Title: *Stroke among African-Caribbean women: lay beliefs of risks and causes*

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Aims and Objectives. To investigate African Caribbean women’s subjective accounts of stroke and how this impacted on their lives and identify beliefs attributed to the causes of stroke in this post stroke.

Background. In the UK, those from African or African Caribbean ethnicity are at an increased risk of stroke, and stroke risks are double that of the UK White population.

This is because diabetes and hypertension are more common in those of African and African Caribbean ethnic groups. The main risk factors for stroke are high blood pressure, alongside obesity and overweight, poor diet and lack of physical activity.

Design. A qualitative study using interpretative phenomenological analysis.

Methods. Data were collected via semi-structured indepth interviews for six African Caribbean women. Interviews were audio recorded and transcribed verbatim.

Interpretative Phenomenological Analysis was used to deconstruct the data and facilitate developing themes.

Results. Six semi-structured interviews were completed with women aged 47–85 years. Two themes emerged (1) the role of lifestyle and biological risk factors linked to the causes of stroke and (2) the role of spirituality, in identifying the lay beliefs and causes of stroke.

Conclusion. Alternative explanations of the causes of stroke that include witchcraft, or wishing someone wrong suggests a lack of perceived control over stroke. This may suggest a focus on less visible risk factors such as hypertension, familial history or diabetes and will need inclusion in health promotion materials. Lay beliefs such as witchcraft can co-exist amicably alongside modern medicine, as long as they do not hinder access to medication, treatment or risk factor management of stroke. Relevance to clinical practice. The results demonstrated that nursing care and health promotion materials should emphasise on obesity, overweight and management of these through diet and physical activity to prevent stroke occurring.

Key words: African Caribbean women, culture, health promotion, spirituality, stroke, stroke causes, stroke risks

Background

In the UK, those from African or African Caribbean ethnicity are at an increased risk of stroke, and stroke risks are double that of the UK White population (Tillin et al. 2012). This is predominately because diabetes and hypertension are more common in those of African and African Caribbean ethnic groups (Wolfe et al. 2006). The main risk factors for stroke are hypertension, alongside obesity and overweight, poor diet and lack of physical activity. The Stroke Association (2013) suggest that around 20,000 strokes in England could be avoided by preventive work on hypertension, diet modification or smoking cessation. Health beliefs are important in understanding health outcomes, as they can contribute to preventive behaviour and engagement with treatment in relation to illness. Health or illness beliefs are different to the concept of knowledge, as they are part of an information-processing model, which constructs levels of danger or threats and determines how people cope with illness or disease (Albert et al. 2013). This means that although knowledge may be one way of constructing beliefs about illness, there are other factors which influence beliefs including previous exposure or experiences of disease, religion, spirituality, personal vulnerabilities or culture of the affected person or groups. In some cultural groups causes of illness may not be linked closely to the biological causes of illness indicated by medicine. For example, a study by (Edge & Rogers 2005) of Black Caribbean women and postnatal depression noted that this group of women were more likely to favour and accept social and psychological over biological explanations of postnatal depression. Personal and societal experiences of illness or disease, particularly illness that may not be fully understood, means people may seek to look for their own explanations as to why they are unwell. Groups that exhibit such ideas are reported by academics and researchers as culturally constructing their illness. Their beliefs can vary as it depends on key factors such as ethnicity, national origin and levels of acculturation. In addition those who do not feel vulnerable to risks may seek other explanations as to why they are unwell. For example beliefs about causes of HIV/AIDS in some communities is still firmly grounded in traditional or lay beliefs such as witchcraft (Golooba- Mutebi & Tollman 2007). Spirituality is a recent term that is in linked to both religion and culture. The term has attracted attention predominately due to the lack of clarification of what spirituality actually means. Generally spirituality is taken to be an aspect of humanity that refers to the ways individuals seek meaning and purpose (Chow & Nelson-Becker 2010). This is a prevailing view that is defined by individuals, and it is often free from the rules or regulations of religion (Lucchese & Koenig 2013). For the purposes of this paper, folklore and witchcraft are subsumed under the term spirituality, as spirituality can be represented as both a positive and negative external force. To develop health promotion interventions that seek to reduce stroke in African Caribbean women health beliefs need to be taken into consideration. Health professionals and those concerned with stroke need to understand the triggers for behaviour change (Corcoran 2011) to be able to ensure that health promotion messages are tailored appropriately. This process has been proposed by various behaviour change theories (such as the transtheoretical model or theory of planned behaviour), and some research has highlighted the importance of health beliefs in modifiable stroke behaviours (e.g. Sullivan et al. 2008). If those concerned with stroke prevention and care seek to understand lay beliefs of causes of stroke in high risk communities they can create health promotion materials that take into account these health beliefs and create messages that are tailored to knowledge gaps whilst recognising these beliefs can be difficult to shift.

Aim

Taking these areas into consideration the aim of the study was to explore African Caribbean women living in London. subjective accounts of stroke and how this shaped their private and social lives. One of the objectives (which this paper focuses on) was to identify beliefs attributed to thecauses of stroke in African Caribbean women post stroke.

Methods

This was a qualitative interview based study that focused on life after stroke among African Caribbean women living in the East End of London. A commonly held belief of qualitative research is that the researcher(s) and participants are both contributors in the knowledge production and knowledge claims that emerge. In this approach participants’ voices are represented, therefore this co-authorship can possibly serve to facilitate greater clarity and awareness of participants’ situation as well as a sense of empowerment. With this in mind our study used the principles of phenomenology as captured in interpretative phenomenological analysis (IPA) (Smith & Osborn 2004). IPA has its origin rooted in psychology and has emerged as a methodological approach to explore in depth how individuals experience and attribute meaning to a specific phenomenon. IPA can be described as a variant of phenomenology, whose aims are concerned with exploring individuals’ perceptions and experiences (Finaly and Ballinger, 2006). To this end it uses an ideographic approach, whereby the focus is on individuals’ cognitive – how the individual reasons and makes sense of their experience, linguist how they use language to express their experience and meanings of those experiences, affective – focusing on the emotional experience and physical being – how the experience of the phenomena has affected the individual’s physical existence. The ideographic research addresses the wholeness and uniqueness of the individual, which presents a complete and in-depth picture.

Accounts analysed using IPA privilege the individual as it offers a different perspective from approaches such as grounded theory, which tend to use larger sample numbers to substantiate a theory (Barbour, 2007). The ideographic emphasis of IPA means that the focus is not on large quantities of data, but on collecting quality data that allow a deeper understanding of participants’ experiences. IPA recruitment can comprise individual case studies and the researcher should use small sample sizes (Smith and Osborn 2008).

Participants/Sample

Participants were all African Caribbean women who had survived a stroke and lived in the East End of London. All the women that were interviewed had migrated to England during the Windrush era, which was the period of Caribbean migrants to the UK. Participants inclusion criteria included having lived with stroke for a minimum of 6 months to allow time for adjustment with the illness.

Data collection & analysis

Ethical approval was granted by the Central Office for Research Ethics Committee and the University of East London Ethics Committee. Following advertisement participants were recruited from a hospital outpatient stroke clinic, local day centres and sheltered accommodation. A pack containing a consent to participate form, an information letter and the contact details of the researcher were given to prospective participants. Participants received no financial incentives or reimbursement but were thanked for their participation. Data were collected using semi-structured in-depth interviews in the homes of participants or a private room in the day centre and was analysed using interpretative phenomenological analysis to access subjective meanings of health and life after stroke (Smith & Osborn 2004). IPA uses an ideographic approach where each case study is examined individually for the researcher to be able to comment in detail about the preconceptions and understandings of the person (Osborn & Smith 2006). There are key analytic steps that the researcher needs to follow when making sense of participants’ experiences and reflections.

The process of IPA not only (as its name indicates) uses phenomenology, (as it involves a comprehensive examination of the participants’ life world) but also it incorporates a hermeneutics inquiry (Eatough & Smith 2006). The hermeneutic inquiry involves the participants making sense of their world or in our case health and life after stroke. It is a dynamic process where the researcher’s role is active in making sense of the participants’ making sense of their life world Smith & Osborn (2008) calls this the double hermeneutic. Unlike other analytic methods IPA does not focus on participant numbers (Smith & Osborn 2004) but on the depth, richness and quality of data.

Data were analysed immediately after each interview our data showed the subjective and collective staying true to IPA and based on data quality we stopped at six participants. To analyse the data, a systematic protocol was used which allowed the data to be deconstructed to facilitate developing themes and interpreted to illustrate the meaning of the phenomenon under investigation (Table 1). At this stage any field notes that were made was used to help facilitate the data analysis process.

The analytic focus of the qualitative framework adopted here allowed the researcher to unpack some of the important ways through which experiences of a major cardiovascular disease (stroke) are narrated, understood and embodied in the everyday lives of African- Caribbean women. This process helped in contextualising the meaning of the lived experiences of those who were interviewed.

Validity and reliability

Tong et al. (2007) published a criterion for reporting qualitative research, in which they identified three main themes for reporting: (1) research team and reflexivity; (2) study design and (3) analysis and findings. The theme of ‘research team and reflexivity’ is subdivided and concerns the personal characteristics of the researcher and their relationship with the participants. In this study each participant was informed that the principal researcher CM is a nurse and he explained his interest in stroke and African-Caribbean women to participants where required. The researchers had little prior knowledge of participants, apart from the fact that they had experienced stroke. Participants were given an information letter, so that they were aware of the goals and reasons for undertaking the research.

The study design was divided into three sub-sections. The first, theoretical framework, was concerned with methodological orientation and participant sampling. The second sub-section covered the setting, and focused on areas such as where the data were collected and a description of the sample. The final sub-section focused on data collection, discussing information on the interview guide and providing information on audio or visual recordings, return of transcripts to participants and the use of field notes. As part of good practice and maintaining rigour the transcripts of two participants were returned for verification. The field notes made were used to help illuminate the analysis.

Analysis and findings is the final domain, and this was sub-divided into two sections: data analysis and reporting. When analysing data, a researcher is urged to report the number of coders used in the data analysis, derivation of themes, software used and details of participant checking. CM was the only coder, however, a final mapping of

themes was presented to the other two members of the research team for discussion and guidance as appropriate. From this discussion themes were clarified, discussed and reshaped to produce a clearer and more transparent narrative.

All data were coded manually, as it was felt that the use of computer analysis would detract from ‘doing’ an IPA study. Table 1 on data analysis indicates this process and how the master and sub-themes were arrived. A final review of how quotations are presented, the consistency of data and the findings, as well as the clarity of the master and sub-themes was performed.

Results

The study participants (6) were between the ages of 47–85 years of age African Caribbean women and had lived with stroke for 1–5 years (all participants were given pseudonyms to maintain confidentiality). Evidence of beliefs attributed to the causes of stroke was illustrated through dialogue with the women, and two main themes emerged.

These themes reflect one of the objectives of the study, which was to identify beliefs about the causes of stroke in African Caribbean women post-stroke. Two themes are

presented, firstly the role of lifestyle or biological risk factors linked to the causes of stroke. The second is the role of spirituality, in identifying the causes of stroke.

Lifestyle risk factors as a cause of stroke

A number of the women identified that there were links between causal lifestyle risk factors and their stroke. Some acknowledged that diet was important, and some focused retrospectively on the potential causes of their stroke. Margo was the only participant to explicitly mention a number of accurate risk factors for stroke, and the only participant to highlight salt and fatty foods. She clearly linked these directly to her stroke when she was asked what caused her stroke:

*I suppose the salt and seasoning, I have cut down on that now. . . I*

*eat more fruits and salads. . . since the stroke I eat more salads, like*

*at work everyday in the week I will have salad rather than fattening*

*things.* (Margo)

Margo’s words highlight that she was aware of what she was eating (that might have been a risk factor) before her stroke, and how she has changed her lifestyle after stroke. Margo however, also indicated that she did not have the risk factors that are linked to stroke, and this is possibly why people look elsewhere for explanations of stroke:

*When I had my stroke I wasn’t overweight, I didn’t have diabetes.*

*I didn’t smoke or drink*. (Margo)

Very few women were this clear in attributing risk factors to their stroke. Some participants noted that now they have had their stroke, they are considering their behavior before their stroke. For example Mildred noted that she follows the hospital orders now for exercise, suggesting perhaps lack of awareness of this before her stroke: *I exercise as my doctor and the hospital say to do.* (Mildred)

Others acknowledged that they knew the risk factors but that they did not do anything about these causes: *I know for mihself that things were said to me years ago and ah had it in my mind all de time and it around but I do nothing*. (Lucy)There were a number of women who focused on worryingand stress as a cause of their stroke. This suggests a tendencyto focus on psychological, rather than biological causes of

stroke. Stress is associated with high blood pressure also called hypertension, and hypertension is one of the main risk factors for stroke. In this group, women linked stress with control, and having the ability to control ones’ health: *I use to always be a worried person, worried over everything, but* *now I try to relax my body, I don’t let everything worry me. I try* *to control myself.* (Jenny) This suggests an understanding of the association between worrying, stress and risk factors such as hypertension. This does not necessarily mean that the women know that their hypertension is the cause of their stroke, rather than worrying leads to high blood pressure, and that high pressure is undesirable. Lucy also talked of the association between stress and blood pressure.

*But if ah (I) is calm yuh know if there is no problem, no trouble,*

*no lickle (little) thing and I’m calm pressure fih (is) down*. (Lucy)

She also noted to try to be less worried post-stroke: *maybe try fih (for) be less worried, yuh know, but in this country yuh cah (can’t) stop worrying, every time is ah worry, worry, worry.* (Lucy)

Personal control over health can result in positive health practice, and allows individuals to take control and ownership of their own health post-stroke. Worry is linked to worsening stoke conditions, a factor that is emphasised by health care professionals: *They (health professionals) speak to me, they say you must not*

*worry about anything, you are carrying on good you are*

*alright. . .and my doctor tell me you should not worry too much.* (Marie)

Spirituality as the cause of stroke Some women ascribed meaning to the cause of stroke as a negative spiritual force and explained this in detail. However, only one of the women actually focussed specifically on a religion and blamed their God, or demonstrated anger against God as the cause of their stroke. Instead, the women identified more sinister images associated with a darker spiritual force. Lucy talks of the unlucky image of a black daddy long leg spider coming down to touch her:

*I saw a daddy long leg coming down, coming down, and to touch mih. So when I take the towel for me to hit it, it turned to soot, black soot. I did not see where it go but it was like in a corner then the pain, the pain suddenly by the time I feel the pain I feel*

*my face getting palsy, I said God help me with that pain, suddenly I cannot see’*. (Lucy)

Lucy also notes that a sister wished her bad, and “sent” her a stroke, but when the same sister died she considers it was vengeance, and the same stroke had returned to her sister:

‘*That sister that wish me bad about 6 years after she was in the bathroom bathing. . .and she said her neck, her whole body is hurting her, her legs hurting her take her to the hospital. . .before she reach there she die on the way. . .it’s the same stroke she had sent me God returned it back to her’.* (Lucy)

Despite the mention of God in Lucy’s extract, this is a God who is looking after Lucy and returning the stroke to the sister who ‘wish me bad’. This notion of wishing someone bad in Caribbean culture is often associated with magic or witchcraft. Other women expressed similar views of people ‘doing you bad’ through magic, despite the doctors saying their stroke was a result of high blood pressure:

*The doctors say its high blood pressure but there is people doing evil as well. Some people if they jealous your prosperity they will fly back home and work dey evil magic on you. They will bring it to you and say Sylvie I bring you back a present and all this time is do they doing you bad. You cah trust some people at all*. (Sylvia)

In the Caribbean the word Obeah represents one form of perceived negative spirituality and witchcraft. Mildred explains that: *Some people believe than ah evil spirit could come pon* *yuh. . .sometimes yuh friend or neighbour, even your own family* *could do yuh bad with Obeah’.* (Mildred)

Some, like Lucy, hold such a strong belief in black magic that they have an embodied fear of calling it by its full colloquial name ‘Obeah’, so she referred to it by its first initial for fear of the power the practice holds. *I think the stroke was caused through the O (whispers in a low* *voice) I believe that and because it cause through that.* (Lucy). These meanings are potentially a way of coping with stroke, and could be seen as an attempt to identify the specific cause as to why a stroke happened to them. Those that are unsure what caused their stroke may seek alternative explanation as to why it should happen to them, or in the case of Sylvia try and seek other explanations when the one given to them (hypertension) is not satisfactory. All of the women spoke positively of the role of religion in coping with stroke, rather than as a causal factor for stroke. Only one of the participants considered that God was punishing

her with a stoke; *Well I is ah Seven Day Adventist I go tuh church every week and*

*have never been unfaithful to me husband. I doh even drink rum or any alcohol and yet God punish me with de stroke.* (Sylvia)*.* This indicates the lack of control Sylvia feels over herstroke happening in the same way that witchcraft or magicis perceived as the underlying cause of stroke.

Discussion

The analysis demonstrates some awareness of the risk factors of stroke but suggest that some of the women do not fully understand what had contributed to their risk of stroke. High blood pressure was a common topic, and the need to control their blood pressure. This is promising as it shows an understanding of the link between hypertension and their symptoms. Whilst there was some recognition of diet, smoking and alcohol, none of the women (apart from Margo) specifically mentioned obesity or overweight as a cause of their stroke, cholesterol or family history. These are all major risk factors for stroke, and this demonstrates either a lack of knowledge, understanding or belief that these risk factors cause stroke. The lack of emphasis on risk factors such as obesity, diabetes or family history may be due to lack of health promotion advice, for example Shah et al. (2007) found that 95% of patients who had experienced stroke and 86% of bystanders (i.e. family) had not received any health education on signs and symptoms of stroke. However, these women are poststroke survivors and the expectation or assumption would be that some level of lifestyle advice would have been given to prevent a second stroke. We can therefore assume that these women do not highlight specific lifestyle risk factors as either they do not consider these to be the main cause of their stroke, or they have not received any health promotion pre or post stroke that was either meaningful or effective.

Worthy of note is this group of women’s belief system was often revealed by the social structures used for dealing with illness. The illness was, we could argue, culturally constructed as a psychosocial experience. There is a general criterion to guide the healthcare seeking process and to evaluate treatment approaches prior to and independent of individual episodes of illness. One notable element in the study was that most of the women interviewed associated worrying and stress with their stroke. This highlights a psychological element to the belief in the cause of stroke, and is closely bound to the notion of blood pressure. This is interesting, as stress is not regarded as formal risk factors for stroke. This is consistent with findings from Sullivan et al. (2008) who also note that their participants who were at risk of stroke also referred to stress as a causal factor in at risk groups, demonstrating gaps in stroke knowledge. It is possible that factors such as worrying and stress are seen as easier to control, and maybe mixed up with experiences of coping with stroke. Alternatively it refers specifically to the relationship between hypertension as the main cause of stroke. Desmangles (1992) found than in terms of health beliefs some followers of Voodoo believed that hypertension was the result of a spell and concluded that stroke was one of the consequences of the spell.

Whilst lack of knowledge of risk factors can be remedied through appropriate health promotion advice tailored specifically to knowledge gaps in this group, spiritual causes of stroke provide much more of a challenge. People look to spiritualism for restoration of health, guidance and hope of survival, this includes a system of cultural management through labelling and explaining that leads to therapeutic outcomes including cure, treatment failure, recurrence, chronic illness, impairment and death. The spiritual meanings that the women attributed to the causes of stroke are situated outside the realm of scientific medicine. Firstly, these beliefs may demonstrate a lack of understanding of the main stroke causes, or low recognition of the early signs of stroke. This has been noted in other chronic illnesses such as HIV (Golooba-Mutebi & Tollman 2007), where meaning is ascribed to bewitchment or violation of taboos.

When individuals hold such beliefs it challenges preventive efforts of health promotion/education. Secondly, these beliefs may result in lack of treatment seeking behaviours or lack of adherence to medication. Fernandez-Olmos and Paravisini-Gebert (2003) study on Creole religions in the Caribbean concluded that many individuals affected by health problems seek the help of the Obeah man or Obeah woman – cultural healers who may replace the role of health and medical professionals.

Patient’s delay in receiving treatment for stroke is the most significant pause in frequency of waiting at a hospital (Shah et al. 2007). If a patient attributes causes of stroke to witchcraft or beliefs in other nonmedical causes this may mean a delay seeking treatment discouraging prompt management of stroke. Finally, strong religious or spiritual attachments may mean a stronger belief in divine healing,

rather than medicine, for example Kretchy et al. (2013) notes that in hypertensive patients, religion and spirituality was associated with nonadherence to medication. This was not an area for exploration in the study but may merit future investigation in this group. We recommend that health and medical professionals acknowledge that some African- Caribbean groups may hold a cultural view of stroke and that this view can affect the way in which the individual accepts and receives treatment and care.

Spirituality is seen as distinct; a construct that acknowledges that individuals may have a faith in a divine being or force that provides a personal sense of meaning and life purpose separate from the beliefs and practices of a particular religion (Van Ness 1996, Mansfield et al. 2002). In this study, the findings suggest that religiosity and spirituality occupy a significant role in the lives of African-Caribbean women who had experienced stroke. It provides a context for making meaning (for example, Lucy’s explanation for her stroke is based on an evil or dark spirituality and Sylvia’s view that it is punishment from God). Religious and spiritual beliefs can be considered a private concept of health and illness. The women in this study who chose to share this private world showed a value of self-sufficiency through spiritual faith and power. The views of illness and healing stress the importance of the individual and of certain religious practices (Baer, Garmezy, McLaughlin & Pokorny, 1987). This type of belief and aspect of a religious faith offers important coping mechanisms, but also implies that the blame for the illness lies with the individual (i.e. the individual has either committed a sin or is being tested by God). This concept can lead the individual to ignore the wider determinants of health.

Study strengths, limitations

There are a number of limitations to this study firstly the data were collected from an inner city area and may not be representative of all African Caribbean women’s experiences. Secondly, stoke can alter cognition cause alterations to memory, including the ability to recall past information. Participants remembering their stroke therefore may not accurately be recalling the same information they believed before they had their stroke. This may be an important distinction when considering primary prevention of stroke as there may be differences between beliefs in causes of stroke in those at risk, and those who have had a stroke. Nevertheless, as stroke risks increase after a first stroke, there is still potential for preventive efforts to focus on prevention

of an additional stroke. A final limitation was that data was collected poststroke there is potential for some causes of stroke to be considered retrospectively. This is especially the case if the women had been searching for meaning as to the cause of their stroke. In addition understanding of causes of stroke after stroke is likely to improve through the involvement of health professionals or family members. However, the data still allowed an insight into what the women thought caused their stroke at this time, which is invaluable for preventive efforts of another stroke.

Conclusion

It is important to acknowledge and understand cultural explanations and lay beliefs. Beliefs such as witchcraft can co-exist alongside stroke medicine amicably, as long as they do not hinder access to medication, treatment or risk factor management of stroke, it is perfectly feasible for example to believe that stroke is caused by witchcraft alongside the belief that medication is needed to control an individual’s

blood pressure. The acknowledgement of this coexistence also reiterates that as a health professional you understand the individual’s culture. Using educators from the local African Caribbean community or designing materials with women from these communities who have a clear understanding of stroke and biological risk factors will help to ensure spirituality and medicine work together in stroke prevention and rehabilitation.

Relevance to clinical practice: This study suggests there are knowledge gaps in some of the major risk factors for stroke in African Caribbean women, suggesting health promotion materials should put emphasis on obesity, overweight and management of these through diet and physical activity to prevent stroke occurring, and to try to reduce incidence of a second stroke. Alternative explanations of the causes of stroke that include witchcraft, or wishing someone wrong suggests a lack of perceived control over stroke. This may suggest a focus on less visible risk factors such as hypertension, familial history or diabetes and will need inclusion in health promotion materials.

What does this paper contribute to the wider global clinical

community?

• Beliefs such as witchcraft can coexist amicably alongside modern medicine, as long as they do not hinder access to medication, treatment or risk factor management of stroke.

• Nurses and health care workers need to emphasise health promotion on obesity, overweight and management of these through diet and physical activity to prevent stroke occurring.

• Religiosity and spirituality offers important coping mechanisms, but also implies that the blame for the illness lies with the individual

Contributions

Study design: CM, SC; Data collection and analysis: CM,

SC, NC; Manuscript preparation: CM, NC.

Conflicts of interest

None declared.

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Table 1

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| PHASE 1 - FAMILIARISATION   * All interviews were listened to, then transcribed into a Microsoft Word document (this made it easy to cut and paste themes at a later stage of analysis). * Lines in each transcript were numbered to link participants’ own words with the emerging themes. * Each transcript was read individually several times, until the researcher was comfortable and familiar with the transcript. * All notes made during the interviews and reflections on the interviews were also read in conjunction with the transcripts to help with clarity. |
| PHASE 2 - SENSE MAKING   * Each transcript was attended to individually and, after familiarisation, themes were identified for each transcript. * A handwritten summary of notes on each transcript was made, identifying meaning making repertoires. * This was presented to research team for feedback and discussion and further clarification and reshaping of themes were undertaken at this stage |
| PHASE 3 - THEORY BUILDING   * From the list of themes, a cluster of themes was created reflecting the idiosyncratic singular to the general (where possible), connected with line numbers. * A master list was created from the cluster list. * Themes were grouped together and linked to psychological and health theory. * A master theme grid was created with/from each transcript and line numbers to illustrate location of the data. |
| PHASE 4 - DATA REFINEMENT & ANALYSIS   * Each individual transcript was read again; with a view to extracting each participant’s own words to support themes, providing the richness IPA adds to analysis. * All texts were checked against original transcripts to ensure accuracy of themes (this provides rigour of inductive reasoning). * Reflections of the researcher on each transcript were read, to help guide the process of interpretation. * An initial write-up and review was created to weed out unnecessary extracts. * A final write-up of the narratives linked to psychological and health theory supported by ‘rich extracts’ of the transcripts provided support for the data analysis. |