the Katriel model could be effective in discerning more about teaching sojourner self-care. Since the function of tourists is basically to see new things and enjoy new experiences and take something home to remember, likewise, sojourners could be asked what they want to learn about while in class, how important is it and what do they want to take home to keep. Subsequent to such decisions, the host may provide the tourist/sojourners with what they want because the hosts have the knowledge to do so. The hosts in this study elected to use the more traditional approach in that they decided what the sojourner group would learn.

The host group avoided communication focused on sojourner feelings and lack of

success in self-care. They aspired to make the communication about self-care teachable for hosts, and manageable for sojourners, thus utilizing stand-alone sessions, taught by different specialists, which were not then integrated into a whole at any point, perhaps reinforcing a parts approach consonant with the machine metaphor of control. Thus, the host group achieved both advantageous and disadvantageous results.

Acculturation

The extent to which the sojourner group attempted to acculturate itself into the host group conceptualization regarding illness and self-care was evident mainly in the type of metaphors used by the groups. Clearly the host group set the direction for the type of source domain metaphors to be used and the sojourner group followed their lead, as evidenced by the lack of metaphor domains exclusive to the sojourner group. But the sojourner group did not use all of the host metaphors. As Lakoff & Johnson (1980) observed early in their work, the dominant culture gets to impose their metaphors on others, which creates a mandate for the host group to examine their own conceptualizations carefully. In this study, the sojourners accommodated the host metaphors but did not metaphorically conceptualize any new metaphors. Nor did the circumstances allow or encourage sojourners to develop metaphors unique to ones' own group. In the pre- and post-sessions, sojourners created the opportunity for own their own cultural communication but continued to use the host metaphors. Perhaps the time limitation of the fifteen (15) or thirty (30) minute pre- and post-sessions simple did not offer the sojourner sufficient time.

Sojourner Identity

An identity for sojourners as individuals or as a group who came to know, support, or communicate with each other was not evident even though, as a group, they were distinctly different from the host group in their communication. They did not seek out each other for support and they remembered each other primarily by unusual signs and symptoms existing in the other person. They actually depersonalized each other by referring to the symptom, "the lady with the 350 reading". Their lack of relatedness to each other was likely due to the practice of omitting the usual social convention of introductions, or wearing name tags, both of which the host group did, but not the sojourners.

Temporality, a defining characteristic of sojourners in any culture, may help explain part of the reluctance of sojourners to get to know each other and create an identity among themselves, as learners or people with diabetes. They knew they would not be together for more than six (6) to eight (8) or ten (10) weeks, and the interpersonal investment may not have appeared to be worth the effort. Temporality seems to be only a partial explanation, however, since the common experience of attending educational opportunities indicates that even for very brief time periods, people still wear name tags, and introduce each other with much less in common than this particular sojourner group.

Basically, the ethnographic findings show two distinct cultural groups engaged in cross-cultural communication who are friendly and respectful towards each other and yet clearly demonstrate a measure of asynchrony in their goals and in their processes of social communication. The asynchrony was associated with sojourner self-assertion in creating

their own sessions (pre and post) and yet the sojourners did not develop a group identity.

Findings regarding the participants in this ethnography are linked with certain findings in the intercultural communication research. Specifically, the work of Katriel (1995) with tourist and host groups, as models for effective intercultural communication, has suggested that host and sojourners (tourists) interactions evidence recent dynamic shifting of influence between the groups. Traditionally, host groups made little effort to assist the tourist experience beyond the provision of services. More recently, the more successful host groups actively reach out to visitors to their cultures. Hosts try to determine the sojourner wants and needs and plan with sojourners to meet their needs. The hosts have become more active participants in the process and sojourners have increased their expectations for that level of proactive involvement from hosts.

The host and sojourner groups in this ethnography followed the more traditional pattern of relating to each other at the outset of sojourner entrance into the host culture, but the sojourners promptly began to shift influence to themselves through forming or participating in the pre- and post-session communications. In those sessions, the sojourner exercised the most communicative influence, although they also used personal narrative acts to assert their influence with the host group.

Lakoff and Johnson (1980) have early on reminded, as well as others since then (Mio & Loverich, 1998; Elwood, 1995), that those groups with powerful social standing impose their metaphoric conceptualizations of reality on less influential others. The result is that reality is often perceived by both parties as the more powerful group perceives. In this study, sojourners employed the metaphoric source domains of the host group in

conceptualizing their illness, and they also did not use any unique to their own group. However, since the meanings were somewhat different between the two groups, the sojourner use of them raises many questions yet to be explained in the metaphor research about how the metaphors were operating.

Acts

The most important finding in this category is the forceful use of the personal narrative by the sojourner group members, especially interjected during the formal presentation of the class content by the host group member.

Personal Narratives

Personal narratives by sojourners were interjected and directed toward the host group somewhat during the pre-and post-sessions, but most frequently during the planned sessions, despite minimal if any encouragement by the host group. Hymes (1996) has discussed the role of narratives and the inequality of voice in classroom situations. Teachers are usually the dominant group and frequently use stories regarding their experiences in order to mutually share knowledge, values and beliefs with others in their own group. Stories told by students to others who are not members of their own group are considered as less interesting and of questionable value. Stories or narratives by other groups are often called anecdotal and as such are minimized types of communication when compared with textbook or lecture-based knowledge. In this way, the "voice" of the other group is unheard or silenced.

According to Hymes (1996), the personal narrative represents "the voice", which may be a complementary or alternative mode of thinking. These narratives are an

alternative to abstract definitions, and impersonal interactions, which are often considered by some to be cognitively superior to the narratives. As such, this phenomenon of devaluing stories is an unfortunate stereotype of both the narrative and the non-narrative in our culture. In learning situations the narrative carries less weight and is often discouraged systematically. Hence, a possibly significant alternative method of thinking and communicating is minimized. However, as Hymes has also noted, narratives are considered legitimate in the service of knowledge when used among co-equal members of a group (Hymes, 1996). The implication for this ethnography of communication is that the sojourners were not viewed by hosts as co-equal members of this speech community.

In his recent work regarding narratives Nelson (1997) has discussed stories patients tell in bioethical, medical and health care settings, and focused on the why and when of narratives. He asserted that the need to tell stories is most acute when people are threatened with being silenced and also to retain standing in their communities or groups. In this study, sojourners told their personal narratives in many situations (See Figure 3, Sojourner Narrative Themes), perhaps indicating their collective voice was threatened in those situations, namely instances of highly didactic or scientific host communication, or when their feelings were ignored. Sojourners created a 'voice' for themselves in their personal narratives which they used to influence the communication to change from disease centered to sojourner centered communication. Sojourners in this study clamored for a voice by means of their persistent personal narratives or stories, yet evidenced little, if any, group or personal identity while in the setting. They wanted to be heard but did not hear each other. They seemed to hear and attend to the host group

message, but as a group were minimally successful by the serum glucose yardstick.

A strong case is also presented by Nelson (1997) as to the purpose of narratives as a resistance against being "hailed" which seems to be a parallel concept to being called something or labeled. When patients are hailed by their health care professionals they are being fit into a category, for example a diagnostic group or an illness identity which already pre-exists the person and is not personal or specific to them. They resist this process, according to Nelson (1997, p.30), and tell a personal story to resist it and to "reclaim their voices and their stories from inappropriate professional dominance". The sojourner group in this ethnography seemed to be engaged in a similar process of storytelling to assert their voice.

Stopped Communication

In contrast to Nelson's (1997) viewpoint that community is formed from telling narratives, however, the sojourners in this study did not appear to form a community. Many members of the sojourner group stopped the communication with the host group, and in some cases, stopped attending. They dropped out in one way or another. Many of these sojourners were not able to meet the goals of self-care in that they were highly frustrated, experience self-doubt, and continued to present with signs and symptoms of uncontrolled diabetes

In summary, the pervasiveness and strength of the personal narrative is distinctly a communication act which, as informed by the work of Hymes (1996) and Nelson(1997), seems to have been the major way the communication was changed from disease-centered communication to sojourner-centered communication. The sojourners caused that to

happen. The only other way sojourners controlled communication was to stop the communication by absenting themselves or by low level involvement in the planned sessions through silence.

Instrumentalities

The guiding research questions focused on the kinds, meanings , and congruency of the conceptual metaphors used by both groups. The extensive analysis in this study of a great number of metaphors used by both groups produced the finding that there was both harmony and disparity between what the hosts group intended to conceptualize and the concepts they selected to communicate their thoughts.

Kinds

Host members valued the concept of balance in learning self-care but they made extensive use of the machine metaphor of control (Ting-Toomy, 1987). Sojourners also used this metaphor of control extensively as they conceptualized their health, illness and self-care. The discrepancy between what was intended by hosts and what was actually used might have produced tension and conflict within the host group and within the sojourner group. The lack of host awareness about the metaphors they used to conceptualize an experience was at the heart of this tension.

The finding that sojourners were interested in different target domains, that is the concepts they wanted to learn, than the hosts desired them to learn about indicates (See Appendix H) that the sojourners had specific ideas about what they wanted to learn about and those ideas had wider range than the hosts.

Control was a pervasive conceptualization used by hosts and sojourners. The

finding that control did not fit neatly as either a source or a target indicates that 'control', a machine metaphor (Ting-Toomy, 1987), was used both as a source and as a target domain, pointing to a more complex metaphoric conceptualization. Both groups wanted to understand the concept of control, using it, therefore, as a target domain. And both groups used "control" as a source domain to explain something else. One conclusion is that the metaphor is indeed a "root metaphor"; Ting-Toomy (1987) asserts that in our larger culture, 'machine' is an ontological metaphor which represents a world view or reality.

Meanings

Sojourner meanings for the metaphors used by themselves and the host group were often non-scientific or practical which is called, in anthropology, folk interpretations (Holland & Quinn, 1987). Inasmuch as the sojourners used many similar metaphors as the host group, they generally did not describe similar meanings as the host group. Frequently, these groups were involved in parallel communication, as opposed to interactive communication, because their meanings were different. Sojourners used folk interpretations much of the time.

Yet, sojourners "parrot-ed" back ideas learned in class and they said it promptly. This seemed to be a rote memory response. On the other hand, perhaps they have accepted the host meaning so completely that it was now their own meaning and, if so, the implication is that shared meaning had occurred. However, perhaps there is not "shared" meaning, only "transferred" meaning, as noted by Chen in her study of sojourners (1994). "Shared meaning" was referred to as "mutually emerged", "developed" meaning, but

"transferred meaning" was "linear/received" by the sojourners and was a less desirable outcome since it is less meaningful to the sojourner.

Congruency

Findings show that sojourners used the host source domain concepts which means there was congruency in the concepts used to explain a new idea. However, sojourners used a number of unique or different target domains which means that sojourners had divergent ideas about what ideas they wanted to learn about. Conceivably, this conclusion could be expected because the concrete domain (source) is so prominent in the larger health care culture that the sojourner would not create a new source domain. For example, in the metaphor "body is a machine", the machine as a source domain is so prevalent that the sojourners continued with it.

In summary, sojourners used the host metaphors and generated few, if any, of their own unique metaphors. The hosts used many unique metaphors which the sojourner group did not emulate. Sojourners were non-scientific in the meanings ascribed to the metaphors and the hosts were scientific. Many metaphors were congruent between groups but many were not, although both groups used the machine metaphor of control. The two groups of participants in this study conceptualized sojourner well-being in fundamentally different ways, as evidenced by the disparity of the metaphoric meanings. For the host group, sojourner well-being was largely a machine (Ting-Toomey, 1987) conceptualization. Their focus was on controlling parts, i.e., diet, stress, serum glucose to achieve well-being. The sojourner group accepted the machine conceptualization but only to a point. They ventured beyond the mechanical view to focus on the intensely personal

aspects of feelings, self-change, and the experiential.

However, since the host group metaphors were more robust, their influence prevailed in much of the communication. The metaphoric analysis indicated that sojourners emulated the host culture in the use of the control metaphor almost entirely. However, although sojourners patterned their source (concrete) domains to those of the host metaphors, they initiated several of their own target (abstract) domains. It is clear that they wanted to communicate about some of the same ideas as the host but expanded into other areas as well.

Norms

Norms are important behavioral patterns in both communication and cultural studies. Several norms exerted considerable influence on the communication in this study, namely, the norms of avoidance, stand alone sessions, and confrontational style.

Avoidance

Avoidance means that certain communication modes are taboo. No one deals with them openly. Both the sojourner and the host group avoided discussions involving certain topics, namely, negative feelings and the obvious lack of success by some sojourners. These are obviously both emotional topics. Perhaps, the staff did not feel comfortable or qualified to deal with sojourners in the psychosocial area of care. The social worker host members discussed stress and coping, and occasionally on a personal level with a member of the sojourner group, but mainly that was problem-solving a stressful situation, such as financial need. An obvious question was whom do the sojourners talk with about negative feelings and particularly feelings of inadequacy when they are not successful in managing

self care for whatever reasons. The question assumes more significant proportions in consideration of the numbers of sojourners who were not able to adhere to diet, exercise and stress management plans, and thus were not able to be successful in their own opinion.

The avoidance findings in this research may be associated with what intercultural communication researcher Burgoon (1995) posits in the expectation violation theory regarding the avoidance by host culture members of sojourners with certain de-valued characteristics such as inability to perform tasks, persistently ill despite host efforts, or obesity. Sojourners are expected to care for themselves once they learn how and those who do not achieve self-care properly are avoided. Nursing studies have found that patients with undesirable characteristics, such as terminal illness, alcoholism or drug abuse and other socially unacceptable conditions, especially those perceived as self-caused, are frequently avoided by health care providers (Olsen, 1993).

Stand Alone Sessions

Each session was a stand-alone, although content, of course, would overlap. Stand-alone session means that each session begins with a communication which is detached from the previous ones.

Part of the culture of the communication was not to directly integrate knowledge provided from previous sessions. The host member who taught at a particular session seemed to come in, lay out information, be friendly and sincere, and then leave. There was no review at the beginning of a session from the previous session. The nurse of course was a bridge person helping to relate the various topics to a sojourner on an individual basis and was present at almost all the sessions, but did not integrate from week to week

in the formal sessions. Part of the time there were different sojourner members present who were not present in previous sessions. This may have made integration of the sessions more problematic. However, enough people had attended a previous session to make a review meaningful.

A question regarding the stand-alone sessions approach might be: how well does that approach contribute to the success of the sojourner group in self-care? Sojourners were simultaneously experiencing many physical symptoms (thirst, itch, dizziness) as well as difficult lifestyle adjustments (diet, exercise, stress management) while attending the classes. The six (6) content areas or topics were very clear to the host members who had long studied diabetes, but much less clear to the sojourner group who were relatively new to the topics. In an attempt to divide a complex subject into manageable parts, or stand-alone sessions, the host group may have sacrificed continuity and comprehensibility towards the sojourner culture. It may be reasonable to assume that all the specific topics were overwhelming when experienced all at once, and may be contributive to the lack of success some sojourner members experienced.

The cultural differences are highlighted again by this communication act and a further indication of the minimal adaptation of the host culture to the sojourner culture in contrast to Katriel's (1995) tourist model for successful sojourner experience in intercultural settings.

Confrontation Style

Confrontation is somewhat the opposite of avoidance in that differences of viewpoints are verbalized. Confrontation by the host group was dependent upon the

personal style of the confronting host member. One might be very indirect, very nurturing and very supportive. Another focused on personal responsibility, choice, "it's your life". These two very different approaches to confrontation might be suitable and effective with one sojourner but not another, but the effect of the different approaches is unknown because the norm was not to discuss it afterward.

The nursing education literature addresses definitions, methods, skills and goals concerning confrontation (Arnold & Boggs, 1998; Blazner-Riley, 1996; Sundeen, Stuart, Rankin & Cohen, 1994) but is not focused on styles of confrontation in response to client needs or characteristics. Findings from health care research indicates that most staff confrontation toward clients has been studied from the perspective of the health care workers' style or the health context/situation (Chalmers, 1994; Rosenheim & Golan, 1986) or from the personal coping characteristics of the patients (Feifel, Stack, & Nagy 1987). One conclusion is that there is sparse attention in the health care literature relating to confrontational style in response to patient characteristics, other than Rosenheim's (1986) study of using ultimatum and service denial to marginalized, substance abusing women. The implications are that client-contingent confrontation style is little developed in the research.

The findings from this ethnography include many examples of cultural norms but the avoidance, stand-alone sessions, and confrontational style uniquely contributed to understanding how the groups communicated cross-culturally.

Genre

A communication genre involves the format for the communication, that is , a

lecture format or a discussion format. Generally, the host members gave information and the sojourners received information, in the traditional classroom lecture format. Recent studies which compare outcomes between lecture and non-lecture formats (video, problem-based learning, peer learning) used in diverse learning situations present a mixed picture. Some researchers have found no differences in learning outcomes, as measured by objective tests (Bertz & Thompsett, 1992; Flynn et al., 1996; Richards, et al., 1996; Schlomer, Anderson, & Shaw, 1997). The lecture format was found to produce better learning effects, when measured by objective tests, for both student nurses (Newsome & Tillman, 1990) and for medical students (Richards et al., 1996), but less effective when measured by faculty ratings of student learning. Occupational therapy students actually preferred lecture when enhanced with student participation (Butler, 1992). However, among smokers, a preference for personalized services versus impersonal assistance (books, mail or phone contacts, or kits) was favored especially by those who were heavy smokers with low expectations for success (Owen & Davies, 1990).

This study supported findings that personalized, significant learner participation was sought by sojourners by means of their persistent interjections of personal narratives during the formal lecture format used for host presentations.

There were times that sojourners identified their own uncomfortable feelings and host members used feeling words regarding possible sojourner emotions. That was as far as the discussion would proceed. In the presence of intense sojourner emotions, feelings were not discussed. Indeed, to stop the presentation of information and deal with sojourner members feelings might result in failure to cover relevant planned content, and

thus change the nature of the presentation. The program was not intended to be a support group, yet, when discussing symptom management with a sojourner's cultural group which is experiencing what is being discussed, expression of feelings would be inevitable.

The dilemma for the host group is clear. When teaching a symptomatic group about symptom control and management, information giving may not be enough because the sojourner group is responding in real time to their own symptoms. They may need support i.e. discussion of feelings at the same time, a double-genre communication act. The question is: is it likely that teaching sessions of this type can actually avoid becoming support sessions and still meet sojourner needs?

Summary

Findings indicated intercultural tensions between the two groups in this study as the hosts and the sojourners sought to exerted alternately more or less influence in their communications with each other. The research Katriel (1995) conducted regarding successful host groups was contrasted with the host behaviors in this study in which sojourners were minimally consulted regarding desired learnings or emotional assistance. The paucity of sojourner identity was also explored in relation to Katriel (1995).

The works of Hymes (1996) and Nelson (1997) regarding voice was explored as insights which were highly relevant to the sojourners in this study as they sought to establish their voice through the use of the personal narrative. Yet, unlike Nelson's (1997) work would predict, the communications of the sojourner group indicated that they did not perceive themselves as a group who provided support and shared information within the group.

The machine metaphor of control, as articulated by Ting-Toomy (1987) was ubiquitous in this study. Comparisons were drawn regarding the machine metaphor and its focus on parts (of machines) and the presence of a parts approach in the metaphors and communications in this study.

Expectation violation theory (Burgoon, 1995) provided some insight regarding the avoidance of certain topics in this study. Avoidance of certain patients was supported by the work of Olson (1993), as well.

The extant work in nursing and health care literature was applied to confrontation as used by the host group. They employed idiosyncratic confrontational styles in communications with sojourners, an ample impact of which was not ascertained in this study.

All the warmth and caring of the host group toward the sojourners did not enhance the effectiveness of the communication between the two groups whose meanings for the metaphoric conceptualizations were divergent. The narratives, so significant to sojourners, earned minimal response from the hosts. Feelings and emotional discomfort were minimally a target of host interventions in comparison to the emphasis on “parts” of the diabetic experience (diet, stress, medications, exercise, glucose monitoring, and medical complications).

CHAPTER SIX

Conclusions and Recommendations

A synthesis of the three constructs of communication, culture and cognition (conceptual metaphor), studied within the methodology of an ethnography of communication (Hymes, 1974), has resulted in findings which serve to extend existing nursing and health care knowledge. The finding regarding the machine metaphor of control is an addition to previous studies of war and battle metaphors in health care research. The findings regarding the sojourner and host cross-cultural communication present a picture of the sojourner experience as a culture with complex communication responses to the host culture. The implications for future nursing and health care research are discussed relevant to the two overarching categories of findings, namely those associated with the conceptual metaphor and those associated with sojourner personal narrative.

Critique of the Study

The original research questions pertained to metaphoric conceptualizations in cross-cultural health care communications, with the emphasis on metaphor kinds, meanings and congruency. Because the study was a cultural study, however, and the methodology was an ethnography of communication, culture was a quintessential element. As the study progressed, the cultural aspects of the communication emerged as highly and uniquely significant, as seen in the numerous findings associated with the personal

narrative phenomenon. The sojourner narrative findings shared importance with the metaphor findings.

Strengths.

The ethnography of communication, as it was employed in this study, exhibited several strengths. First, it is a strength of the ethnographic method that, without a priori assumptions, findings may and should be expected to yield unanticipated phenomena which are operational in cross-cultural settings. In particular, this ethnography of communication produced results that extend our knowledge of metaphors in health care to include the machine metaphor of control, as well as results which articulated the characteristics of sojourner voice. Both these findings represent additional knowledge in health care research which must be extended by means of further research.

The ethnography of communication method also requires a tri-angulation of qualitative research methods (Saville-Troike, 1989). Participant-observation and key informant interview are central to any ethnography, but this method compels the use of varied strategies to assess meanings, as described in chapter three. Hence, it is a very robust method when used in its entirety, as it was in this study.

Secondly, the Hymes method (1974) permitted an in-depth inquiry into the communication and metaphoric cognition of two different groups. This was achieved in a way not previously employed in health care communication, namely from the cultural perspective using a broad view of culture that permitted health care providers and patients to be conceptualized as two cultural groups. The focus of the ethnography was on the communication, and the instrumentalities section allowed the cognitive aspects of

communication to be a further focus within a broader focus. In other words, the Hymes method as refined by Saville-Troike (1989), acknowledged that communication is not limited to the expression of ideas but also the conceptualization of ideas by different groups.

Lastly, a strength of the method in this study pertained to the synthesis of theories from the fields of intercultural communication and cognitive science as applied to health care. The method enhanced the conceptualization of the inquiry because it is sufficiently broad, yet was a specific type of ethnography.

Issues of Rigor

The limitations of the study involve methodology as well. An ethnography of communication, as a cultural study, clearly is a qualitative approach to inquiry, and as such is associated with specific evaluation criteria. Within a framework established by Guba (1990), issues of rigor in qualitative research design include credibility, applicability, consistency and neutrality. The limitations of this study correspond with those guidelines.

Credibility. Credibility assures that the data and the analysis are close to the reality of the respondents. Use of the memo system, participant observation and key informant interviews were all attempts to address the issues of collecting and analyzing ethnographic data which corresponds as closely as possible to the experience of the research participants. A limitation in data collection was the absence of audio tape recording of the interviews which precluded having the actual speech of the participants for reference. Such tape recorded documentation would have permitted subsequent review by the researcher and other researchers as a data source. Secondary analysis of the

data would have been possible at some time in the future. Since there was an initial reluctance of members of both groups to being tape recorded, and the researcher wanted to enhance openness by all the participants, the option selected was to create extensive field notes during all parts of the observation and interviews. To achieve the best data that were available from such small groups over an extended period of time, the taping problem was resolved by respecting the wishes for total anonymity and settling for the field notes.

Applicability. Applicability of findings to other settings was addressed by the use of the Hymes (1976) mnemonic (SPEAKING), a convention which has been and is readily available to other researchers to apply to various health care settings, as well as Saville-Troike's (1989) steps for data collection. However, including in the study an in-depth analysis of conceptual metaphor within the Instrumentalities component rendered the entire study more intricate and thus, perhaps, more difficult to apply to other settings. Subsequent researchers would be required to interpret spoken metaphoric language based on an integration of the work of Lakoff, (1993), Johnson (1987) and Schwartz (1997), within the context of a cultural study. The triangulation of several qualitative data collection and analysis methods such as traditional ethnographic methods of participant observation, structured interview, coupled with metaphoric analysis, and coding of metaphoric parsers also reduces applicability to an extent. The triangulation, however, was a purposive design feature because it made possible multiple sources of data collection and analysis which all relate to one another, forming a web-like convergence of findings, which can be a strength as well as a limitation.

Consistency. Consistency across studies is not, of itself, desirable in qualitative studies because it is assumed that individual meanings are created and expected to vary from group to group. Findings would be unique, depending on the setting. However, the three constructs which have informed this study, culture, cognition and communication are individually well represented in the literature and, although a synthesis of the three, especially in health care literature, is rare, those constructs can form a foundation for studies in many other settings.

Neutrality. Neutrality, also often termed confirmability, is enhanced by prolonged contact with informants and memos, transcribed dialog. The researcher used those strategies to strengthen confirmability in addition to use of a written semi-structured questionnaire in phase two (2) based on data analysis in phase one (1) to assist the researcher to check with informants about meanings they provided previously. The use of memos was intended to highlight and thus minimize the effects of researcher bias.

A serious risk in any ethnography is for the researcher to “go native” (Leininger, in Morse, 1994) which means that one becomes so engrossed in the ways of the informants that one is so hopelessly enmeshed in the culture under study that neutrality is diminished. Nurses are often so focused on patients that the patient perspective is considered to the exclusion of others. A limitation of this study is that the researcher’s background as a psychiatric mental health practitioner increased the focus on non-verbal sojourner behavior which indicated feelings, but which the researcher was not in a position to explore directly. This meant that the sojourner viewpoint was often more sought, more of a focus than the host members who were more verbal, self-descriptive, and considered by themselves and

the researcher to be a less vulnerable group. It is possible that the effect on the data was to produce data and findings which were more sojourner focused. For example, the personal narratives of sojourners are more noticeable in the field notes than the narratives of the host group. Audio taping of all classes and interviews would have been one approach to this situation, but would have compromised the respect for sojourner and host desires for anonymity and jeopardized the open sharing of data.

Another threat to neutrality of the data was the presence of the nurse, a host member, for many of the sojourner interviews because of the logistics of the one room setting and her one-to-one instruction of certain sojourners after class. The presence of a host member conceivably could have influenced the sojourner to provide the socially desirable answers to questions about meanings of certain phrases. This was a worrisome circumstance, which was diminished to some extent by repeatedly asking informants about previously used phrases from the weeks prior.

In summary, the limitations of this ethnography primarily fall into the category of neutrality, less in the sense of confirmability of the data, and more in the inclination of the study toward ascertaining the sojourner perspective over the host perspective.

Implications for Future Research

A pathway for future nursing and health care research should relate to theory development in the areas of conceptual metaphor and sojourner narrative. Relevant knowledge needs to be extended regarding additional kinds of metaphors that nurses and others employ. Machine metaphors may be limited to diabetes or other chronic conditions; however, findings may suggest that metaphors which are neither machine, war,

battle, nor gift metaphors pervade health care. Perhaps, metaphors are illness or health condition specific. In particular, the extent to which the machine root metaphor of control (Ting-Toomey, 1987) played a complex role in the conceptualization of health and illness by both sojourners and hosts is only suggested in this study. The metaphor itself is complex and, as with all metaphors, conceals as well as illuminates our understanding of the experience of wellness, illness, and transitions among various wellness states. Sontag's (1988) essays on metaphors associated with AIDS, cancer, and tuberculosis and the role of metaphors in guiding treatment modalities and self-care have functioned as beacons in the health care literature, but should summon health care researchers to further explicate the types and the effects of metaphors in health and illness. The role of the control metaphor in long term chronic conditions such as diabetes invites further clarification. Other metaphors associated with other illness conditions need exploration and comparison. For example, in this study, Sontag's war metaphors were far less prominent than might have been expected.

Research may indicate that once the types of metaphors become explicit, desired changes are indicated to conform actual conceptualizations of health and health care to become congruent with intended conceptualizations. Congruency of metaphor meanings with patients is important, but further research is needed to determine congruency between actual and intended ways nurses conceptualize health and health care. Once such knowledge of metaphor is increasingly articulated and concepts become linked together, the movement toward theories involving cognitive communication could be initiated.

The personal narrative is connected to culture as strongly as is the conceptual

metaphor. In nursing research, culture is often studied as an ethnic phenomenon, but there are other productive ways to adapt the extant cultural research methods to study the culture of nursing and of health care, as illustrated by the current study. From such novel approaches, nursing research findings can be related to other bodies of knowledge. The advantage is that interdisciplinary research findings serve not only to validate each other's research but to extend nursing's own body of knowledge while potentiating wider applications to the patient populations we serve.

As Witte and Morrison (in Wiseman, 1995 p. 217) point out, "culturally based theories are desperately needed" in cross-cultural and intercultural health communication. This contention has been supported by Leininger (1990) who has submitted that anything less than care within a culturally relevant framework is unethical.

Personal narrative, as a topic for further research, holds much promise as a foundation for cognition and culture-based communication in health care. In particular, research regarding the types of personal narratives used by sojourners in varied health care settings should focus on determining the broad categories of characteristics of sojourner personal narratives. Findings from this study have raised many questions regarding such narratives. Future inquiry should address questions regarding the content of the narratives such as hope, empowerment, preoccupation with diet and stress, all subjects which were present in the study. The question regarding the prompts for narratives flowed from the findings that multiple prompters existed for these sojourners. Other prompts for personal narratives may exist in other health care settings. Further inquiry is indicated.

The purpose of the narratives has also emerged as important. More knowledge is needed regarding how narratives provide a voice for sojourners silenced by the overwhelming complexities of self care. Self-empowerment, as a purpose for narratives or as a communication power struggle is significant. Lastly, additional knowledge is needed about narratives, as used between groups to communicate meanings, or when during communication events the narratives are used, and the effect of using narratives upon health care outcomes. The underlying implication, for future research, of all these potential inquiries is that narratives, as communication between groups of sojourners and hosts, must be better understood to determine how they affect the health of sojourners. Ultimately, the research aim would be to determine the role of personal narratives in the achievement of effective health outcomes.

The sojourner experience, as representative of a culture which is foreign to the health care culture and which must make sense of the larger host culture in order to recover from or prevent illness, warrants better theoretical understanding. Certainly, members of the sojourner or patient group are individuals with a strong claim to be treated as individuals. However, they also hold membership in an aggregate or group which, if better understood by nurses and others, would conceivably be helped better. As suggested in this research, the sojourner culture has unique behaviors, patterns and metaphoric understandings which were more profound than only those behaviors, patterns and metaphors associated with their diagnosis. What are those profound ways? A research focus on the culture of sojourners/patients will provide novel, useful and innovative answers to inquiries such as: what cultural differences exist between groups which are

experiencing the symptoms and how is it different than communication studies with individuals who are not experiencing symptoms? How do research participants talk about their diabetic education at home away from the educational situation? How do sojourners teach their families and friends about diabetic self-care as a result of diabetic education? How are sojourners overwhelmed and to what extent, given all of the information they are expected to integrate and act upon including taking care that their physicians know how to treat diabetes according to new standards and guidelines.

Thus, a unifying element for the myriad of potential research questions is the notion of 'voice'. Knowledge is needed about 'voice', its antecedents, characteristics, functions and its role within a theory of patient behaviors within the unfamiliar environment of the health care setting. This study found that sojourner identity was minimal and the sojourner need for more voice by means of personal narratives and creating unique pre-and post-sessions. Clarification is indicated regarding the relationship between the need for voice and the nature of sojourner identity

From the perspective of the host culture, confrontational styles of hosts when desired outcomes are not achieved by sojourners also invites additional research within an intercultural framework to determine the effect of confrontation as communication as it relates to the voice of the sojourner. In the current study host members evidenced two distinct styles but the effect on the sojourner health outcomes was not ascertained. Studies which explore the sojourner perspective on effectiveness of host confrontational style examined against voice would be significant for host members who plan and implement sojourner/patient education programs.

In addition to theoretical implications for further research, methodological implications exist. Critical ethnography (Conquergood, 1991) has been a recent response by researchers to extend thick, rich descriptions, analysis and comparison of cultures so as to include actions by researchers which proactively assist research participants to change exploitive conditions uncovered during the research process. Although there was no evidence that sojourners in the current study were manipulated or exploited, that element was not examined either. A critical ethnographer researching communication in another setting, or this one, might be required by the methodology to include questions regarding communication success and failure, and subsequently confront the system decision makers and work to improve the situation for both sojourners and hosts. As the methodology of ethnography evolves, studies which include patient advocacy for positive change need to be addressed in those communication situations which suggest either inequality of voice or disparate communication competencies is operative between cultural groups.

Summary

An ethnography of communication has contributed to clearer understandings of the experience of patients and providers who communicate about health and illness and self care. The strengths and limitations of the current study were addressed and explicated.

The current study has implications for health care research which offers opportunities to nursing research regarding metaphors and patient 'voice'. Further study within a cultural context offers researchers opportunities to make explicit those conceptualizations which are, at present, only implicit in our communications.

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Appendix A

Participant Information Sheet

I am a nurse who is studying the ways that people *communicate their ideas* about

Diabetes.

This is important research because the more we know about how groups think and communicate the better we are able to provide effective ways to help people. To study this, I am using a general observation during group meetings. In addition, I'm asking for volunteers who would be willing to talk with me further about how we all got our ideas across in the class. Volunteers will be asked to sign a Consent Form in order to participate before we talk. No names will ever be used in the study. No intruding questions will be asked.

My full time job is nursing faculty at Grand Canyon University in Phoenix. My research is part of my doctoral studies at the University of San Diego. I would be happy to answer any questions regarding my research.

Appendix B

Consent Form

Cheryl Glennon, R.N., a doctoral student in nursing at the University of San Diego, is conducting a research study designed to learn more about how patients, their families and nurses communicate and share their ideas about health and illness. This study is part of her doctoral dissertation.

Since I have been invited to participate in this research study, I understand that there are two parts to my participation. First, I will allow Cheryl Glennon to be present during classes as I and my family learn about my diagnosis and self-care. I understand that the discussion may be audio tape recorded for research purposes only. Secondly, I agree to meet with Cheryl Glennon and the other patients following the classes. She will interview me to ask me and the others about my thoughts and feelings regarding the earlier teaching and learning sessions. I understand that this second discussion will be audiotape recorded for research purposes. My participation in this study should not involve any physical or social risks to me beyond the possible uneasiness I might experience when talking in a group situation..

My participation is entirely voluntary. I understand I may refuse to participate or I may withdraw at any time without any jeopardy to me or my family member, if any are present, whatsoever. Further, I understand that the audiotape recordings will be maintained by Cheryl Glennon personally, in the strictest confidentiality and security, and absolutely no copies will be made without my written permission. My name, if ever identified, will not be disclosed without my written lawful permission. I

understand that the results of the research will be anonymously shared with faculty members and students, and may be published. Nowhere will my identify be disclosed in any of the research reports nor in any other manner.

If I experience feeling of discomfort as a result of the interview about my thoughts and feelings I understand that Cheryl Glennon can refer me to appropriate counseling services for confidential discussion of feelings and thoughts.

Cheryl Glennon has explained this study to me and will continue to be available to answer my questions on research related matters. I can reach Cheryl Glennon at (602) 249-3300. There are no other written or oral agreements related to this study beyond those expressed in this consent document. I have received a copy of this consent form.

I, the undersigned, understand and accept the above explanations and, on that basis, I consent to voluntary participation in this research.

Signature of Participant

Date

Signature of Researcher

Date

Appendix C

Sample Structured Interview Guide

Note: The format for all interviews with participants were structured similarly.

Part 1 included a pre-planned word such as “down” for which a meaning was requested. Sufficient time was allowed for as many responses as provided. These meanings were written down beside the word usually on the white board if interview occurring in the conference room. Usually participants provided 3 to 5 meanings.

Part 2 consisted of a pre-planned phrase which had previously been used by host or sojourner members, such as “keeping sugars down” for which a meaning was requested. Again, sufficient time was allowed and the respondents usually provided 3-5 short phrases. These meanings were quickly written on the structured interview prepared interview form.

The duration of the interviews was variable, usually 15 -20 minutes.

Both groups were asked the same questions in separate interviews.

The following are sample words and phrases were used on the dates indicated:

10/15	down	keeping sugars down
	control	control things
	health	healthy eating
	choice	freedom to make choices
10/22	out	bring self out of it
	into	getting into it

	get	get symptoms
	give up	feel like want to give up
	bottom out	to have problems is to bottom out
	down	my insulin is down
	watch	I watch my diet
10/29	crazy	I ate like crazy
	found	found out about my diet
	stopping	no stopping point when I eat
	on	I'm on a diet
	up	I'm feeling up today
11/5	peak	your insulin peaks
	take	I take my insulin
	deal	deal with my insulin
	work	your meds are working
11/12	repair	tissues repair themselves
	spend	spending energy
	run	it runs in families
	fuel	oxygen is fuel for muscle
	rest	metabolism is at rest
	store	muscles store energy
	bout	exercise bouts
	medicine	exercise is medicine

magic

exercise is magic

Appendix D
Topics Schedule and Speakers

Date	Topic	Speaker	# Sojourners
6/25	Medications	Pharmacist (L)	1
7/9	Exercise	RN (Sub)	2
7/16	Blood Monitor	RN	4
7/23	Stress	MSW (S)	4
8/13	Diet	RD	4
8/20	Exercise	Ex. Physiol	5
8/27	Blood Monitor	RN	5
9/3	Stress	MSW (J)	4
9/10	Complications	RN	2
9/17	Diet	RD (C)	8
9/24	Medications	Pharmacist	5
10/1	Exercise	RN (Sub)	4
10/8	Blood Monitor	RN	4
10/15	Stress	MSW (S)	4
10/22	Complications	MD	4
10/29	Diet/general	RN	2
11/5	Medications	Pharmacist	6

11/12	Diet	RD (C)	5
11/19	Exercise	Ex. Physiol (H)	5

Appendix E
Sojourner Members

Name	Gender	Date 1st Mtg	Insulin Dependent	Control	Orals	Apparent Ethnicity	Key Interview
F	F	6/25		Good	X	European-American(E-A)	
M	F	7/9		Good	X	E-A	
C	M	7/16	X	Ok		E-A	
D	F	7/16	X	Poor		E-A	
B	M	7/16	X	Poor		Hispanic-American (Hisp-A)	
P	F	8/13	X	Poor		E-A	
D	F	8/13	X	Poor		E-A	
C	M	8/20	X	Poor		E-A	
L	F	8/27	X	Poor		E-A	
J	M	9/17		Ok	Diet	E-A	
E	F	9/17		?	X	Hisp-A	X

Table E (Continued)

P	M	9/17		?	X	Asian-American	X
K	F	9/17	X	Ok		E-A	X
A	F	9/17		Non-diab/wanted to Start Progr			
M	M	9/30	X	Poor		E-A	
Mr G	M	10/1		Inpatient / New Diag		Hisp-A	
R	M	10/15	X	Poor		E-A	X
M	F	10/26		Poor	X	African-American	X
K	F	11/5		Good	X	E-A	X
H(b)	M	11/5		Poor	X	E-A	X
G	M	11/12		Poor	X	E-A	X
S	F	11/12	Family of a Pt.			E-A	X
J	M	11/12		?	X	Hisp-A	X
M	F	11/19		?	X	Afr-A	

Appendix F

Source Domains by Group

<u>Source Domains (31)</u>	<u>Shared Both Groups(17)</u>	<u>Never by Sojourner(14)</u>
Balance*	Bind	Balance
Bind	Commodity	Debt
Commodity	Compulsion	First Position
Compulsion*	Container	Floor/Ground
Container	Count	Form
Count*	Counterforce	Iteration
Counterforce*	Cut/Join	Lot
Cut/Join	Motion/Rest	Mechanical
Debt	Path	Mirror
First Position	Rest	Near/ Far
Floor/Ground	Sight	One/Many
Form	Strength	Pattern
Iteration*	Surface	Point/Show
Lot *	Take/Reject	Right/Left
Mechanical	Up/Down	
Mirror	War	
Motion/Rest	Word	
Near/ Far*		

Appendix F (Continued)

Source Domains by Group

<u>Source Domains</u> (31)	<u>Shared Both Groups</u> (17)	<u>Never by Sojourner</u> (14)
----------------------------	--------------------------------	--------------------------------

One/Many

Path*

Pattern

Point/Show

Rest

Right/Left

Sight

Strength

Surface

Take/Reject

Up/Down*

War*

Word

*From the Johnson list (1987)

Appendix G

Additional Examples of Use of Schemas by Host Preference

SIGHT SCHEMA (+4)

Let's look into it

What readings do we see

Keep an eye on your sugar

Focus on carbohydrates

Watch your diet closely

Monitor your glucose

Scan your feet

STRENGTH SCHEMA (+5)

Leukocytes can't work

Make changes in your diet

Exercise works on your receptor sites

Insulin assist the cell

NPH is working

Pills act whether you eat or not

I worked with those patients a lot

Appendix G (Continued)

Additional Examples of Use of Schemas by Host Preference

TAKE-REJECT SCHEMA (+2)

Take your glucose reading

Take in a breath

To make cells receptive to

Take your blood pressure

Make symptoms go away

It takes while to catch out

The tablets deliver 15 grams

It releases happy endorphins

WAR SCHEMA (+3)

There are target levels

Take another shot at it

You do have to have heart attack

You mobilize your flight or fight response

Appendix H

Target Domains by Group

<u>SOJOURNER</u>	<u>HOST</u>
CONTROL*	CONTROL*
PROBLEMS*	PROBLEMS*
SCHEDULE	CHOICE
SELF CHANGE	SELF RESONSIBILITY
TREATMENT	SELF CARE
WELL-BEING	NEWEST CHANGES
FEELINGS/EMOTIONS	HOW IT ALL WORKS
	HOST HELP

* these target domains were shared by the two groups

Appendix I

Dichotomous Meanings of Metaphors by Informants

Metaphor	Host	Sojourner
A. Scientific/ Non-Scientific		
1. Exercise is medicine	Healthy, a way to get better	Muscles get a break
2. Tissues repair themselves	Wound healing; heal; they scar	Rejuvenate; heal; fix; repair after injury
3. Oxygen is fuel the body	Metabolism; Krebs's cycle;	Breathing; creating; the muscle for less fat
4. Muscles store energy	Glycogen	Stores fat; retains energy; and boost energy
B. Given/Received		
1. Don't push it	Don't overdo; don't go beyond The point of injury	Don't over exert; don't overdo

Appendix I (Continued)

Dichotomous Meanings by Key Informants to Selected Metaphors

Metaphor	Host	Sojourner
C. Theoretical/Practical		
1. (my) meds are working	Achieving their expected goals	Sugar is too high; medication reaction
2. Deal with my insulin	How they take it and reference	Take time to do it; nothing I can do
	To how they work with it	About it; reacting to it
3. I take my meds	Using it at that point	Give it; inject it
4. Insulin peaks	At optimum working;	Highest reading; high reading
	Working at maximum	
5. Exercise is magic	Miraculous things; benefits	Lose weight; keeps some people alive up
	Diabetic skin get from exercise	100 years old; lower insurance policy

6. (it) runs in families	Tendency towards; characteristics	Inherited; heredity; eyesight problems in families
7. Exercise bout	All out bursts; one time thing	Contest of some kind; play game against; Body's white cells have a bout with bacteria
8. Healthy eating	Monitor what is eaten to; eat Proper fruits; education is key Piece; related to stress	Less sugar; low-fat; quit smoking; no Fun anymore; no drinks
9. Take control	Freedom to choose; problems in Balance; handle actions; Comfortable; control costs him	Sugar is down; diabetes doesn't control Me; things are under control
10. Keep sugar down	Maintain good levels; monitor Regularly; eating properly	Measurement by need or; reading is down; Or number

Appendix J

Non- Dichotomous Meanings of Metaphors by Informants

Metaphor	Host	Sojourner
A. Explanatory		
1. Exercise at a clip	Fast	Sustained moving
B. Deprivation		
1. Health eating	Balance	No more fun