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ABSTRACT OF THE THESIS

THE RELATIONSHIP BETWEEN ATTITUDE PATTERNS IN SOCIAL FAMILY SUPPORT AND OUTCOMES OF ELDERLY PATIENTS SUFFERING FROM HEART FAILURE

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KEY – WORDS: self-rated health, cardiovascular illness, social capital, familial social support, social integration, modernisation theory, cultural background, mixed methodology, systemic approach, ecological perspective.

THESIS CONTENTS

STRUCTURE OF THE ABSTRACT

1. THEORETICAL AND EMPIRICAL ANCHORS OF THE THESIS

As a professional and also as a researcher that has been involved in the medical technologies and nurse service department in the area of heart diseases for many years now, I discovered a good opportunity to create a research framework in which had participate patients samples from the hospitals I worked, in order to explore the social causes on different paths of health outcomes of the individuals affected by cardiovascular diseases.

The entire doctoral work is placed at the intersection of two generous domains: *Sociology of Health* and *Sociology of Family*. Moreover, social-psychological and medical approaches had been involved in analysis, as inherent domains of interests tied with scientific areas of Health and Family. As an implicit idea, the entire construction of the thesis emerged on the triplet: patterns of social familial support – cardiovascular illness – self-rated (and / or self perceived) health of the patients.

The ***theoretical chapters*** try to summarize the theoretical background on: i) health and illness concepts and their evolution through the history, by various perspectives of sociological and psychosociological approaches; ii) family issues (change in the family structure, functions of the family and familial relationships, social familial support, intergenerational relations, and social capital of older people in contemporary societies, implying both the theoretical points in sociology of family and empirical developments in the area; iii) the causal dependency between social support and health, particularly the relationship between social support and cardiovascular illness (and related mortality) concerning the intersections of physiological, behavioral, and psychological variables and pathways of disease causes, evolution, aggravation or amelioration, and outcomes, designing different ways in which individuals may respond to unexpected events and life turning points (para-normative, stressful life changes), in the same time involving psycho-cardiology developments.

The ***empirical part of the thesis*** engaged two researches conducted by means of questionnaires and in-depth interviews concerning the issues of health status (self-rated health) and elements of wellbeing tied with family's characteristics of support, which are constructed especially for the purpose of the research.

The *purpose of the research was to discover some patterns of common patient's view about their own health, their level of medical information, and about the evolution of their cardiovascular (heart failure) illness*. The main objective was to find possible associations, relations and interferences with social (familial) support, and correspondent outcomes on their illness and level of wellness as well. Meanwhile, my intention was to

contribute to the reflection and explicit knowledge creation on the particular problems may appear in these health-social interactions. The entire study had an *exploratory character, using a mixed methodology*. The patients sample of both investigations was selected (theoretical sample) from the hospitalized individuals from my workplace.

The findings of the observations, questionnaires, and in-depth interviews are analyzed statistically and qualitatively. In the quantitative and qualitative research I try to examine three various types of family support (no family support, adequate, and excessive), and their connection to the mode in which the patients cope with the (heart failure) illness.

Both theoretical and empirical analysis engaged ***three level of knowledge***: structural dimension (societal theoretical perspectives, evolutions and statistical trends related with mortality, etiology, prognosis, and intervention related with cardiovascular illness - with special focus on the Israel situation); mezzo-social dimension (medical institutions – hospitals, rehabs, support groups, and communities – and wider social level); and individual (values, attitudes, beliefs, and patients behaviors patterns related with their social familial support).

2. PRINCIPAL CONCEPTS, THEORETICAL PERSPECTIVES, LITERATURE REVIEW, AND STATISTICAL PICTURE

The purpose of **Chapter 1, *"Health and Illness. Sociological and Social-psychological approaches"*** is to explore the concept of health and identify the means by which it can be achieved, promoted, sustained, and regained by the people, in the light of sociological and social psychological theories and models. From a historical viewpoint it can be assume that both health and illness have been approached mostly in terms of social problems which need to be solved. The fact that they represent sociological and psychological problems whose investigation facilitated social knowledge was a secondary approach. Scholars have identified several examples which sustain the evaluative nature of these two concepts: health can be defined in terms of biological ("healthy body"), psychic ("mental health") or social attributes (health as the capacity to fulfill a social role). All these definitions can differ in their significance as a function of social class, age or geography (Goffman, 1961; Rosenstock, 1974). The distinction between "negative" (medical) and "positive" (social) views of health remain in the middle of various debates, as although negative views of health point mainly on ill health, the

concept of ill health is not deeply established in his dimensions (Downie et al., 1991). The complexity of defining illness implies both subjective and objective perceptions in regard to illness. One step forward, the social or environmental effects on health may be treated as unimportant although it may cause extreme consequences. More positive views of health such as that quoted from World Health Organization (1984) embrace more complex notions of fitness and well-being, as a "whole" integration of body and mind. (Hall & Elliman, 2003, p. 6).

On the basis of the theoretical approaches (from sociology and social psychology areas) and health (health care) models presented, I managed to reveal some major ideas:

As evaluative concepts, health and illness can be largely viewed as ways and mechanisms in which a certain population perceived health upon specific value system, cultural aspects, social norms and attitudes of this population. On the other hand, a scientific approach cannot ignore objective evidences on health, based on measurable indicators of diseases status.

There I contoured several conclusions regarding health and illness as social and psychosocial phenomena, in the light of theories and developments incorporated in this chapter:

- Health and illness are not representing accidental phenomena, and are neither dependent only on the genetic material of the individuals. The *prevalence of specific types of illness is dependent on social backgrounds*, i.e. income, social class, ethnicity or residential environment.
- Being established that the majority of the health domain studies are not explicitly concerned with the testing and developing of sociological theories, these studies have an indirect contribution to the development of theories. Thus, medical sociology can contribute to develop sociological explanations concerning health and illness; empirical research in health domains can bring information on individuals', communities', or other social structures' health behaviour and thus, it can help the development of public health agendas.
- In the new literature approaches, an improving health means a step forward *to positive view of health which underline the importance of fitness and well-being*, and the renouncement to negative view. This move required a new value system to put the light on social rather than medical care (Macdonald, 1998).
- Globally, the first chapter has shown that the concept of individual health is much more complicated than it appears at a first look. It has been shown that *the true concept of health incorporates much more than the absence of disease and illness*. Thus is has been argued that a knowledge of the factors which affect the health care, socialization level, family structure and social support, social class, social exclusion, unemployment, poverty, housing, diet, physical activity, is as important as a knowledge of 'natural' causes

of disease or illness. This suggest that *population health is not the sole concern of the health care professions, but the responsibility of all who contribute to a state of people's well-being*.

- The social inequalities have a major impact on population health. In the light of *current evidence of the social conditions of poor health in adults and older people, policy appears to be taking a firmer stand in supporting the responsibility of families, social networks and support groups, and community*. Specifically, it appears that a more holistic view of family and community health is prevalent in current policy in the developed countries. The proliferation of health and social policies and programmes aimed to prevent and promote health as well as medical and primary care and treatment. Current scholar's evaluation appears to suggest that social intervention of this kind will improve population health, and social welfare as a whole.
- *Health and illness have both micro-, mezzo-, and macro-social consequences*. On the micro-social level, illness affects the psychological as well as the physical condition of people, presupposes economical and emotional costs, etc. On the mezzo-level, illness is altering the well-being of communities and extended families, while on the macro-social level illness affects the condition of workforce, and presupposes financial allowance for children and old people, by growing amounts of money for care (Gwyn, 2002).

Chapter 2, "*Family relationships, social familial support, and social capital of older people in contemporary societies*" aimed to describe how the family relations, family structure, and pattern exchange and functions are changing through the years. There have been a series of social changes that have transformed the "traditional" context of relations between familial generations in the last decades, underlying the modernization process in developed countries. The importance of the theme of relations and ties between generations in the family is obvious, the growing interest being suggested by the multiplication of the empirical researches and theoretical models interested on the area. The growing diversity on social features, the development of economical relations and of the market workforce, and demographical have effects on the life span that has means more years spent in multigenerational families, a large diversity of the family structure, and a greater variety of role and functions to fulfill the psychological, physical, and social needs of family members. Various exchange paths within the family members may occur, especially between older parents and their adult children, based both in structural constraints and cultural norms.

Despite that the structure of intergenerational relations are naturally adjusted to demographic and macro-social and mezzo-social changes, the bonds between generations across life cycle remain in the millieu of the social structure and function, having a pivotal social role. Thus, at different levels of importance,

intergenerational ties contribute to individual and group survival, health and well-being of the generations involved. Another concept involved in analysis was „social support" (sub-chapter 2.4).

The copping process is mediated by social support, favourising complex mechanisms of positive effects on health outcomes, including on health-related issues (fast recovery, lower mortality, sense of wellbeing). (Schwarzer & Leppin, 1991). In today's world, mainly in the developed regions, the decision to start giving informal support to vulnerable older parents cannot be taked for granted anymore. The decision depends on the ongoing quality of social parents-children relationships, on voluntary principles and on individual agreement (Keith, 1992).

Important ideas extracted from this chapter can be organised as follow:

- The amplitude of demographic changes in contemporary societies at demographical, social, economical and cultural levels conduct to several consequences observed on familial social relations and others life domains. As the numbers of older people in Western societies and also in emerging countries continue to grow, the societies requires more spendings for health services and hospitalization.
- Dramatic influences of the maco-social changes is registered on the mechanisms of social support, gender role, marital choice, and lifestyle within the family life domain. Among them, intergenerational ties (support, transfer, and solidarity between familial generations), pesurposing a large variety of manifestations in terms of exchanges, depends on structural constraints and cultural norms, but also on individual choices and the presence or absence of self-determination values.
- Informal social capital, more than formal social capital, appear to be an strong indicator of wellbeing in aged people. The family and community networks, meaning a diverse continuums and levels of exchanges' and actions' family members, friends, colleagues, neighbors, contribute to health and wellbeing at all ages, but more important in the elders group. Naturally, as the family constitute the main source of *caregiving*, the health status appear to be directly linked to the „health relations" of elders with their family.
- The complexity of health problem of olders impose a comprehensive, ecological, systemic approach. As the literature undelined, health preservation, aggravation, and also recovery time depends upon the support the elders receives from the family and other informal social groups, as well as upon their ability to cope both with the illness itself, and the treatment provided. As a core of health protective factors, the generous domanin of social contacts and social participation seems to mediate and reduce the negative effects of aging, by which very important appear the delay of physical and psychological functions decline.

- To touch the aim of health promotion and prevention, the programmes and strategies for it should provide as much as possible, appropiate activities and contents to the elders. In this light, psychosocial interventions among the general population are „cost-effective" for society. In my opinion, rallyed with literature assumptions and proposals (see Forsman et al., 2012), more research is needed on the effects of lifestyle, type of social and familial relations, and types of living arrangements, attitudes and behaviors concerning independence (as possible) at old age, on personal and social wellbeing.

Chapter 3 "*The influence of social support on health - cardiovascular illness*" represented the synthesis of selected concepts of the relationship between social support and health, particularly cardiovascular illness, and related mortality.

From the beginning, based on literature, I made the distinction between social support and social integration. Other conceptual delimitations are made in order to enrich the knowledge regarding the health effects due by magnitude, complexity and multiple functions and levels of interaction processes (Sub-chapter 3.1.).

It is also showed that the biological (physiological) factors are not alone involved on cardiovascular health. As numerous studies demonstrate, social and psychological factors play some important roles there. On a general view which is based on epidemiological results, a lower mortality rates are positive correlated with the presence of the marital partner and also social networks participation, suggesting a positive outcome on longevity. The selected studies exposed on the thesis indicate that the presence of strong social relations (social bonds) tend to increase the survival rate and wellbeing on cardiac patients

At different levels of illness pathways (prevention, beginning, evolution and improvement or aggravation) can be detached different factors: physiological (biological heritage), behavioral (life style – cultural and social attitudes, quality of life – economical level and access to health services), resulting in various ways in which people respond to stressful encounters and critical life changes

The mediated mechanisms that can offer the explanations regarding these epidemiological associations are integrated in the area of health psychology. Connected to this, another psychological domain arised: clinical psychology for cardiac disease, involving the development of psycho-cardiology.

In this light, Sub-chapter 3.2. of the thesis focused on cardiovascular disease based on two areas of evidence: (a) the dominance of cardiovascular diseases (CD) as a cause of death in Western societies, and the growing of death rate incidence by CD's in Eastern Europe and Middle East, in developing countries; (b)

classical and recent studies who, strongly and repeated, underline the ties between cardiovascular diseases and the complex map of social and psychological factors.

In sum, there are numerous studies that confirm the causal relations, at various levels, connecting social factors (social integration, family / social networks, gender) to the disease evolution and outcomes.

Sub-chapter 3.3 and 3.4. described a series of studies who shows that mortality, survival from chronic illness, after surgery, and also recovery from cardiac diseases and morbidity are strongly shaped by quantity and quality of social support.

Sub-chapter 3.5. consists in a synthesis of literature regarding social support effect on behavioral and psychological pathways, as follows: the behavioral pathway approach has been confirmed by results of the researches who indicate that social networks encouraged health behaviors, strongly contributed to the prevention of illness, to the improvement of its progression and outcomes, and positive affect the recovery process, thus prolonging lifespan.

In sum, this chapter describe strong empirical evidences *that social integration and social support are associated with mortality, health and illness*.

Chapter 4 ***"Cardiovascular diseases as a developing issue worldwide: A special focus on Israel case"***, using some selected key-statistics, intend to shape an image about heart disease, stroke, other cardiovascular diseases and their risk factors. Giving the fact that cardiovascular disease is on the top of deaths causes, accounting 17.3 million deaths per year, and taking into account the previsions models that calculate the future trends, this tendency appear to grow, the estimation for the follow decades indicating 23.6 million deaths caused by cardiovascular diseases by 2030 (American Heart Association, 2015). There are described the main risk factors for such diseases, being underlined two major causes: unhealthy behavior and low-income status.

This chapter is also concerned on Israel case, taking into account the residence country of the patients involved in the research.

- In Israel in 2015 there was a *death rate* of 5.3‰ (Israel Central Bureau of Statistics, 2016). Starting from 1999, cancer (first case) and heart disease (second cause) were the most prevalent causes of death, these two conditions being responsible for nearly half of all deaths. Thus, the incidence of these illnesses is much lower compared to the situation of several developed countries, and deaths due to these ill conditions occur usually later in life, especially in the case of people aged over 65. On the third place of death causes, we find diabetes which is somewhat more common among Arabs compared to Jews (8,4% vs. 5,3%). In part, those

differences between death causes by ethnic group come from age distribution differences between the two groups - the Arab population is younger. Compared to developed countries, in Israel there are higher rates for *diabetes related diseases* (and for infectious diseases), and thus we have here higher rates for deaths associated with diabetes and diabetes-related complications than in other developed countries.

- In the *case of Israel*, it can be concluded that the economic and social indicators tell something about the differences in quality of live of the two main ethnic groups of Israel: Jews and Arabs. As the scholars insists, these differences may track a series of serious consequences on health parameters, the standard of living and lifestyle constituting critical factors in the etiology, progression, and treatment of any disease, especially on CVS's, diabetes, and cancer.

The last section offer an set of proposals in order to reduce the burden of cardiovascular disease, according to studies and literature from social and health policies areas; there, my personal view are also involved.

3. MIXED METHODOLOGICAL RESEARCH - THE MAIN RESULTS OF THE EMPIRICAL WORK

Chapter 5 "*Methodological frame: questionnaires and qualitative interviews*" argued the mixed methodological approach and the applicability of the combined methodological model, thus framing the mixed research. In this part there were sustained and explained the objectives, hypotheses and questions of the quantitative research, as well as the questionnaire, the main use of qualitative data, the purpose of the qualitative research, the sampling in qualitative research, validity, reliability and generalization, the interview questions and limitations of the research were discussed.

Chapter 6 "*The quantitative analysis of the empirical results*"

The starting question of the *quantitative research* were: *With regard to patients who suffer from heart failure, is there a relationship between patient's family patterns, repeated and frequent hospitalization, and elderly patient's quality of life?*

In order to investigate the research question the following objectives have been followed: to establish the severity of the illness and the correspondent level of quality of life according to medical evaluation and prognosis's instruments in cardiovascular diseases; to examine the relationship between family behavior pattern

toward the elderly with heart failure and frequency of re-hospitalization; to develop an understanding of the best family functioning and attitude towards the elderly with heart failure in order to decrease frequency of re-hospitalization, days of hospitalization, and quality of life. Additionally to the general research question, I have formulated several specific hypotheses: a) the more the type of social family support is adequate with the real medical situation of the elderly patient, the more the frequency of hospitalization and number of days of hospitalization decreases; b) the more the social family support is adequate to Quality of Life, the more the frequency of hospitalization decreases. The main variables involved in analysis are: hospitalization / day frequency, level of information about the illness, changes in lifestyle, and ethnicity / religion of the patients. Statistical analysis follows the corelational path, by objective-correspondently dependent and independent variables.

The physical and social function and quality of life questionnaire were constructed through the selection and adaptation of the items inspired by *Kansas City Cardiomyopathy Questionnaire (KCCQ-12)* 2012 [1] authored by J. Spertus, who developed and validated this instrument.

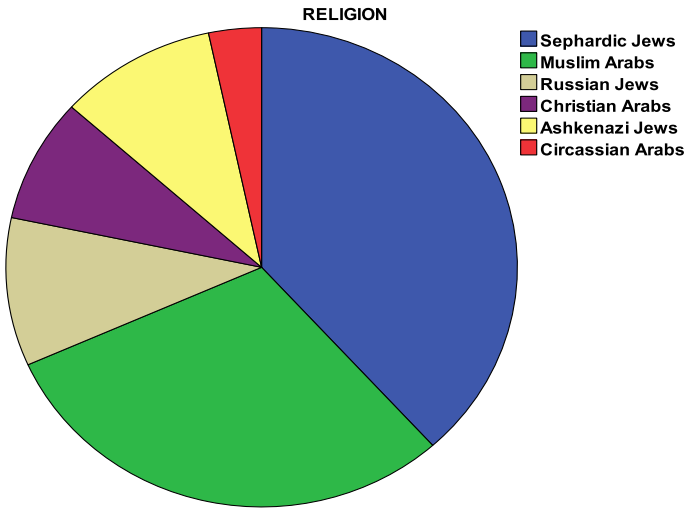
The questionnaire included several health and life domains, divided in 5 scales (12 questions): *Physical Limitation*, *Symptom Frequency*, *Quality of Life*, *Social Limitation*, and *Summary Score*. The scoring scale of KCCQ conduct to achieving of an overall summary score that can be extracted from the physical function, symptom (frequency and severity), social function and quality of life domains. Scores are transformed to a range of 0-100, in which higher scores reflect better health status[2]. The validity, reproductibility, responsiveness and interpretability of each accounting area are independently established.

In the instrument were included also *the Family Support Questionnaire* - developed by Zimmet, Dahlem, Zimmet & Fanley (1988, quoted in Moss-Morris, Weinman, Petrie, Horne, Cameron, & Buick, 2002). This questionnaire examined the total family support that patient receive in emotional, social areas. Additionally, to the items developed on the basis of the *Family Support Questionnaire* I added: several questions on patients' quality of life, made observations, analyzed patients' medical records (document analysis) and applied semi-structured interviews to the patients.

The *participants of the study* were 60 older adults (over 65 years old), hospitalized at least once in our medical unit (in the last two years i.e. 2001, 2012 – the quantitative research were developed in 2013).

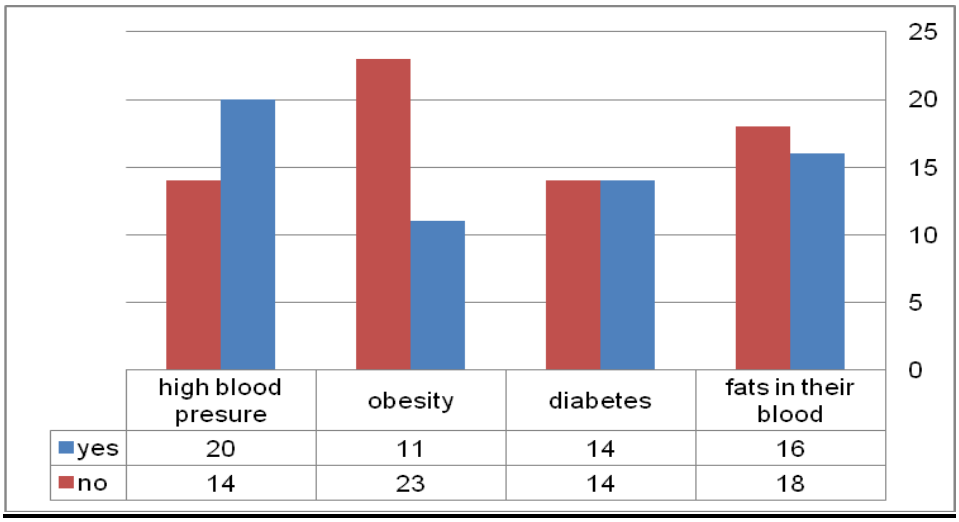
[1] http://columbiaheartvalve.org/sites/default/files/PDF-Kansas-City-Questionaire.pdf
[2] http://cvoutcomes.org/pages/3214

By religion and ethnicity of the sample, 23 (38.3 %) were Sephardic Jews (having oriental / Arab countries or Mediteranean / South Europe origin), 18 (30%) Arabs (Muslim), 6 (10%) Russian Jews, 6 (10%) Ashkenazi Jews, 5 (8.3%) Arabs (Christian) and 2 (3.3%) Circassians (Arabs):



Graph 1. The distribution of the sample according to religion and ethnicity

With regard to *risk factors* 20 (33.3%) patients report that they suffer from high blood pressure, and 14 (23.3%) reported they don't (there is missing data). 11 (18.3%) suffer from obesity, respectively 23 (38.3%) didn't (there is missing data). 14 (23.3%) reported that they have diabetes, and 14 (33.3%) reports that they don't (there is missing data). 16 (26.7%) reported they have fats in their blood, and 18 (30%) report that they didn't have (there is missing data) - see the graph below:



Graph 2. The distribution of the sample according to health risk factors

The main findings of the quantitative research were:

- The *ethnicity* alone is not a determinant explanatory variable related with the social and familial values. Both ethnic groups (Jews and Arabs) can have traditional or modern values, attitudes and behaviors, according to their cultural background. So, Sephardic Jews were most likely to be similar in values and attitudes with Muslim Arabs and Circassians Arabs. Ashkenazi Jews, many of them having East and Central European origins were most likely to be similar in values and attitudes with most of high educated Christian Arabs. Christian Arabs group are high educated and well integrated in society, their level of modernity being similar to the group of Ashkenazi Jews. In conclusion, the religion or ethnicity alone is not a predictive factor for the familial and social behaviors, and health related behaviors, but the cultural background of different ethnic/religious group represent such a predictive factor.
- The *number of hospitalizations* is higher in the case of the previous year of the research (i.e. 2013), which allows the conclusion that the patients are continuously returning to institutionalized medical-care and once a patient suffered a heart failure, there are rare those cases in which he/she does not add further hospitalization experiences to the previous ones.
- *Limitations of patients' quality of life* shows a quite moderate level.
- The *influence of the heart failure on respondents' quality of life dimensions* consisted mostly in life satisfaction issues, while happiness is the least impacted dimension. This occurs, probably, due to the fact that the patients compensate the happiness dimensions with positive emotions and supports coming from

their family members and significant others, while in the case of satisfaction they tend to compare their actual state with their previous, early life's healthier conditions.

- The *limitations due to illness* indicate a higher degree of limitation. Thus if we look at the data, it is obvious that the same pattern occurs for each action, that were the condition of subjects who reported having excessive family support was the worst, in the second place we have subjects who reported not enough family support, and the best condition was attributed to subjects who report on accommodate family support.
- The hypothesis that *there is a linkage between the condition of the ill person and his/her family support* was sustained. Moreover, it seems that not the excessive family support lowers the negative effect of the illness on daily routines, but that of adequate family support. The persons who are 'over-cared' at home by their family members report the worst conditions, which suggest that being excessively supported by the family lowers the ill persons' independence and generates in him/her major frustration, less independency, high level of physical inactivity, and lack in social activities as literature stated. Uchino et al. (1996) in an impressive literature reviews, concluded that an important point of the data generated by the studies is an emphasis on the proper operationalisation of social relationships within a *specific cultural context*. Moreover, the assumption that specific support components may be more effective when they meet the individual needs and *demands of individual situations* were also confirmed.
- For most of the symptoms, the condition of subjects who reported excessive family support was the worst, in the second place we have subjects who report not enough family support, and the best condition was attributed to subjects who report accommodate family support. There it must to be stated that sometimes the excessive support are needed (for the aggravated medical situations), and the quality of life would be worse anyhow, with or without the over-care of the family. But in our sample, these kinds of situations are statistically irrelevant.
- *Hospitalization* is affected by some *variables*, and the main focus was on social familial support, but also in the ethnicity/religion of the subjects. The linear regression in order to find a model that could predict the total days of hospitalization, the results of the analysis indicate that *several health risk factors* are important in leading the patient towards the hospital.
- In terms of *quality of live*, the respondents tend to declare that their illness caused them moderate (37%) or low (35%) limitation; there are less numerous (28%) those persons who declare that their illness caused a high overall limitation in their daily activities.

- Regarding the *knowledge in connection with illness*, it seems that prevention is less well-known than according first aid and handling heart failure. This is a thoughtful conclusion, because having low level of knowledge about how to avoid heart failure – especially when you already suffered such illness – is crucial for survival.
- Moreover, the *relation between ethnicity and religion of the patient and his/her family support* is also important in determining the hospitalization of the patient. As I argued earlier, the religion itself, the same in the case of ethnicity, had little to do with the health-related behaviors. This relation is culturally mediated (Richard & Sloan, 2002).
- The data collected from the main *four ethnic-religious groups of the sample – Ashkenazi Jews, Sephardic Jews, Muslim Arabs and Christian Arabs* (which included samples of *Russian Jews* and *Circassians Arabs*) – underline that a majority of respondents, nearly half of the sample have *large families*, with five and more children, the other half of the respondents have 1-2 or 3-5 children, while small families without children are nearly absent (only 2 out of the 60 respondents are persons without children).
- The *multivariate analysis* revealed that: the *level of family support* were perceived differently by the ethnic/religious groups. The multivariate analysis, counting the relations between family support patterns and others independent and dependent variables included in the quantitative frame sustain the assumptions of the modernization theory, and underline the preservation of traditional family patterns by the strong social and familial relationships in traditional communities in several populations of Israel. *According to these findings, the hierarchy of ethnic-religious groups by social support of families seems to follow a degree of values, attitudes and behaviours from the most secular group (Russian Jews), through Ashkenazi Jews and Christian Arabs (with a lot of similarities in this regard), Sephardic Jews, Muslim Arabs, and Circassians Arabs*.
- The results showed that the main *cultural and social factors* involved in the patterns of the family support are associated with two key variables such as ethnicity and religion (subsequently). But this result must be interpreted in the light of literature findings, who underline the importance of social and cultural context of values, attitudes, behaviours, and less embedded in ethnicity or religion per se (Richard & Sloan, 2002). The interpretations of social family support patterns correlated with self perceived health and social support aimed to search solution for improvements of general wellbeing at familial and community level.

Chapter 7 "*The qualitative analysis of the responses to in-depth interviews*"

The purpose of the *qualitative research* is to collect information about the meaning subjects attribute to the process they go through during this research, beyond the quantitative aspect which mainly examines cognition. Qualitative researchers note that this methodology is inherently multi-method in focus and that it reflects an attempt to use multiple methods or triangulation to secure in-depth understanding of the phenomena where objective reality is difficult to capture (Iluţ, 1997).

The qualitative research used the purposive sample, (8 subjects) implying well known patients from the hospitalized ones, keep in mind that their availability to respond are greater if they are familiarized to the medical personal, being create ties and trust on the interpersonal communication, who are the openness goal of the qualitative investigation.

The *general aim* of this study is to clarify the deteriorating process of heart failure in the studied group. This goal has led us to the questions presented below and which arose out of the study of the literature and discussions that took place during the research process with the subjects in my research sample. They are based on the assumption that their encounter with their new life reality has produced new identity - dependent experiences for them that have either strengthened or released the cognitive and emotional relations they had with the original status (as a healthy person). These research questions have been with me from the very beginning of the research process until the last stage and have directed me as the researcher conducting of the study.

Together with this, they have, on the one hand, become more profound and broader and, on the other, sharper and more focused on additional specific directions.

The analysis of the transcribed answers reveals the fact that the quantitative content analysis alone would have been insufficient, because of the small number of interviews (8 patients). Moreover, the numerical data would have been brought only an apparent precision, insignificant comparing to the richness of the natural language.

In order to get a certain degree of differentiation of the qualitative data, I tried to find subjects representative for *each religious and ethnic group* belonging to the state of Israel (Muslim Arabs, Christian Arabs, Sephardic Jews, and Ashkenazi Jews). The sample of 8 participants of the interview is also equally selected *by gender* (4 male and 4 women, respectively). The age interval was 65-78 years old. Their *marital status* distribution: 3 were widowed or lived alone and 5 participants were married. None of the participants

were diagnosed with cognitive disorders (dementia or Alzheimer). The interviews were taken on January-February 2015.

Respondent's social-demographic characteristics and correspondent social and family support type are summarized in the table below:

Table 1. Social-demographic characteristics of the subjects and the type of family support

	S 1 E.S.	**S 2 G.T.**	**S 3 Z.F**	**S 4 D.M.**	**S 5 A.A.**	**S 6 G.P.**	**S 7 A.S.**	**S 8 M.G.**
Gender	**male**	**male**	**male**	**female**	**female**	**male**	**female**	**female**
Age	**65**	**66**	**78**	**77**	**67**	**65**	**65**	**77**
Marital status	**married**	**divorced**	**married**	**married**	**widow**	**married**	**married**	**widow**
Number of children	**5**	**1**	**4**	**4**	**11**	**6**	**7**	**4**
Religion / Ethnicity	**Muslim Arab**	**Sephard Jew**	**Ashkenad Jew**	**Sephard Jew**	**Christian Arab**	**Christian Arab**	**Muslim Arab**	**Ashkenad Jew**
Other diseases	**High blood pressure Diabetes**	**High blood pressure Diabetes Fats**	**High cholesterol level**	**Diabetes High cholesterol level Obesity**	**Diabetes High cholesterol level Obesity**	**none**	**Diabetes High cholesterol level**	**none**
Number of day / Hospitaliz. / past 3 years	**4 days once**	**65 days 17 times**	**6 days 2 times**	**20 days 5 times**	**33 days 11 times**	**4 days once**	**30 days inpatient 6 days outpatient**	**3 days once**
Type of Social / Family Support	**Moderate**	**Not enough**	**Moderate**	**Excessive**	**Excessive**	**Moderate**	**Not enough**	**Moderate (living in kibbutz)**
The main caregiver	**wife**	**no primary care**	**wife**	**husband**	**daughter**	**wife**	**husband**	**daughter**

The main *outcomes of the qualitative analysis* were:

1. The relation between social and demographical characteristics of the subjects and health status and type of support follows some tendencies: a) the cases in which the social and familial support are not enough the number of hospitalization / days are increased, while in the accommodated ones (moderate support) the number of hospitalization / days are decreased (fewer). In the two cases of excessive family and social support, the number of hospitalization / days is also increased, but these two cases seems to be with multiple other co-morbidities (obesity and diabetes included) – leading to less independency of the patient, worries of the family;

moreover sedentary lifestyle contributes to a negative association between number of hospitalization / days and excessive concern of the family; b) the chronological age of the patients seems to be unrelated with the hospitalization frequency – as the literature shows; c) the situations in which the main caregivers are absent or he is a male (the husband) tend to conduct at an increasing frequency of the hospitalization and, consequently, the number of days spend in the hospital in the past three years increase also. All these results confirm the tendencies obtained by quantitative investigation, in respect with the literature; d) the relation between religion / ethnicity and type of the family support shows that we have two cases of excessive family support in strong traditional-oriented type of families (oriental Jewish, and Arab Christian respectively). Such findings sustain the exchange theory which contends that familial ties are highly valued and translated in caring and helping behaviors towards older parents or relatives; on the other side, the case of a male, divorced, Ashkenazi Jew Subject suggests that the atomization of the family, emerged from a modern lifestyle (shared by a large category of non-traditional families in Israel) – such finding describes the features of modernity postulated by R. Inglehart, i.e. modernity drastically reduces the social and familial contacts, making hard to manage the daily needs as the people become older.

2. The general observation would be that, *from the analysis of the semi-structured interviews*, we can imply that there is *a strong consensus* between responses in the main investigated issues, which derives from the nature of the interviews itself (guided questions). For this situation two factors are responsible, both belonging to the human ontology: i) the generational similarity, the migration or the specific circumstances of the formation of the state of Israel when the subjects have been children or young adults (an important variable is here the great number of brothers and sisters in the original family and in the new one); ii) the direct consequences of the (appeared and installed) disease, which contributed to the reduction of the everyday activities and reconfigured the relations with the family and the friends.

3. Going more deeply in the nuances and details of social semantics, we can notice *differences among the answers, even contrasts*: i) the most relevant differences are those related to gender (household activities vs. work and leisure), indicating again the disadvantaged position of the women, mimicking other results in the gender field study; ii) other differences are related to ethnic and religious groups: Arabs seems to be more attached to their families, enjoy greater support (even excessive in the case of the Arab woman): Jews, especially Ashkenazi men, are more oriented toward an independent life, having less interactions with family and more outside activity, which makes them more susceptible of negative psychological effects once the disease is progressing, confirming the modernization theory.

4. CONCLUSIONS BASED ON THE RESEARCH FINDINGS

The final remarks extracted from the results of both researches, in the light of other studies and theorising literature can be formulated as follows:

In Israel, social support from the families of heart failure patients knows *many levels and aspects*, part of them being multi-faceted in relation with family type, attitudinal patterns in the family, cultural frame, and of course, related with the level of knowledge about the disease.

On the same line of analysis, our three main support patterns of families (involving emotional closeness, frequency of contact, and mostly social support) appear to cover the continuum following the *secularism-traditionalism* degree, as it was shown previously: the hierarchy of *ethnic-religious groups* by social support of families seems to follow a degree of values, attitudes and behaviours from the most secular group (Russian Jews), through the "moderate cluster" of Ashkenazi Jews and Christian Arabs (with a lot of similarities in this regard), to the "traditional cluster" of Sephardic Jews, Muslim Arabs, and Circassians Arabs.

The giving-receiving process gain differences by *gender*. Mainstream literature described women as *kinkeepers* who internalize stronger family obligations, maintain family bonds, offering assistance and caregiving more often (Giarusso et al., 2004; Mancini & Blieszner, 1989; Rossi & Rossi, 1990). My own research confirmed this "traditional" role of the woman as the main social support person to offer and family caregiver.

Regarding the *attitude pattern of intergenerational relations in families* (see the typology of Gillen et al., 2015) it can be detached another degree, such as: i) The *sociable type - obligatory type* was revealed especially in the case of the Russian Jews families; ii) The *tight-knit type – sociable type* is characteristic for the Ashkenazi Jews and Christian Arabs families; iii) The *tight-knit type – obligatory type* in specific for the Sephardic Jews and Muslim (and Circassians) Arabs. In our population samples (both from quantitative and qualitative researches), it cannot be identified the *detached type* (emotionally distant, rare visits, lack in support).

The key variables *ethnicity* and *religion* cover, in fact, the general corpus of *cultural heritage and social factors* involved in the attitude patterns of the family support. It appears from the research that the social and cultural context imprints several sets of values, attitudes and behaviors, and is less embedded in ethnicity or religion as independent variables.

The whole picture of these attitude patterns can be concentrated in a synthetic figure:

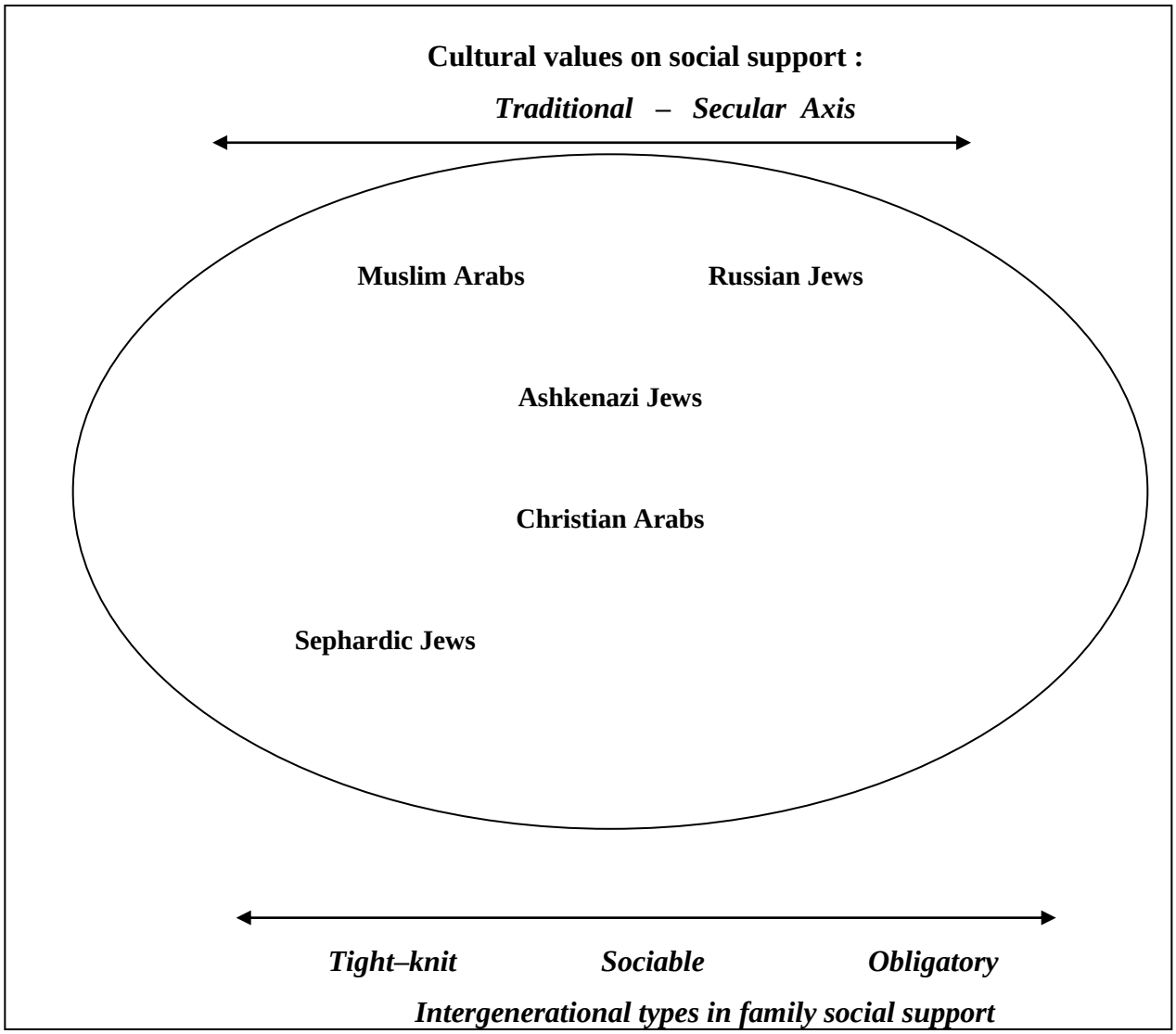


Figure 1. The attitude patterns of social family support by cultural values and intergenerational types of support in the ethnic-religious groups of the research population

The findings underline the certain difficulties elders may confront in their older age, and especially the heart failure patients, in maintaining their lifestyle, preserving their social networks and living an active, participative life within their households and families. The last finding should be viewed as a basis for

encouraging and sustain a sense of wellbeing in later life, through improvements and maintenance of health by medical information and services, by adequate lifestyle and diet, but also through strategies regarding social contacts and informal social capital, both being facets of social support. The main idea detached by my exploratory analysis is that these strategies would be better applied if we follow those value and attitudes which shape the patterns of cultural and social backgrounds of the families and communities.

But familial relations (husband - wife, parent - adult child, and so on) and also social relations often pose the mark of ambivalence. The mixture of ways and generational directions in which the support take place goes beyond the exchange theory (give and take) explanations. This general observation grows in importance as the society values, attitudes and patterns behavior seems to be transformed, puzzling the traditional views and models of action. That mix may offer a much clearer understanding of these facets and avenues of familial and social support, opening fresh perspectives on implications for well-being and for such other outcomes as social support and care giving.

5. PROPOSALS: HEALTH POLICIES AND SOCIAL MEASURES

Proposals in order to reduce the burden of cardiovascular disease

In order to globally alleviate cardiovascular diseases the WHO (*Global action plan for the prevention and control of NCDs 2013-2020*) has introduced several positive scenarios which are claimed to be very cost-effective measures, so that they can be applied in less wealthy contexts as well. These are grouped in macro- and micro-level interventions (*Cardiovascular diseases (CVDs)*, Fact sheet N°317 – PDF Report, Updated January 2015):

i) Macro-level measures target the population and include smoking-reduction policies through taxation, and implementation of better dietary habits and more active lifestyles through specific policies and investments;

ii) On the micro-level we are talking about individuals who are encouraged to better health care in terms of successive, periodic examinations and are supposed to take specific medication in the case of patients with chronic disease, cardiovascular diseases as well.

In Israel, in terms of *health-related information and promotion on health outcomes* in large population, there have been many improvements:

i) National programs for monitoring and collecting data about health and health care and The National Programme for Quality Indicators in Community Healthcare (QICH) was introduced (*OECD Reviews of Health Care Quality: Israel* – Raising Standards, 2014).

ii) Another program targets the monitoring of the hospital care, in order to improve the quality of the treatments offered in hospitals. In spite of these attempts better and stronger measures could be introduced and citizens should become more engaged in order to achieve better results in terms of health promotion and disease alleviation (*Cardiovascular diseases (CVDs)*, Fact sheet N°317 – PDF Report, Updated January 2015).

At social level of intervention, the already existing programmes are concerned with tackling inequalities, supporting families, communities and social networks, involving all citizens in choices about care, and integration and partnership between statutory and voluntary bodies to improve health.

Proposals regarding new ways of social measures on health-related issues

In accordance with the editors of the book titled *Health Behavior and Health Education* (Glanz, Rimer, & Viswanath, 2008), in the domain of health promotion, theories, research and practice need to be interlinked, as much as in the field of health promotion the utility of theory and practice is demonstrated through the well-being of individuals and communities.

From the literature reviewed in the thesis (see Glanz et al., 2008; Forsman et al., 2012; Helliwell & Putnam, 2004; Kawaki et al., 2008; Wenger, 1984;) it can be extracted a series of ideas in the matter of *improvements in health-related measures*:

- There is a need of *more mixed studies* in which statistical data, questionnaires, and in-depth information should be combined, to serve as a foundation for improvements in policy-making in the health domains and gerontology as well. Among them, seems useful to collect informations about: marital status of the older people, distribution of living arrangements among the elders (including new types), the frequencies and quality of contacts and exchanges within family generations, level of social capital and extension of network in family and community.
- A focus on *intervention measures* who should focus on new media communication, i.e., e-learning. In the absence of face-to-face contacts, it can be useful to intensify the information and communication based on e-resources. Anyway, the processes of planning, implementation and evaluation of health could be improved by such interventions, a real need in an informational society.

- An identified domain of future research based on the thesis findings concern *the relation in terms of statistical association between health* and the family arrangements, social support and care to the older people, interpersonal relationships within the family structure. Furthermore, the findings who support the assumption of positive effects of family relations for the various outcomes on health, and for subjective aspects of wellbeing, it is need to analyse the new ways in which this health inputs (as a resource) could be understand better and promoted in a proper manner.
- Moreover, future research strategies should to take into account the various applications of social capital in the intervention area for older people, pledging for its benefits for many social levels (societal, community, individual) and domains of life (work, family, leisure).

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