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Phenomenology of How the Doctor-Patient Relationship Plays a Role in Cardiovascular

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Abstract

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MA, Walden University, 2017

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Dissertation Proposal Submitted in Partial Fulfillment

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Abstract

Cardiovascular disease (CVD) is the leading cause of death in men and women for most racial and ethnic groups in the United States. Physicians are the most frequently sought-after source of support for self-management of chronic diseases of patients. Social support from physicians may help facilitate patient resiliency. This phenomenological study involved using the social support theory as the theoretical lens and health literacy as the conceptual framework to explore how CVD patients perceive experiences with their physicians foster resiliency. Semi-structured interviews were used to collect rich descriptions of CVD patient experiences. Data were analyzed by using Moustakas' modification of the Vaan Kaam method of analysis of phenomenological data. This study provided insight regarding how CVD patients perceive to benefit from support from their physicians as they navigate through the challenges of disease management. Four main themes emerged: informational, emotional, instrumental, and appraisal support. Patients described informational, emotional, instrumental, an appraisal support as facilitating health behaviors such as adhering to treatment and improving health literacy. This research may affect social change through encouragement of physicians to nurture relationships with patients that facilitate resiliency and improved health outcomes.

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Dedication

This dissertation is dedicated to those who we have lost to cardiovascular disease, including Ebrahim Morvari and Paul Becker. This dissertation is also dedicated to those who continue to live with cardiovascular disease and continue to demonstrate their resilience. During the timespan that this study took place, my own family and friends experienced several cardiovascular disease related traumas and losses. It is my sincere hope that research continues in this area to better support patients in the management of and recovery from cardiovascular disease.

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I would like to thank my content expert and second committee member, Dr. Patti Barrows, for having the foresight to advise me to be robust in my preparation for this study. I would like thank my university research reviewer, Dr. Ann Ramosz, for being purposeful and precise in her recommendations. I would like to thank my entire dissertation committee for their genuine support in completing this study and dissertation. Dr. McCann has been an instrumental part of my academic and professional growth. She has been both a PhD advisor and a professional mentor, helping me secure my first professorial position.

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Chapter 1: Introduction to the Study

Introduction

In the United States (US), there is estimated to be a cardiovascular disease related death every 37 seconds (Centers for Disease Control and Prevention [CDC], 2019a). Cardiovascular disease (CVD) is the leading cause of death in men and women of most racial and ethnic groups in the US, many of which perish before reaching 65 years of age (CDC, 2019a). Approximately 647,000 lives are lost due to CVD annually (CDC, 2019a). These statistics will continue to overwhelm the US until CVD risks are reduced.

Factors that have been evaluated for their risk to CVD include age, diabetes, smoking, body mass index (BMI), physical activity, and alcohol consumption (Centers for Disease Control and Prevention [CDC], 2019b; Wallach et al., 2020). Tobacco use is the leading preventable cause of mortality and CVD (Centers for Disease Control [CDC], 2018). Individuals who do not smoke, exercise regularly, and avoid excessive salt and caffeine are less likely to suffer from risks associated with CVD (Candelario et al., 2018). Several studies point out a negative correlational relationship between patient resilience and progression of chronic diseases, such as CVD (Cal et al., 2015; Mun et al., 2019; Nafradi et al., & Schulz, 2018). A lack of resilience is harmful to recovery as it involves acceptance of one's limits and nonadherence to treatment (Nafradi et al., 2018). It was not known how doctor-patient relationships related to resiliency in CVD patients. Primary care physicians play an important role in the diagnosis and treatment of chronic diseases (Cal et al., 2015). Likewise, social support or the lack of social support can play an important role in the disease progression and outcomes in CVD patients (Kaplan et al.,

1994; Uchino, 2004). Social support from physicians may help facilitate patient resiliency through promoting empowerment, health literacy, and providing psychological support (Durif-Bruckert et al., 2014).

This study explored what types of support, from physicians, CVD patients perceive to be beneficial in facilitating resiliency. Gaining insight into how CVD patients perceive to benefit from support from their physicians as they navigate through the challenges of disease management may provide a deeper understanding of how physicians' play a role in the facilitation of resiliency and the health behaviors of CVD patients. Increasing the understanding of the relationship between CVD patients and their physicians may develop opportunities for further research into the doctor-patient relationship and the role it may play in health outcomes. Therefore, this research may affect social change through the encouragement of physicians to nurture relationships with patients that foster resiliency and improved health outcomes.

The remainder of this chapter will provide a brief summary of literature used to develop and justify this study, and stating and justifying the research problem based on evidence and consensus in the field of psychology that the problem is significant. The problem being addressed will then be connected to the research paradigm being used through the explanation of the theoretical framework and the nature of the study. Additionally, definitions and explanations will be provided to assist the reader in understanding terms, assumptions believed to be true and meaningful to the study, and the boundaries of the study, including limitations. Finally, the potential contributions and significance of this study will be presented with a summary serving as a transition to

chapter 2, where the literature used to justify and develop the study will be reviewed in depth.

Background

While some health-related behaviors have been promoted to CVD patients, with an emphasis on nutrition, physical activity, and discouragement from nicotine use, CVD related disability and death continue to obstruct the quality of life of those living in the US (CDC, 2019a; CDC, 2019b; Lisspers et al., 2005; Virani et al., 2020). CVD is widely researched as a significant cause of death and disability in the US, with nearly half of Americans falling into the guidelines of being at risk for CVD (CDC, 2019b). Health behaviors have been identified and when emphasized by physicians, are associated with lower rates of coronary events in coronary artery disease patients (Lisspers et al., 2015). Relationships between physicians and patients, however, are not often conducive to the promotion of necessary health behaviors (Garzon et al., 2018). Physicians are the most frequently sought after source of support in self-management of chronic diseases by patients (Bartlett et al., 2019). Physician behaviors have been associated with patient trust in physicians (Ommen et al., 2011). Resiliency has been associated with health behaviors (Cal et al., 2015). Physicians are often the primary point of contact when managing chronic diseases, and physicians have been suggested to be beneficial in promoting resiliency in chronic pain patients (Nefradi et al., 2018). CVD patients present with a variety of symptoms, and may exclude pain (Balko et al., 2017; Frantz et al., 2020).

This is to say, that while it has been established that health behaviors are critical in managing CVD, and resiliency is often a catalyst to improving health behaviors, little research has been done in the way of improving resiliency in CVD. Because physicians are a primary source of information and treatment for CVD patients, and it has been suggested that physicians have the potential to improve resiliency in chronic pain patients, it is imperative that the CVD patient relationship with physicians in the fostering of resiliency are studied. Researching the perceptions of CVD patients may help deepen the understanding of patient experiences and build upon existing knowledge in the field of psychology.

Problem Statement

Primary care physicians play an important role in the management of chronic diseases, which can involve remarkable levels of psychological burden, indicating the importance of psychosocial support and treatment (Cal et al; 2015; Nikendei et al., 2019). Nearly half of all adult patients, excluding pregnant patients, who are seen by primary care physicians are hypertensive (Stephens et al., 2020). A recent qualitative study explored patient outcomes, coping responses, and day-to-day disease management for patients with chronic pain (Nafradi et al., 2018). Nafradi et al. interpreted themes of doctors providing psychological support, promoting health literacy, and empowering patients to take active roles in their treatment as linked to patient resilience. Nafradi et al. recognized the limited scope of their study to chronic pain patients, and suggest that the doctor-patient interaction could promote resilience in other conditions. Chronic pain is a chronic condition with its own pathology and characteristics (Whitten & Cristobal, 2005),

yet researchers have not explored experiences and perceptions of doctor-patient relationships of chronic disease patients, which may differ from chronic pain patients who may have pain due to injury rather than diseases. Chronic pain is a symptom of a disease or disorder, and on its own may not be fatal, but may lead to excessive stimulation to the brain (Berger and Zelman, 2016). Motivation to seek health care from a physician may differ for patients who are not disabled due to pain as a result of their condition. Of all chronic disease conditions, CVD impacts the greatest number of people in the US (CDC, 2019a). While CVD patient may experience chest pain, symptoms such as heart palpitations, rapid heartbeat, chest tightness, and light headedness are common indicators of CVD (Balko et al., 2017; Frantz et al., 2020).

Unlike previous research, this study focused on patient perceptions of the doctor-patient relationship and perceptions of how the doctor-patient relationship may facilitate resiliency in CVD patients. By exploring experiences of patients living with CVD, which may or may not involve pain, a deeper understanding was gained of patient perceptions regarding perceived support from physicians and perceived benefits of physician support when living with CVD. Patients who do not suffer from severe discomfort may not be similarly motivated to foster self-regulation skills associated with resiliency in order to manage diseases. Self-regulation of lifestyle choices is a preventative measure in reducing risks of worsening conditions (CDC, 2018).

Purpose of the Study

The purpose of this qualitative study was to understand what types of support, from doctors, CVD patients in the US perceive to be beneficial in facilitating resiliency.

To address this gap, the study used the transcendental phenomenological approach in order to understand the essence of participant experiences. Semi-structured interviews were used to obtain experiences, narratives, and stories from CVD patients related to the types of support they receive from physicians that they find to foster resiliency, how that support facilitates resilience, what specific types of support they find to be beneficial, and how that support is perceived to be beneficial.

Research Questions

RQ- Qualitative: What types of support from doctors do patients with cardiovascular disease perceive to be beneficial in facilitating resiliency?

Theoretical Framework

The theoretical framework for this study was based on Wills' (1991) theory of social support. Because this theory addresses ways one experiences being cared for, esteemed, or valued as a part of a social network, Wills' theoretical work has been used extensively in many aspects of health-related research. Social support serves as a protective factor, related to lower levels of psychological and physical symptomology and reduce the impact of negative life experiences on such symptomology. Social support is related to resilience through self-control and behavioral actions such as healthy eating and engaging in exercise, and researching social support may provide additional perspectives of resilience effects (Wills & Bantum, 2012). Concepts explored in the study include what types of support related to the doctor-patient relationship patients find to be beneficial and in what ways such support is beneficial. Wills' theory is useful in exploring social support in health settings (Thoits, 1995). Using social support as a

theoretical lens allows the researcher to better contextualize the role of social support from physicians in the physical health of cardiovascular disease patients.

Conceptual Framework

This qualitative transcendental phenomenological study explored what types of physician support CVD patients find beneficial, and how they find that support to be beneficial through the health literacy conceptual framework. Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand health information and services in order to make appropriate health decisions (Institute of Medicine, 2004). The Institute of Medicine clarifies that health literacy is not limited to the individual's ability to obtain information, but also includes when expectations, preferences, and skills of an individual seeking health information meet the expectations, preferences, and skills of those who provide health information and services. Health literacy may be seen as a means for individuals to exert greater control over their health (Nutbeam, 2008). Efforts to improve health literacy are often focused on developing age and context specific health knowledge and promoting self-efficacy necessary in order to put that knowledge to use.

Using health literacy as a conceptual lens allows the researcher to better contextualize participant responses and perspectives. The Institute of Medicine (2004) makes an example of a two-year-old patient with an ear infection that was prescribed antibiotics as treatment. The mother administered the antibiotic drops directly in the ear canal, as no specific instructions were given to administer the treatment orally. This instance provides an example of how health literacy may impact patient ability to

perform health behaviors, and the role physicians may play in promoting health behaviors. Physicians may play an important role in supporting health literacy in patients (Nefradi et al., 2018). A more thorough explanation of health literacy will be provided in Chapter 2. The health literacy lens provides further context in understanding how CVD patients may vary in the types and amounts of support that is required of their physicians in order to help foster resiliency, and further provides context in understanding how that support may be perceived as being beneficial.

Nature of the Study

The nature of this study was qualitative with a transcendental phenomenological approach. Phenomenological qualitative research is appropriate in interpreting the descriptive investigation of a phenomena in order to understand the essence of the data through the participation of individuals who have directly experienced it (Davidsen, 2013; Miller et al., 2018). Qualitative research is consistent with understanding how patients conceive their relationships with their physicians, which is the focus of this dissertation. Keeping the focus on how patients experience their relationships with their physicians is consistent with Wills' (1991) epistemological expectations (Fiske et al., 2010).

The phenomenon and key concepts being explored in this study include: what types of support, from doctors, patients with CVD perceive to be beneficial in facilitating resiliency. Participants were identified and chosen through purposeful sampling. The criteria for selection will include CVD patients over the age of 18 who live in the US. All potential participants who meet the criteria for inclusion will not be excluded based

upon race, color, religion, sex, national origin, physical disability, or sexual orientation. The sample consisted of seven participants, as data saturation was obtained.

Data was collected through semi-structured interviews conducted over the telephone in order to remove sampling limitations due to geographical location, and pandemic related concerns. Interviews were recorded, with the permission of participants, through the use of a digital voice recorder. Hand-written field notes were taken in order to ensure the accuracy of data. Interviews were transcribed through the use of Trint transcription software and reviewed for accuracy by the researcher. Transcriptions were analyzed through coding, following Saldaña's (2016) guidelines for qualitative data analysis and organized through the use of Microsoft Word documents. Coded data was categorized and interpreted to report a collective theory based on emerging phenomena that is representative of the data collected.

Definitions

Doctor- Patient Relationship: The consensual relationship in which the patient knowingly seeks the physician's assistance and in which the physician knowingly accepts the person as a patient (QT, Inc. V. Jacksonville, No. 05 C 6387 (N.D. Ill. May 15, 2006).

Health Literacy: The degree to which individuals have the capacity to obtain, process, and understand health information and services in order to make appropriate health decisions (Institute of Medicine, 2004).

Health Literacy Practices: The patient-centered practices and protocols and strategies used to minimize the negative consequences of limited or low health literacy (Coleman et al., 2013).

Medical Language (ML): Distinct speech registers used by doctors, nurses use in encounters with one another (Bourhis et al., 1989).

Participant: The research volunteer (Colman, 2009).

Phenomenology: The philosophical method of inquiry that concentrates on detailed descriptions of the conscious experience (Colman, 2009).

Physician: In this study, it is defined as a medical doctor licensed to practice medicine in the US.

Resilience: The perseverance of desirable actions, emotions, and self-esteem in the face of adversity (Nafradi et al., 2018).

Social Support: The perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations (Wills, 1991).

Assumptions

As this study unfolded, assumptions changed to reflect new interpretations (Moustakas, 1994). The perceptions of the participants were used as the primary base of knowledge, and what the participants presume to be true, for the purposes of phenomenological research, are true. This study assumes that humans are motivated to be physically healthy and to avoid premature death or disability in most cases. If people are not motivated to be healthy, then relationships with physicians are based on outside determinants which are not related to the doctor-patient relationship and quality of care. It is assumed that humans are social animals and the presence or the perceived presence of others impacts the thoughts and behaviors of humans. This assumption is necessary in the context of studying social psychology in order to relate feelings and behaviors to experiences with others. This study assumes that the rate at which Americans continue to suffer from or die from cardiovascular related complications will remain high if new or improved interventions are not developed and practiced. As participants were asked to self-identify as cardiovascular patients, it is assumed that the participants are being honest about their health and conditions. It is assumed that participants meet the inclusion and exclusion criteria of this study, as will be noted in recruitment materials. This study assumes that participants have had ample experience with physicians to justify their participation in this study. Lastly, this study assumes that the information provided by participants is accurate.

Scope and Delimitations

This study explored how CVD patients describe their experiences with their physicians, how these experiences facilitate resiliency, and how support from their physicians is perceived to be beneficial in facilitating resiliency. Focusing qualitatively on the lived experiences of CVD patients who are under physician care improves the likelihood that they will have experienced positive or negative interactions related to patient resiliency. Through the telling of their experiences, new insights were realized as to how their experiences with physicians may have fostered or hindered their resiliency.

Adults who identify as CVD patients in the US represent the population of participants in this study, with inclusion criteria requiring a diagnosis of a CVD by a licensed by physician to be self-reported by the participant. The HIPAA Privacy Rule which established conditions under which protected health information may be disclosed or used for research purposes determines that protected entities and information may be disclosed and used for research purposes when a research participant authorizes the use or disclosure of information about him or herself (U.S. Department of Health and Human Services, 2017). Identifying information will remain confidential and be destroyed at the earliest opportunity in order to comply with HIPAA regulations. The rationale for requiring potential participants to self-identify for inclusion in this study relates to the assumption that formally diagnosed patients may result in a greater probability of encountering physicians whose position it is to diagnose and treat patients with CVD. The research could not be reasonably conducted without patient provided self-reports of CVD. No documentation or details regarding health conditions was required or are

necessary. Children under the age of 18 were excluded from this study (Walden University, n.d.). Individuals who are due for surgery or are hospitalized were excluded in order to avoid research during medically stressful periods (George Washington University, 2015).

While the health belief model (Hochmaum, 1958; Rosenstock, 1966) is related to the area of study, this theoretical framework was not investigated because the model states that whether or not a person participates in health behaviors is based on whether they perceive a personal health threat and that participating in a particular health behavior would be effective in reducing said threat (Fiske et al., 2010). As described in chapter 2, research and public health advice has been consistent in identifying health behaviors that can reduce the risk of CVD related complications, therefore, this theory was considered and discarded as social support theory provided an appropriate lens to explore how to more successfully empower CVD patients to improve their health.

Transferability in qualitative research is established by providing evidence that the research findings could be applicable in different contexts, periods, and populations (Ravitch & Carl, 2016). Transferability may be accomplished by providing thick description, or detailed accounts of the data collection experience, providing context and allowing different aspects of the study to be transferred, rather than attempting to be replicated (Ravitch & Carl, 2016).

Limitations

Barriers included difficulty recruiting participants for interviews. Ensuring clear separation of the researcher as a chronic disease patient from the role as a researcher was

also a challenge and mitigating reflexivity in interviewing and interpreting data was essential. Information provided by participants may have been filtered, the researcher's presence may have biased the responses of the participants, and participants may have found some difficulty in articulating their perceptions (Ravitch & Carl, 2012). Participants varied in their comfort in sharing health related information, and this study is limited by the belief that participants will be forthcoming in having a verified CVD condition. This study used a self-report method, therefore statements made by participants must be trusted as accurate despite potential for biases (Adners & Tucker, 2000; Bashirian et al. 2019). Qualitative research cannot be directly applied to other contexts; therefore, transferability should be considered a potential barrier for this study (Ravitch & Carl, 2012). Further, generalizability is neither a goal nor can be used as a measure for validity of this qualitative study.

Significance

This research fills a gap in understanding by focusing specifically on patients living with CVD, support received from their physicians, and how the perceived support relates to their resiliency. This project is unique because existing research does not focus on the doctor-patient relationship and patient resiliency by exploring experiences of patients living with CVD, rather than the unique experience of chronic pain (Náfrádi et al., 2018), and patient perceptions regarding perceived support and benefits of the support of physicians when living with chronic disease. Cardiovascular disease is leading cause of death in the US (CDC, 2019b). This study specifically explored the types of support CVD patients perceive to be beneficial in facilitating resiliency. Social support is a

protective factor that can play a vital role in the development of resilience (Jiang et al., 2019). The results of this study provide much-needed insights into the relationships between individuals who often interact during critical points in treating and managing chronic diseases. The doctor-patient relationship may be a factor in determining the health and well-being of a patient (Kumar et al., 2019). It is necessary to understand how patients who are not motivated by the discomfort of chronic pain to rely on physician assisted relief differ in their perceptions of benefits from fostering doctor-patient relationships. Insights from this study help deepen the understanding of doctor-patient relationships and supporting patient resiliency. Efforts to engage this population in promoting resilience and self-care behaviors need improvement (Bartlett et al., 2019). A deeper understanding of the experiences and perceptions of this population may help inform training curricula and the practices of physicians, so that healthcare professionals can be better equipped to promote disease management behaviors in chronic disease populations.

Summary

Chapter 1 provides an introduction and overview to the problem of CVD in the US research methods that was used to study CVD patients, and an overview of social support theory as the theoretical foundation of this study. This chapter illuminates the role physicians can play in the health of patients beyond the scope of diagnosis and treatment plans. Studied through this research are the perspectives of CVD patients, through in depth exploration of their perceptions of their relationships with their physicians, how those relationships foster resiliency, and how that resiliency manifests in their lives. It was the intent of the researcher to illuminate how the doctor-patient relationship may play a critical role in empowering patients to improve their health. This study may provide insight to health care providers in better initiating and cultivating beneficial relationships with CVD patients. Chapter 2 provides an in-depth examination of the current research available related to the topic.

Chapter 2: Literature Review

Introduction

This literature review includes pertinent information related to the lack of information as it relates to the types of support, from doctors, patients with CVD perceive to be beneficial in fostering resiliency, and how the support is perceived to be beneficial. The role of social support is frequently documented in literature as it relates to the fostering of resiliency, but the role of physicians in the fostering of resiliency is infrequently documented in existing literature (Nafradi et al., 2018). The purpose of this transcendental phenomenological study is to address this gap in the literature by exploring the lived experiences of CVD patients in the US and their perceptions of how their physicians help foster resiliency through social support.

There are numerous studies on CVD, but these studies are concerned with the efficacy of treatments and disease management related to patient behaviors, rather than how patients perceive physicians to play a role in fostering resiliency or empowerment and education of patients to manage and choose the best possible treatment plans for their medical conditions (Lisspers et al., 2005). Significant interest exists in understanding which health behaviors contribute to improved outcomes for CVD patients, and there is an emergent body of research on the importance of treating and managing CVD (Candelario et al., 2018). It is clear that individuals can change their behavior in order to improve their physical health.

Additional research is needed in order to understand how to support CVD patients in their efforts to improve their health and mitigate problems associated with their

diagnoses. There are several potential reasons for the lack of research on the fostering of resiliency through the relationship between physicians and their patients. Relationships between doctors and patients are often strained by a mutual lack of trust (Garzon et al., 2018; Ommen et al., 2011). When resiliency is studied in its relation to social support, community and familial support systems are often prioritized and associated with playing a role in resiliency (Amini et al., 2015). When the relationship between physicians and their chronic disease patients have been studied, only the perceptions of chronic pain patients have been explored (Nafradi et al., 2018). Chronic disease patients who do not have the burden of an encumbering chronic pain reminder to manage their health behaviors may not share the same motivation to avoid or stop pain as chronic disease patients (Navratilova & Porreca, 2016). For this study, CVD patients were studied, as their ailment is the leading cause of death in the US (Center for Disease Control, 2019a). The majority of doctor appointments serve the purpose of managing chronic diseases, and physicians are often the primary source of information and support for chronic disease patients in respect to the management of disease and disease progression (Cal et al., 2015; Nafradi et al., 2018). In this literature review, I will present an overview of CVD and themes that relate to the management of CVD through behavior control and fostering of resiliency to promote behavioral control. A discussion of the theoretical framework for the study will also be presented.

Search Strategy

The following research databases were used in order to search for the studies used in the literature review: PsycINFO, SAGE Journals, as well as in a Thoreau

multidatabase search, Google scholar search, and Google. The key terms used to search for the relevant literature on the research phenomenon, the theoretical framework, and the conceptual framework in these databases were the following: patient resiliency, doctor-patient relationships, chronic illness resiliency, chronic diseases, chronic disease resiliency, chronic pain, pathology, symptoms, motivation, social support, health support, chronic disease patients, chronic illness patients, cardiovascular disease, heart disease, stroke, stroke patient, heart disease patient, cardiovascular disease patients, coronary artery disease, risk, immune function, immunocompetence, health literacy, and health.

These search terms represented, on their own and in conjunction with other terms, the main components of the theoretical framework, research problem, and the research phenomenon for the study. The use of these search terms gave access to relevant literature related to each component for the review. Some texts were not able to be accessed in full online and purchased in order to be thoroughly reviewed. All relevant literature was included in the review in order to ensure the inclusion of the most appropriate information.

Theoretical Foundation

Social Support Theory and its Assumptions

Wills' (1991) theory of social support was implemented in this study. Wills posited that experiences of being cared for, esteemed, or valued as a part of a social network serves as a protective factor, and defined social support as the perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations. Social support promotes psychological adjustment to chronically stressful conditions such as acute or chronic illness (Fiske et al., 2010). The perseverance of desirable actions, emotions, and self-esteem in the face of adversity is the hallmark of resiliency (Nafradi et al., 2018). Social support may serve as a protective factor and reduce the effects of negative life experiences by serving as a stress-buffer and increasing self-esteem and feelings of control, which are important coping resources for individuals who must make adjustments to life stressors (Uchino, 2004). As social support serves to empower individuals, personal behavior plays an important role in mitigating life stressors and making choices that do not cause further damage to individuals (Higgins, 2014; Náfrádi et al., 2018). This ability to make positive changes when faced with stressors is the demonstration of resiliency (Cal et al., 2015). Social support theory operates under the assumption that social support serves as a protective factor by being related to lower levels of psychological and physical symptomology and reducing the impact of negative life experiences on such symptomology through self-control and behavioral actions

(Wills & Bantum, 2012). Social support is a predictor of and associated with resiliency (Stewart & Yuen, 2011).

Social support can be categorized into emotional support, instrumental support, informational support, and appraisal support (Bashirian et al., 2019). Emotional support involves empathy, trust, care, and love; instrumental support involves tangible assistance; informational support involves the advice, information, facts, knowledge, and comments that assist in mitigating problems. Appraisal support involves providing information that one can internally consider in order to mitigate problems. Social support can further be categorized into formal and informal support. Formal support includes spiritual and material support through organizations through policy or laws, and informal support includes support from family, friends, and community members (Lu et al., 2020). Social support from physicians may include emotional support, informational support, and appraisal support through motivating, empowering, and respecting patients, as well as promoting health literacy (Nafardi et al., 2018). The benefits of this relationship may help patients demonstrate resiliency through adaptive coping responses and disease management.

Previous Applications of Social Support Theory to Health

Psychology has been applied to health-related research based on the biopsychosocial model, which describes health and diseases through the interplay of biological, psychological, and social processes (Taylor, 2007). Social support theory has served as a framework for such research in a qualitative study that had the objective of understanding the medication experience of patients with fibromyalgia, a chronic pain

condition, and their relationships with their physicians in deriving treatment negations (Durif-Bruckert et al., 2014). The researchers reported that patients may be in search of validation and recognition from their physicians, and dismissal from providers may lead to unsuccessful pursuits for effective treatments. Patients who experienced social support through the form of developing partnerships with their physicians reported feeling empowered to shape their own illnesses through medication treatment plans, adjusting and negotiating medication choices and changes, demonstrating resiliency through positive changes in the face of stress. Physicians report that developing a good partnership involves patients accepting the expertise of their doctors, while patients report that a good partnership involves doctors sharing their expertise with the patients. Further, the collaboration between patients and doctors on medication, through doctors imparting knowledge on patients, and patients having the ability to negotiate their medication, are hallmarks of developing a partnership between doctors and patients.

Social support may perform an essential role in the dissemination of health information for particular populations, such as those who experience cultural barriers (Kim et al., 2015). A qualitative study explored perceptions of the role of social networks in social support for Korean Americans who were seeking health-related information. When no language barriers were present, participants perceived increased understanding of different health care systems and enhanced feelings of physical and mental health compared to when there were language barriers. Patients who perceived the presence of social support reported feeling a sense of belonging, increased

understanding of health care systems, and enhanced feelings of physical and mental health.

Both formal and informal forms of social support have been hypothesized to improve the health-related quality of life in elderly populations (Lu et al., 2020). A correlational study examined the association of formal and informal social support with health-related quality of life (HRQOL) among the elderly living in rural China. The sample of Chinese rural elders over 60 years old was acquired from the 2015 China Health and Retirement Longitudinal Study (CHARLS). The HRQOL was evaluated by EQ-5D-3L questionnaire. The social support assessment was based on the social support rating scale (SSRS), and a regression analysis was used to examine the relationship between social support and HRQOL. This study found that social support is significantly positively associated with HRQOL in this population. Formal social support such as medical insurance, pension, and social activities were significantly positively associated with HRQL. Simply having more children was negatively associated with HRQOL, but more contact with children and financial support from family were both significantly positively associated with HRQOL. This study does not specify if those who have higher levels of social support were also more adaptive, or resilient, when faced with challenges related to their illnesses.

Baron et al. (1990) investigated if social support was related to immune function in the spouses of cancer patients. The proliferation response of patients to two plant lectin mitogens, phytohemagglutinin (PHA) and concanavalin A (Con-A), which stimulate T-lymphocyte proliferation (the body's response to fight infection) were used to

measure immunocompetence. Social support was measured through the means of a self-report assessment, the Social Provisions Scale. The study found that immunocompetence was more robust in participants that reported higher levels of social support. Further, negative life effects were measured through the use of the Geriatric Social Readjustment Rating Scale and depressive symptoms were measured using the Beck Depression Inventory (BDI) in order to determine if they were mediating variables. No evidence was found to indicate that depression or negative life events mediated the relationship between social support and immunocompetence. This population likely experience stress beyond normal levels due to their spouses' illness, making the data not generalizable, but compelling nonetheless.

Relevance of Social Support Theory to the Current Study

Angerer et al. (2000) sought to determine the impact of social support, anger expression, and cynical hostility on the progression of coronary atherosclerosis. Disease progression was established by conducting baseline and follow-up angiograms after two years. Three self-report questionnaires were used, the State-Trait-Anger-Expression Inventory (STAXI), the Cook-Medly cynical hostility scale, and a questionnaire concerning emotional social support (Angerer et a., 2000). A bivariate analysis of the psychological variables showed a higher risk of disease progression for patients who scored high on the STAXI or low on social support. A causal relationship cannot be drawn from the interaction between these variables.

Lack of social support can be associated with health-related fatalities in individuals with ailments including coronary artery disease, a CVD (Kaplan et al., 1994;

Uchino, 2004). Social support from physicians has been suggested in facilitating patient empowerment, promoting health literacy, and providing psychological support in chronic pain patients (Durif-Bruckert et al., 2014). Furthermore, these social support outcomes (empowerment and health literacy) are related to resiliency outcomes such as remaining employed and maintaining personally and socially meaningful lives in those same patients (Durif-Bruckert et al., 2014; Nafradi et al., 2018).

In health crisis situations, close relationships may not always serve as the most beneficial forms of social support. Bolger et al. (1996) evaluated breast cancer patients and their significant others (romantic partners or relatives) in order to determine how close relationships function during a life crisis. Physical impairment was assessed using a ten-item measure of functional health called the Framingham Disability Study, and enacted support from a significant other was measured using House's four social support functions instrument (House et al., 1988), and distress was measured through the use of Hopkins Symptom Checklist (Degrotis et al., 1974) (Bolger et al., 1996). Control measures included breast cancer stage, distinguished by lymph nodes affected, extent of surgery, and whether the patient was undergoing adjuvant therapy such as chemotherapy or radiation (Bolger et al. 1996). Bolger et al. (1996) found a positive correlation between physical impairment and social support from significant others, but negative correlations between patient distress and social support from significant others. Inferences about causation cannot be made based on these findings.

Social support is amongst factors related to adhering to potentially lifesaving treatments. Catz et al. (2000) examined the role of psychological factors predictive of

successful or unsuccessful treatment adherence for HIV patients. Catz et al. (2000) developed an adherence self-promotion scale in order to identify barriers to adherence, such as large medication containers, and strategies used to overcome such barriers, such as organizing medications and establishing daily routines. Social support was measured through the use of the four-item Social attachment subscale of the Social Provisions Scale (SPS), and depression was measured through the use of the Center for Epidemiological Studies Depression Scale (CES-D). Treatment adherence self-efficiency was measured using an eight-item scale. This study identified that knowledge of medication regimen was a predictor of adherence, and participants who perceived less emotional support and those who were less confident in their ability to adhere were more likely to report inconsistent use of their medications.

The current study aims to better understand how to foster resiliency in CVD patients. The studies included in this literature review support the exploration of fostering resiliency by demonstrating the benefits of making positive adjustments when faced with adversity related to one's health. As the physician's office is often the primary source of information and treatment for chronic disease patients, understanding how to foster resiliency through that point of contact makes sense (Nafradi et al., 2017). Social support through the doctor-patient relationship has been suggested to be an important factor in patients adhering to medical treatments (Catz et al., 2000). Resiliency is an important factor in enhancing patients' ability to act positively when faced with adversity, as they may when dealing with disease (Cal et al., 2015). This is to say, it is important to understand how social support from this primary source of disease

management contact plays a role in fostering resiliency in this population, thus helping enhance disease management.

Conceptual Framework

Health Literacy

The Institute of Medicine (IOM) (2004) defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services necessary to make appropriate decisions concerning health. Further, health literacy involves the expectations, preferences, and skills of the individual seeking health information and services meeting the expectations, preferences, and skills of the individual providing the health services and information. Health literacy skills and capacities are a function of education, culture, and language. The link between education and health outcomes have been established by prior research. The conceptual framework of health literacy offers a pathway to further explore the relationship between health outcomes and education. Health literacy serves as a means to enable patients to navigate and use health services and information (Laing et al., 2020). Health literacy, as a multi-dimensional concept, involves cognitive, social, communication, and technology use skills used to navigate, access, understand, retrieve, and make use of health information (Laing et al., 2020). Health literacy has been associated with an increase in health behaviors such engaging in preventative services and screenings and avoiding risk factors (Koh et al., 2013).

Previous Applications of Health Literacy and Application to the Current Study

Bourhis et al. (1989) broached the topic of health literacy by surveying physicians, student nurses, and patients regarding their usage of medical and everyday language in their interactions. Physicians reported using everyday language when speaking with patients, however, student nurses and patients reported that physicians did not converge to everyday language when addressing patients. Physicians, student nurses, and patients all agreed that everyday language was more appropriate to use when addressing patients than medical language. Despite this early recognition that the skills and preferences of individuals seeking health information do not always match the skills and preferences of individuals providing health services and information, a formal framework for health literacy was not defined until the Institute of Health (2004) released a call to action to explore and improve health literacy. Many individuals have difficulty understanding complex texts, yet an abundance of health-related information and advertising include complex texts. Even those who are able to understand complex texts within their fields of specialization may experience difficulty understanding complex texts related to health. A farmer who understands the use instructions of fertilizer, for example, may not understand the safety precautions related to the use of said fertilizer.

Health literacy practices, or protocols used to minimize the negative consequences of low health literacy, have been applied in order to approve health-related outcomes for patients (Coleman et al., 2013). Coleman et al. (2013) conducted a consensus study to identify a set of health literacy educational competencies and target behaviors or practices aimed at training health professionals. This study represents the

first known attempt to develop a consensus on an agreed-upon list of health literacy practices into a set of measurable educational competencies for medical professionals. This study used the method of group consensus among a professionally diverse group with expertise in both health professions education and health literacy because most health literacy recommendations found in literature are based on expert opinion rather than empirical data. Despite efforts to conduct an unbiased study, potential for both sourcing and source bias exist in the accumulation of the expert panel and the contributions of the expert panel.

Recently, a pilot study was conducted related to fostering health literacy in a remote primary health care setting (Liang et al., 2020). Primary health care settings provide a barrier to accessing and using health care information, playing an important role in promoting health literacy. Lifestyle related non-communicable disease (NCD) deaths have increased globally since 1990. Lifestyle related NCDs include CVD, type 2 diabetes, and stroke. Survey data and semi-structured interviews were used to explore the experiences of medical staff within a primary medical care facility in Australia to determine a baseline of confidence in core health literacy concepts and competencies, and to explore competency and effectiveness of the Organizational Health Literacy Responsiveness (Org-HLR) tool, used by organizations to assess their health literacy responsiveness (Laing, 2020). Research participants aimed to improve organizational health literacy responsiveness in order to address health literacy as a barrier to accessing healthcare and facilitating the self-management of health with the goal of reducing the burden of disease attributable to NCDs such as CVD (Liang et al., 2020). Participating in

the Org-HLR process improved participants' ability to be responsive to health literacy and their confidence in their organization's ability to be responsive to health literacy.

The health literacy framework benefits the current study by providing a conceptual lens though which the research questions, data collection, and data analysis may be developed and interpreted. The health literacy lens serves as a point of reference in contextualizing the experiences of CVD patients and their interactions with their physicians. Using the health literacy lens serves as a reminder to separate from pre-existing biases based on my own experiences and knowledge base. Individuals may differ in their needs and expectations of health-related information and services.

Cardiovascular Disease

Cardiovascular Disease and Risks

Cardiovascular disease (CVD) is defined as any disease of the circulatory system including heart disease and stroke (Virani et al., 2020). The Centers for Disease Control and Prevention (2019a) reported CVD as the leading cause of death for both men and women of most racial and ethnic groups in the Unites States, leading to one death every 37 seconds. Additionally, a quarter of the annual deaths in the US are a result of CVD, resulting in about 647,000 human losses (Centers for Disease Control and Prevention [CDC], 2019a). Finally, of those with CVD deaths, two in ten are adults who have not yet reached 65 years old (CDC, 2019a).

Cardiovascular Disease with the Absence of Pain

CVD may present with or without pain. Conditions such as postural orthostatic tachycardia syndrome (POTS) are characterized by symptoms including increased heart

rate, sustained tachycardia, absence of orthostatic hypotension, and frequency for over six-month period (Dipaola et al., 2020). Transient or permanent dysfunction of the cardiac conductive system can lead to decreased heart rate as a result of diminished cardiac output (Abrich et al., 2020). A delay or block can occur at any level of the cardiac conductive system, and include symptoms such as fatigue, lightheadedness, reduced functional capacity, and syncope. These examples of CVD with the absence of pain serve as reminders that pain is not a necessary symptom to potentially fatal conditions. Pain is an unpleasant experience that may serve in motivating individuals to avoid the pain or seek rewards by relieving pain (Navratilova & Porreca, 2016). This information validates the distinction between CVD from chronic pain, justifying the need to research resiliency in CVD patients, modeled from chronic pain patient research.

Health Behaviors and Reducing Risks

High blood pressure, high cholesterol, and smoking are key risk factors in developing heart disease. Nearly half (47%) of all Americans fall within the guidelines of being at risk due to one of these factors for heart disease (Center for Disease Control [CDC], 2019b). Age, diabetes, smoking, body mass index (BMI), physical activity, and alcohol consumption are among the factors that are largely evaluated for their risk to CVD (CDC, 2019b; Wallach et al., 2020).

Ozkan et al. (2018) found negative correlations between healthy lifestyle behaviors (determined by the Health-promoting Lifestyle Profile Scale and reported as one measure) and cardiovascular risk factors (reported as separate measures including mean arterial blood pressure (systolic (SBP) and diastolic (DBP)), fasting blood level

triglycerides (TG), total cholesterol (TC), hematocrit (HTC), and hemoglobin (HGB)), and between physical fitness (absent of measures for other health behaviors) and cardiovascular risk factors, for both male and female college students. Health behaviors considered in this study were self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management.

According to the Center for Disease Control (2018), tobacco use is the leading preventable cause of morbidity and mortality in the US; and mortality rates for people who smoke in the US is about three times higher than for individuals who have never smoked. In addition to being a contributing factor to vascular disease, smoking may cause cancer and respiratory disease. Smokeless tobacco may increase risk for sudden death by ventricular arrhythmia, causing improper beating of the heart. Along with obesity, lipids, and psychosocial factors, smoking accounts for 90% of attributable risks for CVD in Alaska Native people (Prochaska et al., 2018). Retrospective analytical observations by Candelario et al. (2018) compared how strongly health behaviors were associated with complications of high blood pressure between high blood pressure and control groups. Adverse health behaviors included ingesting high levels of salt, practicing little or no exercise, excessively consuming coffee, or smoking (Candelario et al., 2018). These adverse behaviors were more strongly associated with risk of suffering from complications such as cardio-cerebrovascular and renal issues in high blood pressure patients than control groups (Candelario et al., 2018). Dean (2009) notes that lifestyle changes reduce risk by lowering C-reactive protein levels, which are markers for inflammation.

Dean (2009) notes that not smoking and engaging in physical activity are the top two behaviors that offer the greatest protective factors. While genetic factors may play a role in increased risk of CVD, eating well, exercising, and not smoking can play important roles in lowering inflammation, preventing artery obstructions, and managing blood pressure levels. In a randomized experiment, Lisspers et al. (2005) evaluated patients who had recently been treated for percutaneous coronary intervention (PCI) with aggressive lifestyle interventions including standards for smoking, exercise, diet, and stress. The control group received standard care, which involved only one outpatient visit at the clinic following PCI, and thereafter referred to a family physician for secondary prevention efforts. The group which received aggressive focus on lifestyle changes experienced significantly lower rates of all coronary events and cardiovascular mortality, emphasizing the critical role of physician directed behavioral interventions for coronary artery disease patients.

Resiliency

Cal et al. (2015) define resiliency as the human capacity to respond positively when faced with adverse situation or stressors that may pose a risk to one's health or development. Resiliency would be demonstrated by individuals showing better than expected results, positive adaptation despite experiencing stress, and recovering well from trauma. Ultimately, learning or experiencing growth and development as a consequence of experiencing adversity may signify resilience.

Resiliency and Cardiovascular Disease Patients

Conceicao et al. (2016) conducted a study to investigate the frequency of resilience in Brazilian ischemic heart disease patients. A cross-sectional study was conducted through the use of interviews and the Wagnild & Young resilience scale and sociodemographic questionnaire, whereas participants were assessed as being resilient or not resilient (Conceicao et al., 2016). A high proportion of ischemic heart disease patients, 74.2% of those studied, were considered to be resilient. This study did not demonstrate or consider how resiliency is promoted amongst this population, nor does it address resiliency frequency amongst the general Brazilian population, and thus it offered little context as to the promotion of resiliency for CVD patients in general. No causal conclusions may be drawn from this study.

Toukhsati et al. (2017) conducted an Australian cross-sectional study, examining the relationship between psychological resilience and symptoms of depression in non-acute outpatient populations. Adult cardiovascular outpatients completed Sense of Coherence (SOC13) scale to measure psychological resilience, and the Cardiac Depression Scale (CDS26) to measure symptoms of depression (Toukhsati et al., 2017). Psychological resilience negatively correlated with depression (Toukhsati et al., 2017). The rates of depression among participants, greater than 40%, was high, and supports the needs for improved psychosocial management of CVD patients (Toukhsati et al., 2017). The data does not indicate if health issues are causal of the depressive issues, but does indicate a strong association between low resilience and probable depression (Toukhsati et al., 2017).

Resiliency and Health Behaviors

Cal et al. (2015) conducted a systematic review of literature related to chronic disease and resiliency, and found twelve articles that met the criteria. Depressive symptoms were positively and significantly associated with negative and ruminative thinking, low self-esteem, stressful life events, low social support, depression stigma, and indication of chronic diseases. A significant positive correlation was found between health promoting behaviors and resilience. Health promoting behaviors include proper nutrition, stress reduction, self-realization, and exercise. In patients with metastatic cancer, resiliency levels were significantly negatively associated with emotional distress. In patients with diabetes, a significant negative correlation was found between resilience and glycemic control. Resilience scales capable of evaluating internal resources that facilitate the ability to negotiate, manage and adapt to significant stressors or trauma have been used to measure resiliency (Cal et al., 2015; Windle et al., 2011). In some cases, resilience can be a determinant of self-care behaviors (Cal et al., 2015).

The Role of Social Support in Resiliency

Amini et al. (2016) suggest that social support acts as a shield for individuals who experience difficult situations. In order to better understand the relationship between social support and resiliency Amini et al. studied environmental guards in Iran. Data was collected through self-reported questionnaires, finding a significant positive relationship between social support and resiliency through composite measures of variables. Amini et al do not provide a translation of the questionnaire, but do provide that frequency of meeting criteria for social support and resiliency are measured. Resiliency factors

include personal characteristics such as flexibility, internal locus of control, humor, optimism, valuing flexibility, education, spontaneity, autonomy, individual merit, and ability to love (Amini et al., 2016). Social support is described as receiving emotional support or assistance and understanding the adequacy of the support and feeling positively about the perceived support received (Amini et al., 2016). Amini et al. concluded that promoting education, self-efficacy, and self-esteem in individuals may enhance resiliency. The survey results found a positive relationship between enhancing the social support of environmental guards by the relevant institutions, specifically through increased communication and increased support from friends, and resiliency (Amini et al., 2016). This study is limited by not providing references for the scales that were used to measure frequencies reported, and causation cannot be determined through the causal relationships the researchers suggested.

Even in cases where individuals experience difficulties due to victimization, social support may serve as a protective factor. Fagan et al. (2013) analyzed the moderating effect of collective efficacy on the relationship between exposure to violence and drug use. Drug use was measured through the use of a survey based on a seven-point frequency scale, violence was measured based on frequency of committing seven violent acts over the span of the past year, and collective efficacy was measured through the use of a five-item Liker scale (Fagan et al., 2013). This study concluded that individuals who are exposed to violence are less likely to be drug users if they are a part of socially supportive communities, but causation could not be established based solely on the relationship of the variables.

Taylor et al. (2014) note that internalizing stress can have negative consequences and, in a longitudinal study of college students, found that internalizing symptoms of anxiety and depression were negatively correlated to social support. Internalizing symptoms was measured through the use of the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) and the Anxiety subscale was from the Depression Anxiety Stress scales (DAAS; Lovibond & Lovibond, 1995), and perceived social support was measured through the 20-item Perceived Social Support from Friends (PSS-Fr) and the 20-item Perceived Social Support from Family (PSS-Fa) scales (Procidano & Heller, 1983) (Taylor et al., 2014).

Social support that exists outside of one's own family may play an important role in promoting resiliency. Kennedy (2005) conducted a qualitative study, exploring the experiences of urban adolescent mothers with multiple forms of violence, and the relationships between violence and school, and their resilience. Individuals who find their families to be sources of conflict through violence, abuse, and pain, may make positive connections with people outside of their family for sources of social support (Kennedy, 2005).

The Role of Doctors in Social Support

Nafradi et al. (2018) researched chronic pain (rheumatoid arthritis, fibromyalgia, and other rheumatology) patients through the use of semi-structured interviews that explored their perceptions of how doctors facilitated patient resiliency. Key elements of the doctor-patient relationship that demonstrate support include physicians' patient-centered communication and autonomy support. Nafradi summarizes a systemic review

of literature, noting that when physicians support patients through positive interpersonal relationships and provide informative and instrumental and affective behaviors, patients are more likely to remember, understand and adhere to treatment-related information. This study explored what the factors are that are perceived to promote or hinder resilience in people who live with chronic pain. The patients reported that they perceived their doctors as having the ability to provide psychological support, promote health literacy related to chronic pain and treatment, and empower them to make the necessary adjustments to find the right treatment. The social tie of the doctor-patient relationship may serve as a positive social interaction that patients attributed to the positive affect of coping responses, which in turn they reported as affecting their functional capacity. The patients attributed validation, health literacy, and feelings of empowerment from the social support provided by health care providers. A study of this kind had not been conducted with CVD patients, who may or may not experience pain symptomology.

Ommen et al. (2011) emphasize the importance of psychosocial skills in physicians through their study analyzing the relationship between physician social support and improved health outcomes. Patients in Germany completed the Cologne Patient Questionnaire, a questionnaire developed to measure involvement of patients in care, and through regression analysis, researchers were able to conclude that social support and shared decision-making physician behaviors were significantly related to inpatient trust in doctors. Further, the results of this regression analysis found that socio-economic status, age, and gender of the patient were related to the trust of a patient. This

study was not designed to assess causal relationships between the variables, as it was not experimental in nature.

Physicians can play an important role in providing support for patients, but unfavorable interactions may increase patient distress (Garzon et al., 2018). Garzon et al. conducted a study to examine how doctor-patient interactions impact the relationship between doctors and patients. Garzon et al. provided data through a randomized control trial examining patients' perceived relationships with their healthcare providers and demoralization in patients with advanced cancer in Germany. To assess demoralization, the German version of the Demoralization Scale (DS) was used and self-reported by patients. Depressive symptoms were measured with the German version of the Beck Depression Inventory II (BDI-II). A modified German version of the MSAS was used to assess symptom burden, assessing the presence of physiological symptoms. The German End of Life-Cancer-Psychological Questionnaire (QUAL-EC-P) contains a section related to relationship with health care provider, and this section of the questionnaire was used to measure the relationship with the physician. This study is limited in noting that patient-oriented communication is preferable, as unfavorable conversation styles which are not centered on patient needs are detrimental to the psychological wellness of the patient, but do not note how this variable was the manipulated in this trial. This study found the relationship to the health care provider to be an independent predictor of demoralization. Garzon et al. note that the doctor-patient relationship is important in the context of coping with existential challenges. Only an associative relationship can be

drawn between the variables of demoralization and quality of life due to the cross-sectional nature of the study.

Understanding the role physicians play in helping chronic disease patients manage their diseases may help inform physicians of the effect their support may have on patients. Bartlett et al. (2019) conducted a cross-sectional study on chronic disease patients in Canada to better understand which patients were more in need of support in self-management. Additionally, this study provided information about where chronic disease patients most often received support in self-management. Self-management involves behaviors that protect and promote health and manage physical, social, and emotional effects of chronic disease, helping patients gain confidence in managing their health and dealing with healthcare professionals. Self-management tasks may be disease specific, but often involve physical tasks such as eating, dressing, bathing, toileting, and household chores, or coping tasks such as managing pain, limiting activities, managing fatigue, and coping with emotions and problems. A cross-sectional study was conducted using questions inspired by the Dutch Patient Assessment of Self-Management Tasks (PAST), and a list of twelve sources of self-management support were provided for participants to choose from. The twelve sources of support participants had to choose from included support groups, health professionals, family members or friends, complementary or alternative health option. The most frequent source of self-management support for participants were from health professionals, emphasizing the prominent role of medical professionals in providing support to chronic disease patients. This study, however, does not provide any context as to why medical professionals tend

to be the most prevalent in providing such support or if patients perceive the amount of support they are receiving to be adequate in helping them cope with and manage their diseases.

Summary and Conclusions

In summary, Chapter 2 described social support and the potential consequences of lack of social support on physical health. It is understood that social support may help empower patients to take more active roles in their health, but the correlational research does not provide causational conclusions (Kim et al., 2015; Taylor, 2007). Likewise, qualitative data does not provide causational conclusions, as relationships reported by participants may not reflect actual causes. Furthermore, the qualitative studies provided are not based in the US, where cultural differences may impact the data (Kim et al., 2015; Taylor, 2007). Furthermore, Chapter 2 described CVD and its risk factors, and reviewed the current, yet limited literature on CVD resiliency studies. Studies suggests that health behaviors, such as managing one's diet and exercise, may greatly reduce risks involved with CVD (Lisspers et al., 2005). Experimental research in this area provides strong evidence that can be generalized to related patient populations. Research related to resiliency in this population, however, is limited, and while it is known that CVD patients often do demonstrate resiliency in some countries, it is not known how that resiliency is fostered so that resiliency can be promoted in greater parts of the population in the US, where the leading cause of death is CVD (Conceicao et al., 2016). The studies addressing the role of resiliency in adapting to health conditions are largely correlational, thus causational conclusions cannot be made (Cal et al., 2015; Conceicao et al., 2016).

Doctor-patient interactions have been identified as an important point of contact in promoting health behaviors, but this relationship and the role it plays in promoting resiliency in CVD patients had not been addressed (Nafradi et a., 2018). The existing literature only addresses chronic pain patients, who have different symptomology and risks than CVD patients, thus motivation to seek and practice treatment protocols may differ. Existing research related to resiliency fostered by the doctor-patient relationship does not address populations in the US, therefore do not account for cultural differences that may exist between Swiss Italians and Americans (Nafradi et al., 2018). Research of the potential for the doctor-patient relationship in promoting resiliency in CVD patients may extend knowledge in the discipline and address the gap in the literature by exploring the lived experiences of CVD patients in the US and their perceptions of how their physicians help foster resiliency through social support. In Chapter 3, I provide information about the methodology for this research study.

Chapter 3: Methodology

Introduction

The purpose of this qualitative study was to understand how CVD patients in the US perceive the doctor-patient relationship with respect to support from their physicians as it relates to perceived benefits and facilitating resiliency. To address this gap, the study used a qualitative approach. Semi-structured interviews were used to obtain experiences, narratives, and stories from CVD patients related to the types of support they receive from physicians that they find to facilitate resiliency, how that support fosters resilience, what specific types of support they find to be beneficial, and how that support is perceived to be beneficial.

Chapter 3 provides the research questions and qualitative method that were used to understand how CVD patients in the US perceive the doctor-patient relationship with respect to support from their physicians as it relates to perceived benefits and facilitating resiliency, and the rationale for using this method. This chapter will provide the role of the researcher, and how the researcher relates to potential participants, and how ethical issues were mitigated regarding these relationships. The research methodology will be described in depth and issues of trustworthiness, including measures taken to ensure credibility, transferability, and participant protection will be provided. Methodology will be summarized and reiterated before transitioning to Chapter 4, where the data will be presented.

Research Design and Rationale

The research question explored in this study is:

RQ- Qualitative: For patients with cardiovascular disease, what types of support from doctors do patients find beneficial in facilitating resiliency?

Defining Phenomena of the Study

An exhaustive review of existing literature established social support, health literacy, and resiliency as the central concepts and phenomena of the study. Social support is defined as perception or experience that one is loved and cared for by others, esteemed and valued, and part of a social network of mutual assistance and obligations (Wills, 1991). Health literacy is defined as the degree to which individuals have the capacity to obtain, process, and understand health information and services in order to make appropriate health decisions (Institute of Medicine, 2004). Resiliency is defined as the perseverance of desirable actions, emotions, and self-esteem in the face of adversity (Nafradi et al., 2018).

Qualitative Research Design and Rationale

A transcendental phenomenological research methodology was used in order to better understand what types of doctor support CVD patients in the US perceive to be beneficial in facilitating resiliency. A phenomenological methodology allowed me to explore rich descriptions and meanings of the lived experiences of CVD patients in the U.S. with the benefit of context (Moustakas, 1994). Quantitative methods were not appropriate for this study as a number would not be able to adequately symbolize the

context of the phenomena. While I intended to explore a shared pattern within the US, ethnography was not an appropriate research design for my study because it focuses on cultural description through participation and observation, and this was not the focus of my research. A case study, or multiple case studies were considered, but did not meet the requirement of exploring lived experience. Husserl's (1970) transcendental phenomenology seeks to understand the essence of consciousness. Transcendental phenomenology distills participant experiences into categories which can be taken together in order to describe the phenomena (Miller et al., 2018). Further, in considering health literacy as a lens through which to explore the perceptions of CVD patients, natural attitudes are set aside, and underlying dynamics and structures that account for lived experiences are considered without prejudices and predispositions.

Nafradi et al. (2018) used a qualitative research method in a similar study, aimed at exploring chronic pain patients' adaptation to their condition considering their relationships with their doctors as significant sources of support. Using transcendental qualitative methodology, researchers asked participants to describe how they manage their conditions on a daily basis, how they perceive the doctor-patient relationship and communication, and their perceptions of and experiences with medical treatments. This type of data gathering allowed for the researchers to express the essence of the phenomenon by analyzing the described lived experiences of participants, focusing on categorizing experiences that were highlighted by the patients as prominent topics (Miller et al., 2018). Nafradi et al. note that future studies are necessary to explore how the doctor-patient relationship can promote resiliency in other conditions. Nafradi et al.'s

study was the first known of its kind to explore how the doctor-patient relationship and resiliency are related to coping responses, providing in-depth descriptions of experiences that culminated the essence of the experiences of several participants, or phenomena, which can be further studied with other patient populations. The subject of doctor support in facilitating resiliency in CVD patients, who experience different symptomology from chronic pain patients, had not been addressed, and therefore the phenomenon was appropriately explored through the use of this qualitative research method (Moustakas, 1994). As phenomenological research focuses on mental experiences rather than physical experiences (Colman, 2009), it is an appropriate method to explore the perceptions of CVD patients.

Role of the Researcher

In order to derive scientific evidence in this transcendental phenomenological study, my role as the researcher is to discover a topic or questions that bears social meaning or significance, conduct a comprehensive review of existing literature, develop a set of questions to guide the interview process, conduct and record person-to-person interviews with follow-ups as needed, and organize and analyze the data (Moustakas, 1994). My intention for this study was to explore the experiences and perceptions of CVD patients. My role in this study was to conduct participant interviews and provide rich and thorough descriptions of participant experiences and perceptions. I used broad and open-ended questions in order to facilitate the obtaining of rich and substantive descriptions of experiences from participants (Moustakas, 1994). Descriptions of topics explored by Nafaradi et al. (2018) were used to develop questions for this study.

Power Differentials

The interviews occurred with relative strangers; therefore, no personal or professional relationships existed between the research participants and myself. Likewise, educational and supervisory relationships did not exist, therefore, there were no obvious power differentials. Power imbalances inherently exist between researchers and research participants (Rubin & Rubin, 2012). In order to manage potential power imbalances, interviews were conducted under the premise that a power imbalance exists in order to remain considerate of concerns participants may have regarding their participation.

Mitigating Researcher Bias

Biases inherently exist and consciousness cannot be erased, therefore, the Epoche calls for existing biases to be set aside to view the data through purified consciousness (Moustakas, 1994). Reflexivity was used throughout the study in order to mitigate bias. I understand that my own experiences as a chronic disease patient, as well as a relative and friend to physicians may contribute to inevitable biases. I recognize that these biases exist through my own positive and negative experiences, and I exercised reflexivity in order to mitigate these existing biases. In turn, my prejudgments were corrected, and led to new prejudgments, which were continually corrected and formed. A descriptive protocol of journaling was used to make personal biases explicit (Moustakas, 1994). This study seeks to explore the lived experiences and perceptions of CVD patients, whom are the experts of their own experiences (Ravitch & Carl, 2016). My role was to gather and analyze participant data, and not my own experiences and perceptions.

Incentives

For the purposes of this study, a $25 Visa gift card was offered as a token of appreciation, but not as a benefit for participation in the study. This amount is based on preset amounts available for digital gift cards through Vanilla Visa Gift Card and Walden University IRB recommendations for ethical participant recruitment (Walden IRB, 2020). Participation was voluntary and offered on the sole basis of contributing to the advancement of scientific knowledge (American Psychological Association [APA], 2017; U.S. Department of Health and Human Services [HHS],1979). Participants who shared their experiences and perceptions helped broaden and deepen the field of psychology's understanding of CVD patient perceptions of what types of doctor support patients find to be beneficial in facilitating resiliency.

Methodology

Participants

The population for this study consisted of seven adult CVD patients who live in the US and speak English (Merriam & Tisdell, 2016). Participants were adults, at least 18 years of age and were not currently hospitalized (Walden University, n.d.)

Sampling

Purposeful sampling was used in order to provide context-rich and detailed accounts from the specific population being addressed in this study (Ravitch & Carl, 2016). Purposeful sampling allows for the selection of participants that can answer the study's research questions, as they will have specific experience and knowledge of the

phenomenon being studied. Further, this manner of sampling allows for selection of participants based on meeting criteria of inclusion or exclusion.

Sample Size

While a single case may offer substantive or important data, Morse (1994) suggests that at least six participants be used in studies that are attempting to understand the essence of experience (Dezin & Lincoln, 2000). The sample consisted of seven research participants, when data saturation is obtained. Morse (1995) defines saturation as new data fitting into categories that have already been established. The number of participants was tentatively eight to ten, and changed once the research process began at the point of data redundancy, as I was unable to predict when saturation would occur (Merriam & Tisdell, 2016).

Criteria

Participants were recruited through the distribution of a digital flyer on social media (Appendix A). The flyer was forwarded to social media accounts aimed at supporting CVD patients through providing forums, information, or research. These accounts were identified through the use of the key words and hashtags: cardiovascular disease, CVD, heart health, and cardio health, heart health management, heart disease, and heart healthy. Participants were invited to contact me through email, where they were screened for adherence to (Appendix B) inclusion and exclusion criteria. All potential participants who met the criteria for inclusion were not excluded based upon race, color, religion, sex, national origin, physical disability, or sexual orientation. In order to abide by the HIPAA Privacy Rule, research participants self-disclosed their

status as a CVD patient (U.S Department of Health and Human Services, 2017). Medical records were not verified or viewed for the purposes of this study. Children under the age of 18 were excluded from this study (Walden University, n.d.). Individuals who were due for surgery or are hospitalized were excluded in order to avoid research during medically stressful periods (George Washington University, 2015). Participants used the English language. Participants self-reported adherence to criteria inclusion and exclusion. Self-disclosure was a limitation to this study, as no medical information was verified by the researcher.

Recruitment

Once approval was gained from Walden University's Institutional Review Board (IRB), participants were recruited through a digital invitation (see Appendix A), which was distributed through social media (Instagram, Facebook, Twitter, Reddit, Pinterest, Craigslist, LinkedIn) accounts aimed at supporting CVD patients through providing forums, information, or research. These accounts were identified through the use of the key words and hashtags: cardiovascular disease, CVD, heart health, and cardio health, heart health management, heart disease, research, and heart healthy. Participants were invited to contact me through email, where they were screened for adherence (Appendix B) inclusion and exclusion criteria. Snowball sampling was used by providing existing participants with copies of the digital flyer to share with potential participants.

Potential participants responded to the flyer by email. Once appropriate participants were identified, I provided a more detailed explanation of the research purpose and goal, as well as explained the data gathering process and procedures by

email response. At this time, I offered to answer any questions through email, as well as offered to answer any questions that may arise at the time of the interview. A copy of the consent to participate document was sent at this time for review. Once informed consent had occurred, audio interviews through telephone, through zoom, or skype, based on participant preference, were scheduled.

Informed Consent

Participants contacted me through the e-mail address provided on the digital flyer (Appendix A). I provided a more detailed explanation of the research purpose and goal, as well as explained the data gathering process and procedures through e-mail (APA, 2017). At this time, I offered to answer any questions though email, as well as offered to answer any questions that may arise at the time of the interview. A copy of the consent to participate document was sent at this time for review. Participants were asked to respond with "I consent" once they reviewed the consent to participate document.

Interview Procedures

Participants were informed that audio interviews would be conducted by telephone, through zoom, or skype, based on their preference, in order to make participation more convenient and to protect both the participant and myself from any potential exposure to the ongoing COVID-19 pandemic (Centers for Disease Control and Prevention [CDC], 2020). The use of these means of communication also removed any geography related limitations. Participants were informed that interviews would take approximately an hour to complete. A time was scheduled by email for the interview,

and I was contacted by the participant at the time of the interview via the preferred communication method.

Instrumentation

Instrumentation for this transcendental phenomenological study included a combination of interviews, follow-up interviews, journaling, audio recordings, and field notes. A dynamic research approach to data collection helped ensure collection of rich and complex data (Ravitch & Carl, 2016). A semi-structured interview guide can be found in Appendix C.

Interviews

Responsive interviewing was used in order to accept and adjust to personalities of both conversational partners (Rubin & Rubin, 2012). Responsive interviewing involved using main questions probes, and follow-up questions. I collected the data using the semi-structured interview guide that can be found in Appendix C. The interviews were focused on exploring what types of support, from doctors, CVD patients find beneficial in facilitating resiliency and lasted between 30 and 90 minutes. Interviews were sufficient in answering the research question, as they provided deep, rich, and contextual data (Ravitch & Carl, 2016). Questions were contextualized, leading to individualized and complex structures of participant experiences rather than broad or dichotomous responses. The semi-structured interview guide and interview questions (Appendix C) were developed through a comprehensive review of existing literature and based on existing interview questions used in a qualitative research study which explored a similar phenomenon in a different population (Náfradi et al., 2018). Náfradi et al. is translated

from Italian, therefore the interview questions for this study were reviewed based on recommendations of experts in qualitative research (Ravitch & Carl, 2016; Rubin & Rubin, 2012; Merriam & Tisdell; 2016; Moustakas, 1994; Vagle, 2018). Validity has been established by deriving questions from those successfully used by previous research (Nafradi et al., 2018; Shenton, 2004).

Audio Recordings

Participants were informed that interviews would be recorded, through the use of a digital recorder, in order to ensure accuracy in transcription and representation of participant accounts (Ravitch & Carl, 2016). Participants had the option to refuse audio recordings, in which case, field notes would have been used to record data. All interviews occurred through telephone, and, upon participant permission, were audio recorded through the use of two different audio recording devices in order to ensure accuracy. The audio recorders to be used were a Lyker HD voice recorder (model: VM31) and a Dictopro digital voice recorder (model X200). The audio recorders did not function on the first interview, but a backup method was used. Fortunately, the voice memo application on my Mac computer functioned as a recorder and was used, along with the voice memo application on my iPhone in order to record the remaining interviews. Audio recordings enable the researcher to keep accurate records of what is said in order to be analyzed at a later time (Rubin & Rubin, 2012). The storage of data for later review offers the opportunity for further scrutiny of the interview in order to formulate follow-up questions if necessary. Additionally, some participants may appreciate the presence of a recording to ensure accuracy of their statements. In some

cases, the recording of an interview may be a hindrance, as participants may feel hesitant to share or may grandstand for the recorder. Nonetheless, in order to ensure ethical research practices, participants were reminded that the interview was being recorded when appropriate.

Follow-up Interviews

It was expected that follow-up interviews could be necessary in order to gather the necessary data related to the phenomenon (Rubin & Rubin, 2012; Vagle, 2018). Follow-up interviews were considered if the opportunity to gain more in-depth details and clarifications was needed (Rubin & Rubin, 2012). Participants were contacted through their preferred means (phone or e-mail) to schedule follow-up interviews if necessary. Participants were informed that follow-up interviews should take no longer than 30 minutes, and may be much shorter, depending on the follow-up information needed. Only one follow-up interview was requested, and the participant did not respond to the request for a follow-up interview. The follow-up interview was requested to expand on data that was gathered during the initial interview.

Journaling

A hand-written journal served as an instrument to practice reflexivity. Description and reflection were integral components of making biases explicit (Moustakas, 1994). Journaling is an adequate instrument to keep track of biases as they are revised through the study of the phenomenon. Journaling took place after each interview has concluded.

Field Notes

In cases when participants preferred not to be recorded, thorough field notes were written (Ravitch & Carl, 2016). Detailed notes on specific phrases, descriptions, and observations were written when appropriate to describe experiences of the phenomenon to be analyzed (Moustakas, 1994). Verbatim transcripts of relevant statements were included in the field notes to be included in individual textural descriptions. The hand-written journal being used for this study also house field notes.

Debriefing

At the conclusion of each interview, I thanked participants for their contributions to the study and provided them with the opportunity to ask any questions they may have had (APA, 2017; HHS, 1979). I reviewed the purpose of the study and offered to send a summary of the research findings to them by mail or email once the study has been completed.

Data Analysis Plan

The single research question guiding this study focuses on what types of support, from doctors, CVD patients in the US find to be beneficial in facilitating resiliency. All data analysis processes refer back to the exploration of this phenomenon when evaluating and interpreting the transcripts, codes, and themes of the data.

The seven steps of Moustakas' (1994) modification of van Kaam's (1959, 1966) method of analysis of phenomenological data was used. Interviews were transcribed through the use of Trint transcription software and reviewed for accuracy by the researcher. The coding and analyzing of data was done by hand. Each of the seven steps

were used for each participant. Step one, listing and preliminary grouping, involves the process of horizonalization by assigning equal value to all data (Moustakas, 1994). Step two, reduction and elimination, is accomplished by determining if the data contains a moment of the experience that is sufficient and necessary for understanding it, and if it is possible to abstract and label it. If not, the data can be eliminated. Step three, clustering and thematizing the invariant constituents, involves clustering the unique qualities of an experience into themes. Step four, final identification of the invariant constituents and themes by application: validation, involves checking the invariant constituents and their accompanying themes against the complete record of the participant for explicitness, compatibility, and relevance. Step five, individual textural descriptions, is the inclusion of verbatim examples from the transcripts that are relevant and validate invariant constituents and themes. Step six, individual structural description, is the construction of the experience based on the vivid accounts of underlying dynamics of the experience. The seventh step is a textural-structural description of the meanings and essences of each participant experience, incorporating invariant constituents and themes that were previously constructed.

A group composite was constructed from the textural-structural descriptions of each participant in order to develop a composite description of the essence of the experience being studied (Moustakas, 1994). The composite structural description describes how the participants experience what they experience. The composite-structural and the composite textural descriptions require synthesis as the final step in providing the meanings and essences of the experience being studied.

Discrepant Cases

Moustakas' (1994) method of data analysis calls for data that is neither a necessary or sufficient constituent for understanding the experience being studied to be eliminated. Any data that is not possible to abstract or label, is repetitive, or vague was be eliminated. Everything else that remained (the horizons) was treated with equal weight.

Issues of Trustworthiness

The criterion for validity of phenomenological research is not reduced to whether another researcher would produce the exact same words or descriptions of data, but that the same meanings and similar essential meanings should be derived by that data as explained by the original researcher (Kruger, 1981). Guba (1981) proposed that four criteria should be considered by qualitative researchers in the pursuit of trustworthy research: credibility, transferability, dependability, and confirmability (Shenton, 2004). Strategies to meet each of the four criteria are provided in this section.

Credibility

Credibility established trustworthiness through establishing that the phenomenon under scrutiny has been accurately recorded by the researcher (Shenton, 2004). This can be done by adopting a method that has been well established in qualitative research and information science. The line of questioning being used to gather data should be derived from those that have been successfully used in previous studies. The questions used for this study are derived from those provided by Nafradi et al. (2018) in a similar study.

There is only one question that needed to be altered, changing the condition from chronic pain to CVD.

Triangulation involves using different methods in order to collect data (Shenton, 2004). The use of a wide range of participants may serve as a means of data triangulation, verifying individual viewpoints and experiences against each other (Ravitch & Carl, 2016; Shenton, 2004). While interviewing participants, tactics to ensure honesty may be used. Building rapport with research participants may help participants feel relaxed and unthreatened (Kruger, 1981). Being accommodating to participants allows them to feel comfortable and have the time to provide their full attention to the research. Further, not collecting personal data may afford participants greater ease at honestly expressing their feelings. Participants were not required to provide identifying information and were afforded the opportunity to choose the time, date, and means of communication. Participants were given opportunities to refuse participation and were encouraged to be frank at the onset of each session (Shenton, 2004).

Iterative questioning and using probes can be used to elicit data and to uncover contradictions in data (Shenton, 2004). Likewise, member check provided immediate and ongoing assurance of accuracy of data. These helped ensure that the participants words align with their intended messages. This sort of responsive questioning and communication with participants led to thick descriptions of the phenomenon under scrutiny. Frequent debriefings took place between my dissertation chair and me in order to benefit from the vast experience and expertise of my committee chair. This allowed for alternative approaches to be discussed and flaws in my methodology to be corrected.

Finally, I was able to assess the degree to which my results are congruent with a Nafradi et al. (2018), a similar study with different populations.

Transferability

Qualitative research must be understood through context, and transferability of such research is the way in which the research is transferable to broader contexts will remaining context-specific (Ravitch & Carl, 2016; Shenton, 2004). A method for achieving such transferability includes including thick description, data that is rich with detailed descriptions as well as context, allowing readers and subsequent researchers to transfer aspects of the study to different contexts in order to replicate the study (Ravitch & Carl, 2016). Information is also to be provided regarding the boundaries of the study such as inclusion criteria, sample size, data collection methods, number and length of data collection sessions, and the time period of which data will be collected (Shenton, 2004).

Dependability

Qualitative research that is consistent and stable over time is considered dependable (Ravitch & Carl, 2016). In order to address research dependability, the process of research is reported in detail, enabling future researchers to repeat the work, thus creating a prototype model from which the reader may assess the extent to which proper research methodology was used (Shenton, 2004). The details include the research design and its implementation, operational detail of data gathering, and reflective appraisal of the project. An audit trail was created, detailing researcher predispositions,

making decisions and methods explicit, as well as explaining weaknesses in the techniques employed.

Confirmability

Qualitative researchers do not seek to be objective, but rather to have confirmable data (Ravitch & Carl, 2016). Confirmability in qualitative research involves taking steps to ensure that the study findings are a reflection of the experiences and ideas of the participants, rather than the researcher's biases (Shenton, 2004). The Epoche was used to mitigate researcher biases and making biases explicit through instrumentation of a journal helped ensure confirmability (Moustakas, 1994). The use of journaling will provide the reflective processes.

Ethical Treatment of Human Participants

Institutional Review Board approval (Appendix D) was gained before the commencement of research. The Institutional Review Board Approval number is 08-24-21-0175198. The basic ethical principles, as summarized by the Belmont Report and the Ethical Principles of Psychologists and Code of Conduct, were used as guidelines for the design and practice of conducting this study and are documented through the IRB application (Appendix E) (APA, 2017; HHS, 1979). The obligation of respect for persons demands that participants are treated as autonomous agents. Vulnerable populations were not excluded from participation as a form of protection in order to avoid stigmatization. The obligation of beneficence demands that harm is avoided whenever possible, and that possible benefits be maximized. If it was determined that participation in this study could lead to undo harm for a participant, their participation would have

ceased and actions would have been taken to provide resources to minimize the harm. The obligation of justice calls for scrutinizing the participant sample in order to ensure that particular populations were not being systemically selected.

Ethical Recruitment

A digital flyer (Appendix A) was used to recruit adult CVD patients in the US through social media profiles targeting CVD patient support. The flyer invited participants to contact the researcher by email. I emailed a screening form (Appendix B) and a consent to participate document and asked them to respond to the consent document with "I consent" if they wished to participate. At this time, I offered to answer any questions.

The screening form included criteria for qualifying for participation. These qualifications excluded minors and individuals being hospitalized for an upcoming surgery.

The consent to participate document used language that is easy to understand and appropriately addressed the participants' rights and the limitations of confidentiality (APA, 2017; HHS, 1979). The document includes the purpose of the study, expected duration, and procedures; the participants right to decline or withdraw at any time; the foreseeable consequences of withdrawal; reasonable factors that may influence participation; benefits of participation; limits of confidentiality; incentives for participation; and whom to contact with questions regarding participant rights. The consent to participate document also addresses consent to create audio recordings of the interviews. Confidentiality was prioritized by eliminating identifying information from

the data and deleting storing identifying information such as consent to participate documents and contact information in a password protected digital file. The email address being used to communicate with participants was securely accessed through password protected devices. Despite all best efforts, breaches are possible, and in the case of breached security, participants would be informed. Further, participants were informed that confidentiality would be broken in the case of potential harm to oneself or the harm to others. Both the consent to participate document and the recruitment flyers noted a $25 Visa gift card incentive as a thank you for participation. The amount was not likely to be considered coercive or an inducement for participation, and was offered as a thank you to all participants, regardless of withdrawal. No participant withdrawals occurred. Snowball sampling was used by providing existing participants with copies of the digital flyer to share with potential participants.

Ethical Data Collection

Once participants submitted the consent to participate response through email, the first interview was scheduled. The scheduling took place through email and participants were asked for some times and dates that work best for them. The interviews lasted about an hour long. Follow-up interviews lasted about a half hour long, if necessary. Participants decided if they would like to speak through telephone or use a communication platform such as Zoom or Skype. Participants were reminded that audio recordings of the interviews would be made, and if participants declined the use of audio recordings, field notes were taken. Identifying information was removed as early as possible and does not appear in any data analysis (APA, 2017; HHS, 1979). Participant

demographic detail was not collected, but when demographic information was revealed as a part of the interview and was important to the context of the data, according to the participant, then it was included in the study, but was not published in a way that would render the participant identifiable.

Identifiable information was only necessary on consent to participate documents and by providing necessary contact information for conducting interviews. This identifiable information was only seen by the researcher and was secured through password protection on the email account, cloud storage, laptop, and smart phone. Each participant was assigned a number for the purposes of the study (i.e. P1, P2, P3, etc.). Interviews were transcribed by Trint software, an artificial intelligence program that was not accessed by anyone other than the researcher. Further, identifiable information was edited out before the audio was submitted to the transcription by the researcher.

Treatment of Data

Participants were offered the opportunity to opt into receiving a copy of the study once it was complete. Those who would opt-in would provide an email address they would like the report sent to. The laptop computer used for this study is password protected. The cloud data storage being used (Dropbox) is password protected, able to disable permanent deletions, has monitoring of account access and activities, and configurations for sharing permissions. Identifiable information was not stored on the cloud data storage. The mobile phone being used for the study was separate from my personal phone and was password protected (APA, 2017; HHS, 1979).

Upon completion of the study, all data will continue to be stored securely for five years. Journals and field notes will be stored in a locked safe for five years. Information from the email account was deleted from the email account, but will be saved to a password protected cloud storage account for five years. Consent to participate documents and a copy of the voice interviews will be stored in the same cloud storage account. All remaining digital data was deleted from devices that were used for the study. After the five years of storage, all remaining data and information will be destroyed. Paper will be shredded and digital information will be deleted.

Summary

Chapter 3 provided a detailed overview of the qualitative research design and the rationale for using a transcendental phenomenological approach. The purpose of the study and the research question were reiterated. The phenomenon was defined and the role of the researcher was identified, addressing power differentials and the mitigation of researcher biases. The inclusion of incentives was disclosed and justified as appropriate.

Research methodology was discussed in depth, identifying participants, sampling styles, the sample size and justification. Inclusion and exclusion criteria were made explicit and explained. Recruitment methods were reviewed and procedures to provide informed consent and conduct interviews were detailed. Instrumentation including interviews, audio recordings, follow-up interviews, journaling, and field notes were detailed. Debriefing procedures were provided. A data analysis plan was detailed and organized in phases, along with an explanation of how discrepant cases were treated.

Issues of trustworthiness in the research process were provided, including information on how credibility, transferability, and dependability were established in this qualitative study. Ethical treatment of research participants is discussed at length, and provides information on how participants were respected and protected. Details of ethical data collection are provided and include information on confidentiality. Finally, the treatment of data discusses how data will be stored, kept secure, and disposed of after five years' time.

Chapter 4 will review this study's purpose and research question and identify the setting and its potential influence on this study. The data collection and data analysis

processes will be detailed, along with the evidence of trustworthiness in this study through descriptions of implementations of strategies stated in Chapter 3. Chapter 4 will conclude by revealing the results of the research and answers to the research question.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore what types of support, from doctors, CVD patients in the US perceive to be beneficial in facilitating resiliency. To address this gap, I used a qualitative approach. Semi-structured interviews were used to obtain experiences, narratives, and stories from seven CVD patients related to the types of support they receive from physicians that they find to facilitate resiliency. I interviewed seven participants who met the inclusion criteria for this study, using the procedure protocols outlined in Chapter 3 and the semi-structured interview guide (Appendix C). Each audio recording was transcribed using Trint transcription software. I reviewed and made corrections to each transcription. I used Moustaka's (1994) modification of the Van Kaam method of analysis to analyze the transcriptions of each participant's interview. Three themes emerged, and were supported by subthemes which define the types of support from doctors that the participants described as beneficial in facilitating resiliency.

RQ- Qualitative: What types of support from doctors do patients with cardiovascular disease perceive to be beneficial in facilitating resiliency?

In Chapter 4, I will provide information on the setting in which the study took place and the relevant demographics of study participants. Data collection procedures will be specified. I will describe the process by which the data was analyzed, including a description of a discrepant case. Evidence of trustworthiness will be addressed through a description of strategies that were used to confirm credibility, transferability,

dependability, and confirmability of this study. Finally, I will provide the research findings and summarize how these findings answer the research question, before transitioning to chapter 5.

Setting

I conducted interviews from the privacy of my home office by telephone. I was alone in my home at the time of the interviews in order to protect participant confidentiality. All seven participants chose to be interviewed by phone. Skype audio and Zoom audio were provided as options through email when scheduling appointments. There were no participants that requested either of those options. Informed consent was provided by email to each participant once they requested to take part in the study. Each participant responded to the email with "I consent" in order to consent to participate. I provided each participant with a phone number to a mobile phone that was dedicated to the study, which they called at their scheduled interview times. Prior to the initiation of recording, each participant was offered the opportunity to ask any questions they may have had and reminded that they could stop the interview at any time without any consequences. Participants were reminded that they did not have to share any medical information that they did not wish to share. I asked each participant for permission to begin recording before each interview. Each participant consented and each concluded their interviews without any concerns expressed regarding the line of questioning.

Due to the ongoing COVID-19 pandemic, and the nature of the interviews being conducted by phone, it is uncertain whether participants were alone at the time of their interviews. All interviews were conducted without interruption; however, a tornado siren

was heard in the background during one interview, and a television was heard in the background of another.

Demographics

The participant population for this study was targeted at adult CVD patients who live in the US. Participant inclusion focused on age of 18 years or older, living in the US, speaking English, and formal diagnosis of CVD by a physician, which was self-reported by participants in order to abide by the HIPAA Privacy Rule which established conditions under which protected health information may be disclosed or used for research purposes (U.S. Department of Health and Human Services, 2017). Vulnerable populations were not excluded from this study, as required by IRB, in order to avoid stigmatization.

To safeguard the privacy of participants, they were each assigned a participant number. In order to protect identity, they were referred to in gender neutral pronouns (they and them), unless gender was noted as an important factor related to care by the participant. Identifying information was removed from interview transcripts in order to protect participants. The participant population included four females and three males. One male identified as black. Three participants shared that their ages were 59, 66, and 72 years old. Three participants did not share their age, but noted that they were young, and confirmed that they were over 18 years of age before participation.

Table 1

Participant Demographics

Participant	Sex	Age	Race
P1	Female	Young	Unknown
P2	Male	66	Unknown
P3	Female	Unknown	Unknown
P4	Male	59	Black
P5	Female	Young	Unknown
P6	Female	72	Unknown
P7	Male	Unknown	Unknown

Data Collection

Data was collected from seven participants. Data was collected through semi-structured interviews which consisted of the same interview questions (Appendix C), and were modified by follow-up questions as appropriated based on participant answers. Some of the questions on the interview guide were answered by participants without prompting, and were therefore skipped.

Each participant was interviewed one time, with interviews times ranging between approximately a half hour to an hour and a half, based on the amount of information each participant was willing to share and the amount of time each participant had available. I interviewed participants from my home office using an iPhone that was activated for the purposes of this study and used exclusively for participant interviews.

Participant interviews were scheduled by email, and participants called the research phone at the time of their scheduled interviews. Interviews were conducted from my home office. There was no other person in my residence at the time of interviews.

The first interview was recorded using three recording devices, two of which were planned to be used as presented in chapter 3 (Lyker HD voice recorder (model: VM31) and a Dictopro digital voice recorder (model X200). The third device was the voice memo app on the MacBook I used for this study. I was unable to transfer the audio recordings from the Lyker HD voice record and the Dictopro digital voice recorder to my computer and instead used the voice memo app on both the MacBook computer and my personal iPhone to record the remaining 6 interviews. The recordings were immediately uploaded to the Dropbox folder designated for this study and deleted from the iPhone. One recording is partially obstructed from what sounded to be a tornado siren, but was able to be transcribed in full. Another recording was partially obstructed by the sound of a television in the background, but was able to be transcribed in full. Data collection occurred during the COVID-19 pandemic, so participants may not have been home alone when interviewed, but did confirm that the phone call was occurring at a good time when they had privacy (CDC,2020).

Data Analysis

Moustakas' (1994) modification of the Van Kaam method of analysis of phenomenological data was used to analyze the data that was collected. Once data was collected and recorded, I listened to each recording prior to submitting it to Trint for transcription. Once recordings were transcribed, I listened to the recordings several times

while making corrections to the transcriptions. The transcription software widely lacked accuracy, leading to most of the transcriptions needing to nearly fully revised. Thus, I heard each recording at a minimum of four times to assure accuracy of transcriptions.

As called for by the Epoche, existing biases were set aside to view the data through purified consciousness (Moustakas, 1994). These biases were made explicit through journaling throughout the process of listening to and transcribing the interviews. Further, data collection reflections, researcher experiences, and general impressions were journaled (Ravitch & Carl, 2016). This researcher-generated data was used throughout the data collection and analysis process as discussion points when seeking guidance from my dissertation committee chair.

Coding Procedure

Using Moustakas' (1994) modification of the Van Kaam method of analysis of phenomenological data, the data was horizonalized, equalizing the value of all data, and seeking to capture the essence of the data through coding. Each passage of data was reviewed several times in order to capture the core meaning (Saldaña, 2016). Codes were written in the margins of the transcripts to reflect the essence of each passage.

Reduction and elimination was accomplished by reviewing whether passages of data contained information that was sufficient and necessary for understanding the essence of the phenomenon being studied (Moustakas, 1994). I reviewed every passage that was coded, and each passage that did not contain information meeting this standard was eliminated.

The data which met the standard of inclusion were clustered into labels (Moustaks, 1994). Each code was listed in a word document in order to compare them to one another. Codes that shared a category were clustered under the same label in order to identify the category that had emerged. Each category was then highlighted with the same color throughout each transcript.

Each invariant constituent was then checked against the transcript to ensure that it was either explicitly expressed or compatible with what was explicitly expressed (Moustakas, 1994). Categories were updated if the surrounding expressions or meanings clarified the category of the passage. Some passages appeared to represent one category when read on their own, but when considered within the context of the participants' narratives, were better suited for different categories.

A textural description was created for each participant by grouping passages under each category and emerging themes were identified in individual structural descriptions (Moustakas, 1994). A separate document was created to keep track of emerging themes. A description of the themes and categories that emerged for each participant were created that included verbatim examples from the transcripts. I took time between each round of data analysis to consider the essence of the participant experiences and properly label them. This process involved journaling and self-reflection, which resulted in several iterations of data analysis. Finally, I extracted four themes, and categories within those themes that helped distill the experiences of the participants.

Codes, Categories, and Themes

The research question for the study asked what types of support from doctors do patients with CVD perceive to be beneficial in facilitating resiliency? This research question involves exploring a phenomenon that can be sensitive in nature, as it involves the health and wellness of participants, and therefore resulted in data that was also personal and at times sensitive. Questions were balanced based on participant responses, using follow-up questions and probes, as appropriate in order to fully understand responses and to ensure proper interpretation of responses (Rubin & Rubin, 2012). The participant experiences were distilled into four themes and categories within those themes. The themes that emerged were informational support, emotional support, instrumental support, and appraisal support. Each theme is divided by the categories that make up that them, and the categories are organized by codes that arose from the data.

Theme 1, Category 1: Informational Support- Diagnostics

Each of the seven participants expressed a need for physicians to provide them with diagnostic information. Diagnostics included blood pressure readings, blood tests, radiological labs, and other monitoring devices or tools.

Disease Onset

The first expression of informational support was often at the onset of their conditions. When asked about the history of their conditions, each participant recalled being diagnosed by their physicians. Some participants were not aware that they could have cardiovascular conditions. Participant 1 stated, “I actually did not know I was hypertensive until my annual check-up”. Participant 2 explained, “You don’t feel

anything. It had been gradually rising and got to a point that he said we really need to do not just yearly physicals, or regular physicals, even if not yearly…[My blood pressure] was coming up, but when you don't feel anything, it's hard". Participant 6 expressed surprise at their diagnosis, "I asked my doctor. I was like, I don't understand. [My blood pressure has] always been so low. Are you sure you didn't read it wrong or are you sure it wasn't just a fluke? And she's like no, it's actually been climbing up. You just never paid attention to it because you never though it was an issue. Now, it's to the point where we're talking prescriptions and all of a sudden it's a diagnosis".

Three participants recalled experiencing symptoms. Participant 4 noted a subtle change in their health, "My experience with it was I was listening to my body. I was pretty active and my body, I was at certain points in times I would have extremely rapid heartbeat and I would have this shortness of breath… he gave me the diagnosis of high blood pressure". Participant 3 experienced more severe symptoms:

> I woke and did not have my balance, and I typically don't go to doctors enough, and don't really believe in the medical setup, and don't have regular visits, so I got up and I couldn't walk because my balance was completely off and I was super dizzy, and prior to that I was feeling nauseous on and off for over a week, and that morning I felt like I was drunk. I couldn't feel my legs, I couldn't put one in front of the other, so I went ahead and called and made and appointment and then went in. And she said, "when was the last time you had a check-up?" and I said, "I don't remember". So, I had blood tests done, and the first time I had the blood test done, it was not a fastest blood test. But my cholesterol, triglyceride

> was 630. And that's like over 400 and something points higher than even the higher level of normal.

Disease Tracking

In addition to diagnostics bringing awareness to the onset of disease, participants noted diagnostics as helpful in keeping track of their health. Participant 3 explained:

> She gave me about three months or so to kind of do this and then retest, and the next time I did the blood test, I had fasted in the morning and I had it pretty much in a normal range for most of my numbers. I was still on the high end, but normal.

Participant 7 noted their experience tracking their condition with diagnostics:

> My heart, a patch, a monitor to study the condition. When they did that, they just seemed to feel that everything seemed to be OK. But prior to that, when I before the stroke when I first fell my heart had a flutter.

Theme 1, Category 2: Informational Support- Health Education

Every participant discussed health education as something that either has been or would be helpful if provided by their physician.

Condition/Treatment Information

Health education included information about their condition or treatments. One participant noted that they did not know that a symptom was a due to their CVD. Participant 1 said, “I had nose bleeding once in a while and they said it’s related to my hypertension”.

Participant 6 stated that health education helps them weigh the risks of continuing or ceasing treatment:

> No, but I have migraines, anemia, malabsorption syndrome, osteoporosis. We treat that, but that would involve stopping, so irritable bowel syndrome, overactive bladder, these other things would get worse. And what impacts your personal experience of life more your blood pressure or having you go to the restroom more often or being laid up with a migraine for three days or a broken bone? She goes, yeah, it is a bit of swelling and, you know, you have the management.

Health education is gathered from a number of sources, including physicians, nurses, pharmacists, and literature. Some participants found their physicians to be accessible in providing information. Participant 1 stated:

> If I want more explanation, she'll do it and I'll explain more or she will explain it the way she things it should be explained. If I have questions, then I will ask the questions…She mentions to me that sometimes she talks to her colleagues about my case. So she gets advice from other doctors too, and the she'll let me know what they say. Some information was provided in the form of resources to review on their own. "If I have questions, please ask. If I did, he would give me things to read. He would give me websites to go to, just kind of follow up on what he and I discussed.

Participant 4 stated, "They told me how to navigate or they supply me with reading materials".

The importance of this health education provided by physicians is explained by Participant 2:

> I don't want to say it's hard to take it seriously, but it never seemed like a big deal to me until he said that you really need to do something…You impress upon me that it's something I need to do. Give me the reason. I'll take it seriously.

Health Literacy

Some participants emphasized health education as a facilitator of health literacy. This literacy involves being more aware of what to take under certain circumstances. Participant 5 explained:

> The last 10 years ago or more, my blood pressure has been going extremely high so I had to go to the emergency room, and they controlled it there, so I learned that sometimes before I go there, I can take a little relaxation medication and that helps so it comes down.

Participant 4 explained that the literacy involved a greater awareness of the purpose and function of their medication:

> I've got two medications that are actually one. One dosage of a pill that I take. and that's just the wonders of new technology where they can combine whatever dosages you need of similar medications to kind of help you. So I don't have to take two additional pills, I just take one pill that my doctors have explained to me, you know what Potassium does as far as your heart and your vessels need potassium to be able to constrict and to relax. And if you don't have that, then you'll have problems with the chambers of your heart, the Atenolol,

chlorthalidone is something that actually helps the lower chamber of my heart be able to push all of the blood out versus pushing it out halfway and then going to another beat. So it always needs blood in that in that chamber, so to speak. So pretty graphic, pretty detailed descriptions of what each medication does. My Lipitor, of course, is a cholesterol medication that actually is one of the it's probably the only owned patented cholesterol medication that actually cleans plaque from your veins and arteries as well, you know, it doesn't just slow it down, it actually cleans plaque. So that's why it works best at night when you're sleeping and your body is in a prone position. So all of those things were explained to me. And as I did my research on those particular medications, that's what it said. Between hearing from the doctor between, reading about it myself, doing the research and by actually seeing it impact how I felt and how I moved in and when I was highly stressed or in a position where my heartbeat was going to increase it was everything that they said it was going to be. My doctors we're pretty forthcoming with I was on this medication longer that I would still feel tired like any other human would after an exercise or what have you. I just wouldn't be so stressed during the exercise period. So, once again, when I'm in shape I can move around really, really good. I can tell when I'm not in shape, you know, just like anyone else, when I move around and I'm winded, I'm like, Oh my God, you know? But it's more about me being winded and not being in shape versus my heart's not functioning correct?

Theme 2, Category 1: Emotional Support- Caring

Six of the seven participants noted caring as a way that their physicians could help facilitate resiliency in their treatment of their conditions.

Personal Interest

Participants expressed that they appreciated it when physicians showed a personal interest in their health. Participant 1 stated that when their physician goes out of their way to gather information for them, "I like it because it means she's concerned". Participant 5 speaks to their history with their physician "I have been seeing this doctor for almost 40 years and we know each other a lot. He knows a lot about me. He knows that I am a person who mostly likes to do everything naturally".

Participant 2 noted that they would prefer physicians to take greater personal interest in their health:

> It would help if it was somebody who seemed to have a little more personal interest. I see him very irregularly, which is a good thing for me, but it's just like you go, here's where you are, and leave…I have to say this in the negative. I am a very outgoing person. In my practice, I am very personable. I'm not very formal. That's how I grew up. I would help me if he took more time to say hi, how are you, what's going on. He's a bit, I don't want to say perfunctory. He does everything he's supposed to do, I guess, be he doesn't seem very warm.

Participant 6 gave an example of the experience a family member had with a new physician. They expressed that their family member was very active for their age, but their appetite and weight was fluctuating, "He said he's experienced some frustration

when his doctors changed and the new person came in and kind of was like, you've got a good problem, and just kind of a little more dismissive".

Participant 7 suggested that more training in psychology may help physicians better understand their patients:

> But the big thing is they know they need to know the person. They need to spend some time with that person. They need to know that person's background. They need to know why they think the way they do. They don't know why I think the way I do, they never even asked. It's sad. These things, in my opinion, are important. I could never perform my service if I never asked and got to know something about that person. Because what I always tell the person when I get done with you, I'm going to know more about you than you know about yourself when it comes down to [my profession] and what you should be doing and why you're doing something that's probably not correct. And I'll explain why, and I will calculate it out and show you how it's affecting you. They don't do that. They don't show how it's affecting you. They don't really explain things the way they should. There should be a course in human nature the doctor should have. You probably know more, the courses you've taken in psychology, I've only taken one course, that you begin to understand the human being. And I think probably, maybe all doctors should maybe take some of those courses and actually have the understanding of the human being.

Theme 2, Category 2: Emotional Support- Trustworthiness

Four of the seven participants mentioned that trustworthiness of their physician helped to facilitate patient resiliency.

Transparency

Some patients noted that feeling as though their physicians were transparent with them illustrated trustworthiness. Participant 6 provided an explanation of how their physician offers emotional support through caring behaviors. When asked to clarify if those caring behaviors help them stay on track and manage their condition, the participant noted transparency as another factor, "being forthright with [patients]". Participant 7 noted that their physician demonstrated transparency by admitting to their limitations:

> And it was my doctor that did that, the one I had for 11 years. He says, I think you need to see this person. That's the way I like it. He's honest, he's saying, I think you need to see [him] because he knows more about this.

Participant 4 made explicit the relationship between physician transparency and their likelihood to follow recommendations:

> Just the transparency and just being able, anyone can go anywhere and get treatment. It doesn't mean that you're going to follow the course of treatment or doesn't mean that you're going to believe it. It doesn't mean you can't believe a diagnosis or what have you. I mean, you can get numbers, you know good cholesterol, bad cholesterol, high blood pressure, heartbeat, oxygen level. I mean, you can get all that general data from any physician. But I think the biggest part of a doctor client relationship, is the rapport back and forth and being able to

> listen to one another. I would tell my doctor, like man, I'm in a car eight hours a day and then I'm working in a unit, what can I do? First, it's just, you're kind of stuck with it so let's up your medication. He would suggest things that he knew, hey if you love tennis why don't you get out there a couple times a week and that'll help you tremendously, just half an hour, twice a week and can you fit that in and I would say yeah, try to fit that in and sometimes I would sometimes I wouldn't. By the time I went back to my next visit, I would tell him, hey I'll only did this about 40 percent of the time, I lost two pounds, if I had done it all of the time, I would have lost that 10 to 12 you're telling me to. So, if they see that you have the opportunity to improve then they'll, once again, it's that relationship of transparency, I think, on both sides.

Medical Competency

Participant 4 expressed more trust in physicians that they felt were more medically competent:

> I think whenever someone first gets a diagnosis we all look at, it's the old thing about just because someone's rich doesn't mean they're smart, and there are different levels of performance and knowledge when it comes to physicians as well, or just because someone gets assigned to you doesn't mean that they're the one for you.

Participant 5 noted that even though they did not feel that their physician excelled at medical competence, they trusted the known competence of their physician over the unknown competence of other physicians:

> I don't think he is that good, but how do I know if I choose another doctor [if they will be good]. Another thing about me is that when I get used to things, like people who give you haircuts or somethings, maybe you will go somewhere and they will do a better job, but still, I am not an easy person to change that. In the bottom of my heart, I know he is not an excellent doctor. At the beginning, he discovered something about my brain tumor that was hormonal, so I just trusted him from that beginning because from my blood test he found something. I don't know how bad that would be if he didn't take care of it, so I like that he found that and he didn't let it go and he sent me to a specialist. He saw my prolactin or something was high. Somehow, I trust him, and somehow, I don't know if another doctor would be as good, or not.

Cultural Competency

Cultural competence played a role in the trust of physicians for two participants. Participant 4 made note that their race was an important aspect of their patient experience:

> I pretty much told him from the very beginning, I'm a black man and I know that we are susceptible to certain things that other cultures aren't, and he realized that as well. He would always speak to me and communicate to me in that vein. So, he and I had a really strong trust. And now that he's retired, I'm in the process of trying to find someone that I have that same level of trust with, and I haven't found anyone as of as of yet.

Participant 7 stated that physicians lacking cultural competence can affect their trust in test results:

> I think that the people giving it don't really understand too much about the human being because they should know a little bit more about the background of the person, educational background, foreign born, or whatever it may be. Because what they didn't realize is that I was never good in English, mainly because my parents were foreign born, and they always spoke [a different language]. And as a result, not until the first grade did I start to learn how to speak English. English has been a very tough subject of mine, so they should understand that, parents did not speak any English. So, as a result when they go rambling around and stories, like I say English has always my bad subject and since it was my bad subject, I kind of ignored it makes and excelled in math. When I was in the fourth grade I could do seventh or eighth grade math already. That was always easy for me. But English, because I was not brought up speaking English all the time, therefore, even to this day, English is still a tough subject for me. I can write things and I think I can explain things reasonable. But when people use the more difficult words, the higher and higher educated people. I'm probably higher educated than most of them because I got a master's, but I don't have it in English. But I always understood what I was doing when I was reading. But when somebody just reads and rambles on and reads a whole bunch of stuff to me, I kind of closed my mind to it because I'm not understanding some of the words that they that they're speaking off. So, as a result of that, you just don't, you can't really repeat a lot of

> stuff they're saying because you don't understand them. It's not because I don't understand, it's just because I was brought up to speaking a different language. And as a result of that, English has always been a tough subject for me. And it's always been from the very first grade on up high school and college and in working on my master's degree, English has always been a tough subject. So, doctors should understand that and I don't think they do. They never asked me about that. They don't know my background. So how can you go to work and if you don't know a person's background, how can you go to work and consult and make a recommendation when you don't have all the tools that are available to you. I don't think they know how to interview a person. You really know a person's background before you can say anything about them. You really need to know it. And they did not ask me about anything about my background. So, I think, I'm opposed to what they're recommending, because they don't really know what you're talking about.

Theme 3: Treatment Plans

Six of the seven participants explained how treatments plans provided by their physicians helped them manage their conditions.

Medication

Every physician provided treatment plan involved taking medication. Participant 4 described their experience:

> I know that the reason why individuals are prescribed medications is to help your body and to protect your body and to be prescribed something and to be stubborn

> and say, oh, I'm not going to take this off, I don't want to be on this medication. I think to myself is kind of foolhardy. If you can get to the point where you are doing all the necessary nutritional things, all the necessary movement and physical things to help your body and you can either lower those dosages or eliminate those dosages I'm all for that as well. But I think to get something prescribe and then just say, I'm going to take it when I feel bad or I'm only going to when I don't feel well, or I'm going to take it intermittently, according to my schedule, I'm not about that because I know that it would've been prescribed in the very beginning if it wasn't of good intentions.

Participant 2 explained the ease of managing their condition through the use of medication, "It's the easiest thing in the world. I mean, I take two medications. It's pretty simple. I keep organized. I take them at night before I go to bed".

Procedures

Participant 7 explained that their treatment plan combined both procedures and medications:

> Before the stroke when I first fell my heart had a flutter. The doctor that handle that seemed to know exactly what was going on. And he gave me the electrical shock and got everything back in place…We switched doctors then and the doctor said, you should be taking an additional amount of this other kind of medication, which [my wife] got put together and that seemed to help. And he seemed to know more about the high blood pressure and what you have to do. After having that, my blood pressure went down. It was under control. And right now it seems

> like pretty much everything seems to be under control and I'm still taking my medication.

Theme 4, Category 1: Appraisal Support- Patient Collaborator

Three of the seven participants expressed feeling empowered when their physicians either asked for their input or respected their positions on collaborating on their treatment plans.

Treatment Plan Collaboration

Participant 4 pointed out the importance for patient collaboration in treatment plans, “Now you can be taking medication and not feel well, but that’s for every individual to communicate and advocate their own position as the process goes along”.

Collaboration for one patient involved using medications provided by their physician in a way that they felt comfortable with. Participant 5 stated, “This medication I have started six months ago, and I saw the last time, my doctor, a month or month and a half ago. I told him I did that. He said ok, then good if it’s helping. He approved what I decided”.

Patient 6 explained that their physician provides ideas and then opens the discussion to feedback from the patient in order to facilitate collaboration:

> So instead of being like, this is what we're going to do. She's like, I have some ideas. Did you have any? She knows that when I bring something to the table, I've researched it myself. I mean, she will look at it and I have a pharmacist case manager who's a person who looks at all the interactions and she'll run it by my. She'll be like, on paper that looks all good and handy, but let's make sure there's

> no interaction. She really does not disregard what I already provide. She values my input. Almost as, I don't want to say as much as it seems from my perspective that she values my input as legit. And I think, not like a medical professional, per se, but she does not just discard.

Participant 6 likened physicians as being a part of a team, and explained that each medical provider must understand what other players of the team are doing in order to properly serve the patient:

> They didn't prescribe it, but when I kind of said this is what this food does to me. She's like, yeah, that isn't a good one to have, maybe you should. Like I know onions don't work for me. So even though they're healthy. And I'm allergic to mangoes and things like that, and it's like I learned those things. So she's not going to tell me, here's your list of what to do and what not to do. It's kind of like she goes, you're. That's the other thing, is it I it took me 20 years to find her. A lot of doctors were like, we're looking for somebody that only wants a flu shot and an annual exam once a year. You're too hard, you're too difficult. She actually, I have I have what's called a hematologist, which is a blood lab person who actually works in a cancer center as an Oncologist for some people. I personally have the opposite of cancer; my white blood cells are low but that person is one of the more specialized people in my care because they track all my absorption of everything. And he is of sort of a Pakistani eastern Indian descent, which is actually so helpful because he has eastern and western medicine. And he has a different credential over there for their residency. And he has thought holistically,

which is how I got a prescription for my osteoporosis that was actually off label pharmaceutically, instead of going on the Prolia. And my general practitioner and him are on such good terms that they actually were mentor mentee when she was going through her residency, so they knew each other before me and now they're both working on my complex conditions. I call it my baseball team. I say I am the ball. The game is not going on in our outfield. If you have the ball, you are in control, but you must work with and transfer the information to the other people on the team work with me. Because otherwise you can be there and be the best player on the field. But if you're working in your own left field, right field out field, la la land and you're on your own island of my health then you're probably messing up what the other team members have figured out and are using and if you want to work with me, you have to put up with that, I am complex and I don't like having this many ongoing diagnoses. I'd like them to go away, but they are what they are, so I work with them in the best way possible, and I have found people that are willing to, bounce ideas off each other to work together to not overstep their bounds, et cetera…I've got so many doctors who weren't ready to [collaborate]. It's me. What I say is law. No, no, no, no, no. If you're fixing one part of the problem, and you're not looking at the whole puzzle.

Theme 4, Category 2: Appraisal Support- Patient Self-Management

Three of the seven participants considered self-management of their condition to empower them to cope with CVD.

Patient Decision Maker

Participant 3 explained that while their physician made recommendations, ultimately the choice was theirs, and feeling that they had that choice was important to them:

> I think it's different for everybody. Some people like to really just go to the doctor and get their orders and just go through. I don't really believe in pharmaceutical medication as much as the next person, probably. So for me, it was important to have someone that basically kind of allowed me, you know, would move at my pace. Suggested, recommended, but didn't say, well, you know, because there are doctors that I've seen that just says, if you don't do this, I don't see any hope. I don't see any. And she was very open to, if that's what you want to do, you can. But this is always here for you if you want to do otherwise… She'd still make a point that she was a medical doctor, and this is the pharmaceutical products available, but she definitely did not disrespect my way of seeing things. So that was really important to me.

Participant 5 found that using medication they had been prescribed for other uses, or using other substances or supplements helped their condition:

> My daughter, took me a few times to the emergency room and they gave me something to relax to me, Or I believe she thought that it was some IVs that relaxed me so my blood pressure came down. So the last couple of years, that’s what happens so I don’t have to very many times to the emergency room, I’ve been taking a half of a Lorazepam, 1 mg, and that relaxes me and it calms down.

Discrepant Case

Only one participant did not use a doctor guided treatment plan, nor did they note emotional support as instrumental to managing their condition. This participant was informed of the urgency of their condition by their physician and used diagnostic tools available by their physician in order to research alternative health practices and construct a treatment plan on their own. The data from this participant was factored into the analysis as it was meaningful and met the standards for inclusion. Despite differing from the other participants in the ways mentioned above, the data from this participant supported data provided from other participants.

Evidence of Trustworthiness

Credibility

Credibility established trustworthiness through establishing that the phenomenon under scrutiny was accurately recorded (Shenton, 2004). This was done by adopting a method that has been well established in qualitative research and information science. The line of questioning used to gather data was derived from those that have been successfully used in previous studies. The semi-structured interview guide (Appendix C) for this study are derived from those provided by Nafradi et al. (2018) in a similar study. Questions related to chronic pain were altered to address CVD.

Triangulation was achieved by using different methods in order to collect data, including field notes and journaling (Shenton, 2004). The use of a wide range of participants served as a means of data triangulation, verifying individual viewpoints and experiences against each other (Ravitch & Carl, 2016; Shenton, 2004). While

interviewing participants, tactics to ensure honesty were used. Building rapport with research participants helped participants feel relaxed and unthreatened (Kruger, 1981). Being accommodating to participants allowed them to feel comfortable and have the time to provide their full attention to the research. Further, not collecting personal data may have afforded participants greater ease at honestly expressing their feelings. Participants were not required to provide identifying information and were afforded the opportunity to choose the time, date, and means of communication. Participants were given opportunities to refuse participation and were encouraged to be frank at the onset of each session (Shenton, 2004).

Iterative questioning and using probes were used to elicit data and to uncover contradictions in data (Shenton, 2004). Member checks were used often to ensure immediate and ongoing assurance of accuracy of data. Debriefings took place between my dissertation chair and me in order to benefit from the experienced input of my committee chair. This allowed for alternative approaches to be discussed and flaws in my methodology to be corrected. Finally, I was able to assess the degree to which my results are congruent with a Nafradi et al. (2018), a similar study with a different population of chronic pain patients in Italy.

Transferability

Transferability was achieved by including thick description, data that is rich with detailed descriptions as well as context, allowing readers and subsequent researchers to transfer aspects of the study to different contexts in order to replicate the study (Ravitch & Carl, 2016). Information was provided regarding the boundaries of the study such as

inclusion criteria, sample size, data collection methods, number and length of data collection sessions, and the time period of which data was collected, providing readers with enough information to justify whether the information can be applied to another setting (Shenton, 2004).

Dependability

Qualitative research that is consistent and stable over time is considered dependable (Ravitch & Carl, 2016). In order to address research dependability, the process of research was reported in detail, enabling future researchers to repeat the work, thus creating a prototype model from which the reader may assess the extent to which proper research methodology was used (Shenton, 2004). The details included the research design and its implementation, operational detail of data gathering, and reflective appraisal of the project. An audit trail was created, detailing researcher predispositions, making decisions and methods explicit, as well as explaining weaknesses in the techniques employed (Shenton, 2004).

Confirmability

Confirmability of qualitative research involved taking steps to ensure that the study findings were a reflection of the experiences and ideas of the participants, rather than the researcher's biases (Shenton, 2004). The Epoche was used to mitigate researcher biases and making biases explicit through instrumentation of a journal to help ensure confirmability (Moustakas, 1994). The use of journaling provided a reflective process.

Results

The research question for this study explored the types of support from doctors that patients with CVD perceive to be beneficial in facilitating resiliency. There were four themes identified in this study: (a) informational support, (b) emotional support, (c) instrumental support, and (e) appraisal support. There were seven subthemes identified: (a) diagnostics, (b) health education, (c) caring, (d) trustworthiness, (e) treatment plans, (f) patient collaborator, (g) patient self-management. The theoretical foundation for this study was social support theory. Social support theory assumes that social support serves as a protective factor by being related to lower levels of psychological and physical symptomology and reducing the impact of negative life experiences on such symptomology through self-control and behavioral actions (Wills & Bantum, 2012). The four types of supportive behavior identified by social support theory were identified by participants as the four types of support that they found to be beneficial when provided from their physicians. The details of the participant experiences revealed categories within each type of support, providing examples of how support can be applied by health care providers.

For example, patients used informational support from physicians to take control of their health. Participant 3 described their experience:

> What I learned from it is, even if it's not your way of doing it, definitely take advantage of the testing in gauging where your health is, because that was something that I was not very open to either and it's been definitely a positive for me, because if anything, it's encouraged me to take more care of myself, or if I do

> more of this, I'm getting results no matter what the treatment was. So that's something that, you know, I've learned kind of that. Hey, it's not as scary as you think if you just have a gauge to go by.

Emotional support made participants more likely to continue care with physicians. Participant 4 stated:

> My last physician was really in tune to my conversations, to my needs, to my wants, while still being able to be very literal and very direct with me, understanding that he always had continuing education going on, he was always on top of his game.

Instrumental support was provided through treatment plans, including prescriptions and procedures. Participant 5 explained how integral adhering to a treatment plan can be to a CVD patient's health:

> My cousin, he was taking and not taking his blood pressure medication and he had a heart attack in his 50's, and his wife said it was because he wasn't serious about his blood pressure medication. He had a heart attack and he didn't survive. He died in his 50's in front of my eyes. My father was very young. He had high blood pressure and he had a couple of heart surgeries, and the second one he didn't survive. He was a little bit not serious, in the beginning, until he had to have his first open heart surgery at 55. The second one at 62 years-old he died on the surgery table, so I know it's serious.

Appraisal support empowered patients to take part or take control of their own health-care, as described by Participant 3:

> Typically, I'm not a big self-care person, so, with this, I was very focused. I'm the type of person that if you give me an assignment, I'm just going to try to go over and above. This was a self-assigned project for me to try to get this under control on my own. I knew that I had a timeline to work with. Once I did the research, I did a deep dive in.

A discrepant case emerged from the data as a participant only desired two types of support from their physician, informational support and appraisal support. The participant found the diagnostic tools and basic information from their physician to be motivation for self-care. This participant wanted far less support from their physician than other participants, but the support that they did find to be useful was consistent with the support other participants wanted as well.

Summary

The purpose of this research was to gain more insight on the types of support, from physicians, CVD patients living in the US find to be beneficial in facilitating resiliency. I recruited seven participants for the study and the semi-structured interviews generated rich data about their lived experiences of CVD patients who have interactions with health-care providers to treat and manage their conditions. I interpreted the data using the seven steps of Moustakas' (1994) modification of van Kaam's (1959, 1966) method of analysis of phenomenological data which yielded four themes and seven categories.

In Chapter 4, I have provided the details of how I conducted the study, including details about the setting, demographics, data collection, data analysis, and evidence of

trustworthiness. The results of the study have been included in Chapter 4, along with quotes from the transcripts to support statements made throughout. Chapter 5 will conclude this dissertation with an interpretation of the findings, limitations of the study, recommendations for further research, the implications of this study, as well as a conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Despite health-related behaviors having been promoted to CVD patients, CVD continues to be the leading cause of disability and death for those living in the US (CDC, 2019a; CDC, 2019b; Lisspers et al., 2005; Virani et al., 2020). Nearly half of all Americans fall into the guidelines of being at risk for CVD (CDC, 2019b). The purpose of this qualitative study was to understand what types of support CVD patients in the US perceive to be beneficial in facilitating resiliency when received from their physicians. Semi-structured interviews were used to obtain experiences, narratives, and stories from CVD patients related to the types of support they receive from physicians that they find to facilitate resiliency.

This chapter contains discussion and future research possibilities to help answer:

RQ- Qualitative: For patients with cardiovascular, what types of support from doctors do patients find beneficial in fostering resiliency?

A transcendental phenomenological qualitative research approach was appropriate in interpreting the descriptive investigation of the phenomena in order to understand the essence of the data (Davidsen, 2013; Miller et al., 2018). I recruited seven participants to describe their experiences as CVD patients and to reveal what types of support from physicians they found to facilitate resiliency in them. Four types of support were identified: (a) informational support, (b) emotional support, (c) instrumental support, and (d) appraisal support. Categories within each type of support were: (a) diagnostics, (b) health education, (c) caring, (d) trust, (e) treatment plans, (f) patient collaborator, and (g)

patient self-management. In Chapter 5, I will interpret the findings of this study, discuss the limitations of this study, make recommendations for further research, provide the implications of this study, and provide a conclusion to this research.

Interpretation of the Findings

While the specific support received from physicians may include variation for each individual, informational support, emotional support, and instrumental support were prominent types of support that CVD patients found to be beneficial in facilitating resiliency. Appraisal support was a notable type of support that was considered to be beneficial by four of the seven participants. These themes contain dynamic dimensions, and the categories that were revealed throughout each theme is described in detail in the following sections.

Informational Support as a Facilitator for Patient Resiliency

This study's conclusion that informational support is a facilitator for patient resiliency is consistent with existing literature that indicates promoting patients' health literacy can promote patient resilience (Durif-Bruckert et al., 2014; Náfradi et al., 2018). Health literacy was categorized as health education in this study. The Institute of Medicine's (2004) definition of health literacy aligns with how participants in this study explained receiving and understanding information from their health care providers, as information was provided to them in ways that they could absorb it. Health literacy was promoted to this study's participants in a number of ways, including personal communications, technology, and information on how to navigate resources. The way in which health literacy was promoted with participants in this study were consistent with

Koh et al.'s (2013) description of health literacy as a multi-dimensional concept. Participants in this study noted that they were better able to respond to their conditions when they were given information about the seriousness of their conditions. This is consistent with Laing (2020), who noted that health-care providers who took steps to improve their organizations responsiveness to health literacy felt that they could reduce the barrier to accessing health and facilitating the self-management of health in conditions such as CVD.

Náfradi et al. noted physicians making reasonable arguments for treatment and expanding patient knowledge about medication and treatment plans as facilitators of resiliency in their patient population. Durif-Bruckert et al. stated that physicians imparting medication knowledge onto patients gave patients the ability to make educated negotiations related to their treatment plans. This study was consistent with those findings, and found additional types of informational support, such as information about one's diagnosis and the risks of one's diagnosis. This study expanded on those findings by including a patient population that did not involve chronic pain. Additionally, diagnostics were noted as a beneficial type of support that provided necessary information to patients in both understanding and managing their conditions. Diagnostics included blood pressure readings, blood tests, radiological labs, and other monitoring devices or tools. Náfradi et al. studied patients with chronic pain, while this study researched participants with CVD. Some of the participants for this study noted that they did not experience symptoms of their condition or were not aware of their conditions until diagnostics were performed. Bartlett et al. (2019) found that the most frequent

source of self-management support of chronic disease patients were physicians, but did not offer any context as to why physicians were a source of support. This study expands on Bartlett et al. by providing that patients often do not know they are ill until they are seen by their physicians. The difference in symptomology between the conditions may explain the discrepancy in the types of informational support these two patient populations found to be beneficial in facilitating resiliency.

Emotional Support as a Facilitator of Patient Resiliency

This study's conclusion that emotional support is a facilitator for patient resiliency is consistent with existing literature that indicates psychological support can promote patient resilience (Kim et al., 2015; Náfradi et al., 2018; Ommen et al., 2011). Previous studies indicate that the physician may be a source of social support through trust and the validation of patient symptoms (Garzon et al., 2018; Náfradi et al., 2018; Ommen et al., 2011). Náfradi et al. attributes feelings of trust to physicians caring. Participants in this study noted that physicians who show caring through the giving of time and attention help facilitate resiliency. Participants in this study made special note of medical competency and cultural competency as factors that contributed to the trustworthiness of their physicians. This study expands on Náfradi et al. by expanding the ways in which a physician may promote resiliency through emotional support. Náfradi et al. indicate that validation of symptoms help promote resiliency in chronic pain patients. Kim et al.'s study explored how language could be a barrier to health information, but their findings also spoke to how patients from ethnic minorities felt about physicians from different cultural backgrounds. The patients in this study echoed

the same apprehension to seeing physicians who lacked cultural competency as patients in Kim et al.'s study. Furthermore, this study expanded on the sentiments shared in Kim et al.'s study as it pertained specifically to patient support received through physicians, while the previous study focused more narrowly on receiving health information in the Korean American community. Ommen et al. (2011) performed a regression analysis and found that trust of a patient was related to socio-economic status, age, and gender of a patient. One participant in this study noted that gender was a factor in determining the cultural competence of their physician as an indicator of trust, which appears to be consistent with the previous study, but as the study did not contain a qualitative approach, it is not possible to determine the context of the results. Further, Garzon et al. (2018) note that unfavorable interactions with physicians not only distress, but also demoralize patients. CVD patients in this study did not note validation of symptoms to be an essential component of emotional support from doctors, likely due to the nature of their conditions being diagnosable through objective testing. This is consistent with literature indicating the CVD patients often have pain-free symptoms, and that pain can present a unique motivation to engage in health behaviors to alleviate the pain (Abrich et al., 2020; Dipaola et al., 2020; Navratilova & Porreca, 2016). Dipaola et al. note that symptoms of CVD which can be present without pain include increased heart rate, sustained tachycardia, absence of orthostatic hypotension. Many of these symptoms are consistent with symptoms patients in this study reported, and in some cases, were specifically indicated by patients in this study to have occurred without pain or their knowledge prior

to diagnostics being performed by their physicians for physicals and other types of routine check-ups.

Instrumental Support as a Facilitator of Patient Resiliency

This study's conclusion that instrumental support is a facilitator for patient resiliency is consistent with existing literature that indicates adaptive coping responses can promote patient resilience (Náfradi et al., 2018). Náfradi et al. categorize (a) pacing activities, (b) acquiring optimism, and (c) engaging in physical and social activities as adaptive coping responses and disease management. These types of coping responses and disease management can be considered treatment plans, and therefore are consistent with the instrumental support of treatment plans that the participants in this study found to be beneficial in facilitating resiliency. Náfradi et al.'s participant (Ines) noted:

> I need to get by, also he [the doctor] told me that this disease cannot be completely healed, but he can help me, and then I started [to follow the treatment]. He even convinced me to go to the gym, to be in a group and to go to a physiotherapist.

Medication was noted as the primary source of treatment from providers that helped CVD patients in this study treat and manage their conditions. Similarly, to the chronic pain patients in Náfradi et al.'s study, exercise and social activities were considered helpful by patients, but were not considered a part of treatment plans that were provided by physicians.

Appraisal Support as a Facilitator of Patient Resiliency

This study's conclusion that appraisal support is a facilitator for patient resiliency is consistent with existing literature that indicates facilitating patient empowerment can promote patient resilience (Durif-Bruckert et al., 2014; Náfradi et al., 2018, Ommen et al., 2011). Patients in Durif-Bruckert et al.'s study, pertaining to fibromyalgia patients, and this study noted that they felt empowered through the support they received from their physicians to shape their treatment plans through making adjustments to their medications, and negotiating or adjusting medication terms. Appraisal support was provided by physicians in both Náfradi et al.'s study and this study through treating patients as collaborators and respecting patient's attitudes towards self-management. This treatment served as a reminder that the patients were capable of managing their conditions. Patients were treated as collaborators in both studies by having the ability to modify their own treatment. Ommen et al. (2011) indicated that patients were more likely to trust physicians that allowed them to share in decision-making. In this study, patients modified their treatments by lowering medication doses or choosing alternative treatments. Self-management was achieved through setting boundaries as to the amount of involvement patients allowed physicians to have in their treatment plans. Náfradi et al. noted that some patients preferred to administer their own treatments as prescribed by their physicians. In this study, patients discussed experimenting with their medication under the approval of their medical providers. One participant explained that they used the diagnostic information provided by their physician in order to research and implement their own treatment plan. This could offer some explanation as to why participants in

Bartlett et al.'s (2019) study most frequently obtained self-management support from their physicians in managing their chronic diseases. Access to diagnostics were instrumental in determining the effectiveness of self-management for participants in this study. This participant found the encouragement by their physician to be self-empowered to be beneficial in facilitating resiliency. The types of health behaviors that participants felt empowered to engage in were consistent with existing literature that indicates that cardiovascular risk factors are negatively correlated with healthy lifestyle behaviors such as self-actualization, health responsibility, exercise, nutrition, interpersonal support, and stress management (Ozkan et al., 2018).

Limitations of the Study

Information provided by participants may have been filtered, the researcher's presence may have biased the responses of the participants, and some participants found some difficulty in articulating their perceptions (Ravitch & Carl, 2012). This study used a self-report method, therefore statements made by participants must be trusted as accurate despite potential for biases (Adners & Tucker, 2000; Bashirian et al. 2019). The inclusion of additional authors would have enabled individual researcher bias to be further mitigated. Qualitative research cannot be directly applied to other contexts; therefore, transferability should be considered a potential barrier for this study (Ravitch & Carl, 2012). Further, generalizability is neither a goal nor can be used as a measure for validity of this qualitative study. Transcripts were not provided back to participants as a step to increase vigor. It was beyond the scope of this study to compare patients based on diagnoses or duration of their illness. This study could have been strengthened if

diagnoses were authoritatively ascertained. Resiliency was conceptualized based on the operational definition provided by Náfradi et al. (2018), but even Náfradi et al., state that there is a lack of agreement in literature of resiliency as a process. This study did not collect demographic information, and therefore it is beyond the scope of this study to compare resiliency in participants based on age, location, or race. Other factors that may be attributed to facilitating resiliency were not considered in this study, and personality traits of participants were not taken into account. Duration and seriousness of illness were not taken into account for this study. Finally, this study was conducted by a doctoral candidate researcher, and therefore, lack of experience was a limitation.

Recommendations

The present study showed that specific elements of the doctor-patient relationship can help facilitate resiliency in CVD patients, but further investigation is necessary to explore how this resiliency manifests in patients. The present qualitative study explores the link between the doctor-patient relationship and resiliency. Future studies could explore how the doctor-patient relationship may play a role in facilitating resiliency in CVD patients based on seriousness and duration of illness. Future studies could consider how social support from physicians compares to social support from other social groups such as friends or family in the facilitation of resiliency in CVD patients. Future research could also consider how resiliency in patients with conditions that include pain symptoms compares to patients with illness that do not involve pain. Future studies applying a quantitative method could help determine which types of support from physicians are most often considered to be beneficial in fostering resiliency by CVD patients. An

experimental method could further test the most effective types social support physicians can provide patients to facilitate resiliency. This study explored the types of social support that were beneficial in facilitating resiliency in CVD patients, but did not explore how the physicians felt about their training in this area. Future research could explore this topic from the perspective of physicians.

Implications

Increasing the understanding of the relationship between CVD patients and their physicians may develop opportunities for further research into the doctor-patient relationship and the role it may play in health outcomes. Therefore, this research may affect social change through the encouragement of physicians to nurture relationships with patients that foster resiliency and improved health outcomes.

This dissertation study illustrated several ways that physicians may help facilitate resiliency in CVD patients. A possible approach to helping physicians help facilitate resiliency in CVD patients would be to rely on the principles associated with Wills' (1991) social support theory. Wills' beneficial forms of social support (informational support, emotional support, instrumental support, and appraisal support) can be used to restructure physician interactions with patients. Wills believed that social support serves as a protective factor for individuals coping with stressful conditions, and such support could be provided by individuals with social or community ties (Fiske et al., 2010). Hence on an individual level, physicians can play a role in helping patients cope with their diseases and promote health behaviors by offering the types of support discussed herein. This may benefit both the physician and their patients, as improving the

relationship may not only benefit patient resiliency, but also improve patient retention and a physician's reputation amongst patients in their community. In terms of CVD patients, they may feel further understood and esteemed on the individual level by having their perspectives and concerns heard. This study demonstrated that patients engage in conversations with their family members and friends related to their healthcare and their experiences with physicians. On a community level, improving relationships with patients can not only benefit the patient, but also improve the outlook of their friends and family on engaging in a relationship with a healthcare provider.

Further, educational organizations can incorporate training related to social support in relation to health-care. Social support theory is well established in health-related psychology literature (Fiske et al., 2010). A participant in this study stated that they felt that physicians would benefit from further education in psychology. The recommendation for practice is that organizations incorporate health related psychological research findings in their training of health-care providers. Improving patient participation in health-care may help patients better adhere to provider recommendations, be proactive in their health, and improve patient outcomes. Psychological knowledge is a tool that can assist physicians in their relationships with and treatment of patients.

Conclusion

This study sought to explore the lived experiences of CVD patients living in the US with the hopes of providing strategies and interventions to facilitate resiliency through interactions with physicians. The participants of this generously shared

experiences of being diagnosed with and living with their health conditions. The findings indicate that while disease management can be physically, emotionally, and socially challenging, physicians have the ability to ease the burden and promote health behaviors through social support.

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Appendix A: Recruitment Flyer

Appendix B: Screening

PARTICIPANTS MUST

1) be 18 years of age or older.

2) identify as a cardiovascular disease patient (heart conditions, blood pressure conditions, etc).

3) live in the United States of America.

4) use the same language of the researcher (English).

5) must not be currently hospitalized.

Appendix C: Semi-Structured Interview Guide

Semi-Structured Interview Guide

After a brief introduction about the focal point of the research, the participant will be asked to describe their lived experience as a cardiovascular disease patient.

The queries that frame the discussion will be the following:

Medical History
1) Can you tell me the story of your disease?
2) What is your experience with cardiovascular disease like?

Treatment and Self-management
1) Can you describe a usual day regarding your medication taking?
2) What do you think about your current treatment?
3) How do you inform yourself about your treatment?
4) Can you tell me about how you feel about your treatment?
5) Can you tell me about your self-care behaviors?
6) Have you ever tried something else to treat your disease apart from taking prescribed drugs (e.g. alternative medicine)?

Health care professionals' roles
1) Can you describe your relationship with your physicians?
2) How did your doctor explain your treatment?
3) How was that situation for you?
4) What does a typical meeting with your doctor look like?
5) What are the most helpful aspects for you in the doctor-patient relationship?

Social norms
1) What is the general experience with physicians in your family and circle of friends and acquaintances like?

Appendix D: IRB Approval

IRB Materials Approved - Sanam Sarahbi

IRB <irb@mail.waldenu.edu>
Tue 8/24/2021 11:26 AM
To: Sanam Sarahbi <sanam.sarahbi@waldenu.edu>
Cc: IRB <irb@mail.waldenu.edu>; Kimberly M. McCann <kimberly.mccann@mail.waldenu.edu>

1 attachments (48 KB)
Sarahni Consent Form.doc;

Dear Sanam Sarahbi,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "Exploring the Phenomenology of How the Doctor-Patient Relationship Plays a Role in Cardiovascular Disease Patient Resiliency."

Your approval # is 08-24-21-0175198. You will need to reference this number in your dissertation and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on August 23, 2022 (or when your student status ends, whichever occurs first). One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

Your IRB approval is contingent upon your adherence to the exact procedures described in the final version of the IRB application document that has been submitted as of this date. This includes maintaining your current status with the university. Your IRB approval is only valid while you are an actively enrolled student at Walden University. If you need to take a leave of absence or are otherwise unable to remain actively enrolled, your IRB approval is suspended. Absolutely NO participant recruitment or data collection may occur while a student is not actively enrolled.

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 10 business days of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

When you submitted your IRB application, you made a commitment to communicate both discrete adverse events and general problems to the IRB within 1 week of their occurrence/realization. Failure to do so may result in invalidation of data, loss of academic credit, and/or loss of legal protections otherwise available to the researcher.

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained on the Tools and Guides page of the Walden website: https://academicguides.waldenu.edu/research-center/research-ethics/tools-guides
Doctoral researchers are required to fulfill all of the Student Handbook's Doctoral Student Responsibilities Regarding Research Data regarding raw data retention and dataset confidentiality, as well as logging of all recruitment, data collection, and data management

Appendix E: Institutional Review Board Application

Form C: ETHICS SELF-CHECK APPLICATION FOR IRB APPROVAL

INSTRUCTIONS:
Section 1: The researcher must first complete the brown column A of the table below to document how the research procedures comply with the university's 40 ethical standards for research studies. Mark "Not Applicable" only when there is no possible way to address that ethical issue.
Section 2: Provide electronic signature.
Section 3 (students only): Have your faculty supervisor review this form and supporting documents so they can enter their email address to provide an electronic signature. Then you will need to copy (CC) your supervisor when you submit to IRB@mail.waldenu.edu. The IRB staff cannot accept any IRB forms or documents unless the supervising faculty member is CC'd on the submission.

IRB approval will be issued when the IRB confirms that there is adequate evidence that the university's ethical standards have been met, based on this form and the necessary supporting attachments. Within 10 business days of receiving a researcher's submission (including all applicable attachments), the IRB will notify the researcher of one of the following outcomes:
(a) that the IRB has provided ethics approval based on the submitted documents; or
(b) that the IRB requires revisions and/or additional documentation as specified in the Ethics Reviewer's column (such as column B for the first review or, if needed, column D for the second review).

Questions can be sent to IRB@mail.waldenu.edu. Click here to view IRB policies, sample informed consent documents, and FAQs about conducting research in specialized contexts such as international, workplace, educational, or clinical/intervention settings. The footnotes in this document contain tips, examples, and definitions. Reading these footnotes can reduce the likelihood of needing revisions. The most common request for revisions is to resolve discrepancies so check carefully to ensure that all documents reflect the final set of data collection steps.

SECTION I: RESEARCHER'S CONFIRMATION OF ETHICAL STANDARDS COMPLIANCE	**A. In this column, the researcher should confirm compliance with each ethical standard by entering Yes or NA, and defending the response by providing supporting details.**	**B. Ethics reviewer** will confirm compliance with each ethical standard in this column by entering "Confirmed" or providing a request for revisions.	**C. Researcher response:** The researcher must use this column to describe how and where each of the ethics reviewer's concerns (in the yellow column) has been addressed. The researcher's questions or explanations are also appropriate here if a researcher wishes for the IRB to reconsider an issue. For those rows containing "NA" or "Confirmed" in Column B, no researcher response is necessary.

Sample: Will data be stored securely?	Sample response: ***Yes. Supporting details: Paper surveys will be stored in a locked file cabinet at the researcher's home. Electronic files will be stored on the researcher's password-protected computer and backed up on a password-protected cloud drive.***		
1. **Has each** recruitment**, consent, and data collection step been articulated such that the responsibilities of the researcher and any partner organization(s) are clearly documented?** (Provide a numbered list of the data collection steps that includes **how/who/where**[1] details for each step, in sequential order. Here are samples. Describe **pilot**[2] steps first if you are doing a pilot or road test.)	***Yes, the steps are described below:*** ***i.. Study Recruitment*** ***Researcher will post flyer to various social media sites in order to reach cardiovascular disease patients in the United States to recruit 8 to 10 potential participants. Flyer will ask them to contact the researcher by email to volunteer to participate.*** ***ii. Study Consent*** ***Researcher will email the consent form to the study participants and ask them to reply with the words, "I consent" if they wish to move forward with the study.*** ***iii. Study Data Collection*** ***Researcher will interview the study participants via phone, zoom audio, or skype audio (depending on the participant's preference).*** ***iv. Study Follow-Up Interview*** ***The researcher will contact study participants by email to schedule a follow-up interview if necessary.***	**Confirmed**	
2. **Will the research procedures ensure privacy**[3] **during data collection?** Describe how.	***Yes, the steps are described below:***	**Confirmed**	

[1] HOW = Write this like a recipe, including enough details so that a person could replicate your study. Submit copies of any of the following that apply: flyer, invitation email, ad/posting.
WHO = Which parties are involved in each step? In particular, we need details about any partners who might be assisting the researcher in identifying or contacting participants. Note that doctoral students may not delegate the tasks of obtaining consent or collecting data to anyone else.
WHERE = Specify whether the interactions will take place via phone, email, online, or in-person at a specific location.
[2] It is fine to road test an interview or survey with friends or family prior to IRB approval and that data may not be used in the study's analysis. However, any piloting done outside of friends/family requires prior IRB approval, regardless of whether the data would be included in the final analysis or not.
[3] Privacy risks might include unintended breach of confidential information (such as educational or medical records); being observed/overheard by others while providing data; or intrusion on the privacy of others who not involved in study (e.g. participant's family).

	The researcher will be the only person present at the researcher's residence when data is being collected via audio communication. ***Medical records will not be viewed or in the possession of the researcher.***		
3. **Will data be stored <u>securely</u>[4]?** Describe how.	***Yes, the steps are described below:*** ***<u>i. Physical Data</u>*** ***Physical data will be locked in a secure safe. The only person that will have access to the safe will be the researcher.*** ***<u>ii. Electronic Data</u>*** ***The laptop computer used for this study will be password protected. The cloud data storage being used (Dropbox) is password protected, able to disable permanent deletions, has monitoring of account access and activities, and configurations for sharing permissions. Only the researcher will have access to this account and the password for this account. Identifiable information will not be stored in any capacity. The mobile phone being used for the study will be separate from the researcher's personal phone and will password protected.***	**Confirmed**	

[4] Secure data storage requires password protection on electronic files and locks for physical data.

4. **Will the data be stored for at least 5 years?** Describe how data disposal will occur.	***Yes, the steps are described below:*** ***i. Date Storage*** ***Upon completion of the study, all data will be stored securely for five years. Journals and field notes will be stored in a locked safe for five years. A copy of the voice interviews will be stored in the cloud storage account (Dropbox). All remaining digital data will be deleted from devices that were used for the study.*** ***ii. Data Disposal*** ***After the five years of storage, all remaining data and information will be destroyed. Paper will be shredded and digital information will be permanently deleted. The cloud storage account will be deleted.***	**Confirmed**	
5. **If participants' names or contact info will be recorded in the research records, are they absolutely necessary[5]?** Describe why or clarify that data collection is 100% **anonymous[6]** (which is preferable).	***Yes. Supporting details: Participant's email addresses will be stored until the study has been completed so that the researcher is able to contact to participant to schedule a follow-up interview, if necessary. Further, participants will be given the opportunity to be sent a scholarworks link to access the research once it has been completed. Once the study is complete and scholarworks links have been sent to participants, email address contact information will be permanently deleted.***	**Confirmed**	
6. The research procedures and analysis/writeup plans must include all possible measures to ensure that participant identities are not directly or indirectly disclosed. a. Only for research topics that possibly involve some stigma (i.e., workplace	***Yes. Supporting details: Identifying information will be deleted from recordings through the use of audacity audio recording and editing software to ensure that no identifying data will reach the transcription stage of this study.***	**Confirmed**	

[5] Retaining identifiers and/or contact information might be necessary if the researcher needs to follow up for a memberchecking step. Note that consent forms do not require signatures if the participant can indicate consent by some action such as clicking on a link, returning a completed survey, etc. Whenever possible, data should be collected without names or other identifiers.
[6] "Anonymous" means that no one (not even the researcher) knows who volunteered or declined. If a researcher documents consent in a manner that tracks their names, then the data is "confidential" rather than "anonymous."

bullying): **Can you confirm that the volunteering and data collection process will not result in others learning of your volunteers' participation in the study?**			
b. For all topics: **If participant demographic details (i.e., age, ethnicity, number of years in a position) are going to be shared in the final results, will they be shared in a manner that will not render certain participants identifiable[7]?**	***Yes. Supporting details: Demographic descriptors will only be reported if they are provided by the participant as a relevant factor to their experience. Details will not render participants identifiable, as only generalized descriptors would be used in this case, (i.e. a sex, race, living in the general country region).***	**Confirmed**	
c. For all topics: The standard for Walden capstones is to not name the partner organization in published reports, including ProQuest. **Will you mask the identity of any partner organizations that are playing a role in data collection and/or recruitment of potential participants?** Exceptions to the organization-masking practice must be granted by the Program Director and approved by the IRB. Place an X here ___ if you were granted an exception as part of your prospectus approval.	***N/A. Supporting details: There is no partner organization for this study.***	**Confirmed**	
7. **Will confidentiality agreements[8] be signed by anyone[9] who may view data that that contains identifiers?** (e.g.,	***N/A***	**N/A**	

[7] Participant identities might be indirectly and unintentionally disclosed if a researcher's final research report fails to withhold demographic details or site descriptions that might permit a reader to deduce the identity of a participant. So the researcher needs to think about which demographic descriptors are most important to collect and report, while ensuring that the identity of individual participants is protected. For example, readers may be able to deduce a participant's identity if a qualitative analysis stated, "One African-American vice-principal with 14 years of administrative experience described her professional development experience as…" A general rule of thumb is to only include a particular demographic descriptor combination if at least 3 people have that combination of demographic details. So if a district had 4 African-American vice-principals with 10+ years experience but only 2 were female, then an appropriate demographic description would be: "One African-American vice-principal with 10+ years of administrative experience described the professional development experience as…"

[8] A sample confidentiality agreement can be found here.

[9] Confidentiality agreements are required for transcribers or translators but not for the researcher or Walden faculty/staff (who are all automatically bound to confidentiality). Some professional transcribers/statisticians/etc address confidentiality in their work agreement and this is acceptable.

transcriber, translator) If so, submit a blank copy. If only the researcher and Walden faculty/staff will view the raw data, then enter NA.			
8. The ProQuest publication at the end of the doctoral program is for the academic community. **Is a specific plan[10] in place for sharing results with the participants and community stakeholders?** Describe.	***Yes. Supporting details: A scholarworks link will be emailed to participants who wish to have access to the completed study results.***	**Confirmed**	
9. Social science research typically involves **minimal**[11] risks and sometimes involves **substantial**[12] risks. Those risks must be acknowledged and described in order to mitigate them and document that they are outweighed by the study's benefits (in #12 below). **a. Are potential psychological[13] risks acknowledged and described here?**	**Mark one:** **__NA** **_X_Minimal psychological risks include: Stress** **__Substantial psychological risks include:**	**Confirmed**	
b. Are potential relationship[14] risks acknowledged and described here?	**Mark one:** **_X_NA** **__Minimal relationship risks include:** **__Substantial relationship risks include:**	**Confirmed**	
c. Are potential legal[15] risks acknowledged and described here?	**Mark one:** **_X_NA** **__Minimal legal risks include:**	**Confirmed**	

[10] Sharing the study's results with participants is required. It is important that the format is audience-appropriate. Stakeholders may lack the time or inclination to digest a full dissertation. Typically, a 1 to 2 page summary or verbal presentation is most appropriate. Note, member checking and transcript review are not applicable to this section. If you plan to do transcript review or memberchecking, these steps need to be described as part of your data collection procedures in #1 above.

[11] Minimal risk is defined as follows in U.S. federal regulations: "that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves THAN THOSE ORDINARILY ENCOUNTERED IN DAILY LIFE or during the performance of routine physical or psychological examinations or tests."

[12] Substantial risk is anything beyond the "minimal risks" of daily life. Substantial risks are acceptable when justified by the research problem and research design, as long as adequate preventive protections are in place.

[13] Psychological risks are present if materials or questions could be considered embarrassing, stressful, sensitive, offensive, threatening, judgmental, triggering, etc. Psychological risks are typically present if any of the other risks below are also present. SAMPLE DESCRIPTION: Some participants might disclose things that they later regret sharing, causing mild distress.

[14] Relationship risks are present if the recruitment or data collection process could impact the existing dynamics between the researcher and participant (who may be coworkers or have some professional relationship), dynamics among participants (if they know one another), or dynamics between the participant and the participant's friends, coworkers, or family members. SAMPLE DESCRIPTION: Since I am recruiting people I know professionally, they might have concerns about how volunteering or declining could impact our professional relationship.

[15] Legal risks are present if data collection might result in a participant's disclosure of violation of laws (by the participant or others). SAMPLE DESCRIPTION: Participants could inadvertently disclose a legal violation during the course of the interview.

	__Substantial legal psychological risks include:		
d. Are potential economic/professional[16] risks acknowledged and described here?	**Mark one:** **_X_NA** **__Minimal professional risks include:** **__Substantial professional risks include:**	**Confirmed**	
e. If there are any other potential risks, have they been acknowledged and described here?	**Mark one:** **_X_NA** **__Other minimal risks include:** **__Other substantial risks include:**	**Confirmed**	
10. **Have the above risks been minimized as much as possible?** In other words, are measures in place to provide participants with reasonable protection from loss of privacy, psychological distress, relationship harm, legal risks, economic loss, and damage to professional reputation? In the brown column, explain how each risk identified in #9 above will be minimized.	***Yes. Supporting Details: Participants have the right to end participation at any time and without consequences.***	**Confirmed**	
11. **Will the researcher be proactively managing any potential conflicts of interest[17] (particularly when researcher is known to the participants in some professional role)?** Describe how.	***Yes. Supporting Details: Participants will not be known to the researcher.***	**Confirmed**	
12. **Are the research risks and burdens[18] reasonable, in consideration of the new knowledge[19] that this research design can offer?** Describe why.	***Yes. Supporting Details: This study will effectively address a gap in existing literature and enhance the understanding of the phenomenon of how the doctor-patient relationship may facilitate***	**Confirmed**	

[16] Economic/professional risks are present if data collection could result in the participant disclosing violation of workplace policies, disagreement with leadership decisions, poor work performance, or anything else that could be damaging to the participant's position, professional reputation, promotability, or employability. SAMPLE DESCRIPTION: Since the questionnaire asks participants to rate their agreement with leadership decisions in their workplace, there could be an impact on a participant's promotion opportunities if there were a confidentiality breach.

[17] A conflict of interest is caused when the researcher has some sort of dual role in the research context, such as being a teacher, therapist, investor, business-owner, manager, etc. Conflict of interest must be managed to ensure that the research reveals "truth," not just the outcome that the researcher might desire to see due to their other role. The simplest way to ensure this impartiality is to conduct research OUTSIDE of one's own context but other methods are possible (e.g., using anonymous data collection to encourage honest responses).

[18] All research activities place some degree of burden on the participants by asking the participants to share personal information, volunteer time, and assume risks.

[19] Examples of "new knowledge" include: effectively addressing a gap in the literature, generating new theory, enhancing understanding of a phenomenon, assessing effectiveness of a particular professional practice, addressing a local practical problem via data analysis.

	resiliency in cardiovascular disease patients.		
13. **Will[20] the research partner organization(s) grant permission[21] for all relevant data[22] access, access to participants, facility use, and/or use of personnel time for research purposes?** IRB staff will advise which type of partner agreement is needed, if any. State whether you will be obtaining written partner organization approval before or after Walden IRB approval.	***N/A. No partner organization for this study.***	**Your Form A refers to recruiting via the Walden Participant Pool, but that is not described in this self-check form. It is thus unknown whether this is still a recruitment method you intend to use. Please clarify and revise as needed, noting that if any revisions are needed to your Form A, you can use the attached document.**	**Form A has been revised and the Walden Participant Pool has been removed.**
14. **Is participant recruitment coordinated in a manner that is non-coercive[23]?** Describe. Coercive elements include: leveraging an existing relationship to "encourage" participation, recruiting in a **group[24]** setting, extravagant compensation, recruiting individuals in a **school/work[25]** setting, involving a service **provider[26]** in the recruitment process, etc. A researcher must disclose here whether/how the researcher may already be known to the participants and explain how	***Yes. Supporting Details: Participants will respond to a recruitment flyer on their own volition. Participants will not be known to the researcher. The study is voluntary in nature. A "thank you" gift of $25 will be emailed to the participants and is based on i: the recommendation of the Walden University IRB recruitment video and ii: the preset amount available by the company "Vanilla Visa Gift Cards" that allows emailed Visa gift cards to be sent.***	**You are the sole researcher for this study, please do not use the term 'we' on the flyer.** **Also, it would be useful if you added that you are conducting this study for your Walden dissertation.**	**The term 'we' has been removed from the flyer and replaced with "I am".** **"This study is being conducted for a Walden University dissertation" has been added to the recruitment flyer.**

[20] If a partner organization requires the researcher to obtain Walden's IRB approval before they can provide their written approval, that's fine. (Walden can issue a "conditional IRB approval" letter to the researcher and then Walden's IRB approval will then be finalized once the Walden IRB receives the partner organization's letter of cooperation.)

[21] No Letter of Cooperation is required (a) if the researcher will simply be asking organizations to distribute research invitations on the researcher's behalf, or (b) if the researcher is using only public means to identify/contact participants.

[22] Note that when medical, educational, or any type of operational records would be analyzed or used to identify potential research participants, the partner organization needs to explicitly approve access to data for research purposes (even if the researcher normally has access to that data to perform their job).

[23] For example, anonymous surveys and/or low-pressure communications such as email invitations permit potential participants to opt out with minimal fear of retaliation or other negative consequences.

[24] It is not ethically acceptable to invite a "captive audience" to participate in research on the spot (i.e., to ask an entire class or a group of meeting attendees to complete a survey during their session). Such a dynamic would not provide sufficient privacy or respect for their right to decline research participation. However, a researcher may use the last few minutes of a class session or meeting to introduce a study and distribute materials, such that the potential participants can then take their time to decide later about participation.

[25] Generally, data collection cannot be approved during work hours or school hours unless a "free period" has been identified (e.g., break, study hall) so the research activities can be separated from the participants' regular activities. It is important to maintain an "opt in" dynamic rather than implying that employees/students/group members are expected to participate.

[26] A researcher can ask a service provider (nurse, physician, therapist, etc.) or an aid provider (shelter staff) to give research invitations to clients who meet the inclusion criteria. However, we cannot approve for the service/aid provider to answer questions about the study, obtain consent, or collect data (unless the data is being collected by the organization itself for purposes other than the study).

perceptions of coerced research participation will be **minimized**[27].			
15. If you were directed to complete Form D in order to specifically recruit certain **vulnerable individuals**[28] as participants, answer the following question: **Is targeting this population justified**[29] **by a research design that will specifically benefit that vulnerable group at large?** Describe why. If you were not directed to complete Form D, enter NA.	***N/A***	**N/A**	
16. All samples could potentially include adults who are **vulnerable**[30] (without the researcher's awareness) and it is important to include their perspectives. **Would the benefits of including these individuals outweigh the risks?**	***No. The benefits of inclusion will not outweigh the risks and I will not recruit vulnerable popultations.***	**No, the response to the left is not accurate and is actually the opposite of what is described in the presented ethical standard.** **Please carefully review the ethical standard in the far left column, as it is important to include the perspectives of all potential participants. Whether individuals belong to vulnerable populations would have no bearing on their ability to be interviewed if they otherwise meet the inclusion criteria. They would deserve to**	**Yes.** **Supporting details: Screening for vulnerable populations would be overly invasive and exclusion criteria of vulnerable populations will be removed.**

[27] Doctoral research directly benefits the student (allowing him or her to obtain a degree), and so the researcher should minimize the potential for either (a) conflict of interest or (b) perceived coercion to participate. Researchers who are in positions of authority or familiarity must take extra precautions to ensure that potential participants are not pressured to take part in their study.

EXAMPLES:

- A professor researcher may recruit her students AFTER grades have been assigned.
- A psychologist researcher may recruit clients from ANOTHER psychologist's practice.
- A manager researcher may conduct ANONYMOUS data collection so that subordinates do not perceive their responses or [non]participation as being associated with their job standing.

[28] For this purpose, vulnerable individuals include children, prisoners, people with cognitive impairments, on-duty military personnel, people living in an institutional setting such as a prison, inpatient care, rehab center, or shelter.

[29] Convenience sampling is not approvable. Targeted recruitment of children as participants can only be approved when a majority of the IRB votes that the study's benefits justify its risks/costs (such as disruption to instructional time). For recruitment of adult vulnerable populations, IRB staff will determine on a case-by-case basis whether approval must be issued via the full board's vote (as opposed to expedited ethics review).

[30] It is ethically appropriate to include certain vulnerable adult populations if screening for that particular status would be overly invasive, given the research topic. For example, a researcher might unknowingly have participants who happen to be pregnant, residents of a facility, low-income, mentally/emotionally disabled, victims of a crisis, or elderly. We don't expect researchers to screen for these statuses routinely for minimal risk research. However, minors may never be unknowingly recruited; adult recruitment procedures must deliberately avoid recruiting minors and/or include a reliable way of discerning that participants are 18 or older.

		have their voices heard as well. You have no ethical justification to ascertain this information about participants nor to exclude them because of it.	
17. **If anyone would be excluded from participating, is their exclusion justified?** Is their exclusion handled respectfully and without **stigma**[31]? Describe.	***Yes. Supporting Details: Inclusion and exclusion criteria for vulnerable populations will be provided to the participants, who will self-report their adherence to the criteria. No invasive screening will take place.***	**No, you have no ethical justification to ascertain whether individuals belong to vulnerable populations nor to exclude them because of it.**	**No. Vulnerable populations will not be excluded from this study and language excluding such populations has been removed.**
18. **If the research procedures might reveal criminal activity or child/elder abuse that necessitates**[32] **reporting, are there suitable procedures in place for managing this?** Describe.	***Yes. Supporting Details: The researcher is not a mandated reporter and will contact the Walden University IRB if any concerns arise.***	**The IRB would not be in a position to address any mandating reporting responsibilities you may have, as this is dependent on state law.**	**State law confirms that the researcher is not a mandated reported and IRB will not be contacted regarding questions related to state law.**
19. **If the research procedures might reveal or create an acute psychological state that necessitates referral, are there suitable procedures**[33] **in place to manage this?** Describe.	***No. Supporting Details: The study is not expected to involve more than minimal psychological stress.***	**N/A**	
20. **If the research design has multiple groups, are measures in place to ensure that all participants can potentially benefit equally**[34] **from the research?** Describe how.	***Yes. All participants will have equal access to the study results.***	**This ethical standard is not applicable to your study.**	**N/A**

[31] When a study has exclusion criteria, they should be listed upfront in the recruitment material (flyer, invitation email,etc.) or consent form to prevent situations in which the researcher rejects volunteers in a stigmatizing manner.

[32] Typically, researchers only break confidentiality when they are LEGALLY REQUIRED to report certain information to authorities. Mandated reporting requirements in the USA vary by state so researchers will need to make themselves aware of state requirements. (Typically, mandated reporting only applies to researchers in professions that involve a sworn oath such as police officers or professions with licensure requirements, such as teachers and some other care providers.) Outside of mandated reporting, researchers are expected to maintain confidentiality. Any professional limits to confidentiality (i.e., duty to report) must be mentioned in the consent form.

[33] At minimum, the consent form should describe a free or low-cost referral to a support resource when it is possible that the study activities may cause distress.

[34] Control groups must be eligible to partake in the intervention after the study, if results show the intervention to be beneficial. If the design does not involve a control group, then the researcher only needs to ensure that all participants have equal access to the study results.

21. Applicable for all student researchers: **Will this researcher be appropriately qualified[35] and supervised[36] in all data collection procedures?** Describe **how[37]**.	***Yes. Supporting Details:*** ***The student has completed all required qualitative research classes through Walden University including: RSCH 8100- Research Theory, Design, and Methods, PSYC 8703-Ethics and Standards of Psychology, RSCH 8310-Qualitative Research and Analysis.*** ***The student has also completed: The National Institute of Health web-based training course "Protecting Human Participants" on 4/3/2016. Certificate Number: 2045191*** ***Collaborative Institutional Training Initiative (CITI) Doctoral Student Researcher's Course completed on May 23, 2021. Record ID: 41593478***	**Supervision will be provided by your committee chair.**	**Yes. Supervision will be provided by my committee chair.**
22. **If an existing survey or other data collection tool will be used, has the researcher appropriately complied with the requirements[38] for legal**	***N/A***	**N/A**	

[35]Researchers must be able to document their training in the data collection techniques and the IRB might require the researcher to obtain additional training prior to ethics approval. For most student researchers, the research course sequence is sufficient but some research procedures (such as interviewing people with mental disabilities) may require additional training. For psychological assessments, the manual indicates specific qualifications required. Data collection from children requires a background check/clearance through a local agency.

[36] Remote supervision is suitable for most studies but onsite supervision may be required for certain types of sensitive data collection (e.g., interviews or assessment regarding emotional topics).

[37]If your study is targeting a vulnerable population or involves a sensitive topic, describe any additional training or experience beyond the research courses and ethics training you have completed.

[38]IF YOU ARE USING A PUBLISHED INSTRUMENT: Many assessment instruments published in journals can be used in research as long as commercial gain is not sought and proper credit is given to the original source (United States Code, 17USC107). However, publication of an assessment tool's results in a journal does not necessarily indicate that the tool is in the public domain. The copyright holder of each assessment determines whether permission and payment are necessary for use of that assessment tool. Note that the copyright holder could be either the publisher or the author or another entity (such as the Myers and Briggs Foundation, which holds the copyright to the popular Myers-Briggs personality assessment). The researcher is responsible for identifying and contacting the copyright holder to determine which of the following are required for legal usage of the instrument: purchasing legal copies, purchasing a manual, purchasing scoring tools, obtaining written permission, obtaining explicit permission to reproduce the instrument in the dissertation, or simply confirming that the tool is public domain and providing credit by citation. **Even for public domain instruments, Walden University encourages students to provide the professional courtesy of notifying the primary author of the student's plan to use that tool in their own research.** Sometimes this is not possible or there is no response. We recommend that the student make at least three attempts to contact the author at his or her most recently listed institution across a reasonable time period (such as 2 weeks). The author often provides helpful updates or usage tips and asks to receive a copy of the results. This type of communication with the author is not necessary when a website or publisher clearly states that the tool is public domain or can be used for academic/research purposes. Some psychological assessments are restricted for use only by suitably qualified individuals and these requirements are typically covered in the assessment's manual. When in doubt, researchers must check with the assessment's publisher to make sure that the student (or their faculty supervisor) is qualified to administer and interpret any particular assessments that they wish to use.

usage? Describe how and submit relevant documentation.			
Questions 23-40 pertain to the process of ensuring that potential participants make an informed decision about the study, in accordance with the ethical principle of "respect for persons."			
23. **Do the informed consent[39] procedures provide adequate time to review the study information and ask questions before giving consent?**	***Yes. Participants are emailed informed consent and will be able to provide consent at their convenience.***	**Confirmed**	
24. **Will informed consent be appropriately[40] documented?**	***Yes. Informed consent will be emailed to participants and participants will respond via email with "I consent".***	**Confirmed**	
25. **Has the** consent form template **been tailored using language that will be understandable[41] to the potential participants?**	***Yes. The consent form has been written in plain language and based on the consent form provided by Walden University IRB, and participants will be English speakers.***	**There are various grammatical errors that need to be resolved.**	**Grammatical errors have been resolved.**
26. **Does the consent form explain the sample's inclusion criteria in such a way that the participants can understand why THEY are being asked to participate?**	***Yes. The consent form explicitly lists inclusion and exclusion criteria to which participants will self-identify.***	**Please remove the following bullet as it is not appropriate and you have no ethical justification to exclude individuals based on these conditions:** • must **not** be a pregnant woman, physically or emotionally disabled, hospitalized, incarcerated, under community supervision for a crime, or an elderly person	**Exclusion criteria has been removed.**

IF YOU ARE CREATING YOUR OWN INSTRUMENT OR MODIFYING AN EXISTING INSTRUMENT: It is only acceptable to modify data collection tools if one explicitly cites the original work and details the precise nature of the revisions. Note that even slight modifications to items or instructions threaten the reliability and validity of the tool and make comparisons to other research findings difficult, if not impossible.

[39]Informed consent is not just a form; it is a process of explaining the study to the participant and encouraging questions before the participant makes a decision about participation. The IRB website provides an informed consent form template that researchers are invited (but not required) to use.

[40] While documenting consent via signature is common, note that anonymous surveys can obtain "implied consent" by informing the participant, "To protect your privacy, no consent signature is requested. Instead, you may indicate your consent by clicking here/returning this survey in the enclosed envelope.") See posted sample consent form for email options.

[41] Walden encourages tailoring the language to the readers as long as a professional tone is maintained. For the general population in the USA, aim for grade 5 to 7 reading level.

		under assisted care.	
27. **Does the consent form include an understandable explanation of the research purpose?**	***Yes. The consent form makes the following statements:*** ***The purpose of this study is to explore the lived experience of adult cardiovascular disease patients, living in the United States of America and how the doctor-patient relationship may facilitate resilience in cardiovascular disease patients.***	**Confirmed**	
28. **Does the consent form include an understandable description of the data collection procedures?**	***Yes. The consent form states: This study will involve you completing the following steps:*** • ***Take part in a confidential, audio recorded interview (phone option available) (1 hour).*** • ***Take part in a confidential, audio recorded follow-up interview if necessary (phone options available (30 minutes).***	**It is not accurate to state you have provided sample questions when you have really provided all of your interview questions.**	**All interview questions, with the exception of three sample questions, have been removed.**
29. **Does the consent form include an estimate of the time commitment[42] for participation?**	***Yes. The consent form estimates the interview to take 1 hour and a potential follow-up interview to take 30 minutes.***	**Confirmed**	
30. **Does the consent form clearly state that participation is voluntary and that the participant has the right to decline or stop participation at any time?** When recruitment occurs through the researcher's network or through an organization, the consent form must include written assurance that declining or stopping will not negatively impact the participant's relationship with the researcher or access to services provided by the organization, as applicable).	***Yes. The consent form states: Research should only be done with those who freely volunteer. So everyone involved will respect your decision to join or not. If you decide to join the study now, you can still change your mind later. You may stop at any time. Please note that not all volunteers will be contacted to take part."***	**Confirmed**	

[42] Provide an estimate (in minutes or hours) of each component of data collection (e.g., survey, interview, memberchecking. etc.)

31. **Does the consent form state how many participants the researcher is seeking?**	***Yes. The consent form states that the researcher is seeking 8-10 participants.***	**Confirmed**	
32. **Does the consent form include a description of reasonably foreseeable risks[43] or discomforts?**	***Yes. The consent form states: Risks and Benefits of Being in the Study: Being in this study could involve some risk of the minor discomforts that can be encountered in daily life such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your wellbeing.***	**Confirmed**	
33. **Does the consent form include a description of anticipated benefits to participants[44] and/or society?**	***Yes. The consent form states: This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by expanding knowledge in the field of psychology. Once the analysis is complete, the researcher will share the overall results by e-mailing a scholarworks link to the study to participants who have requested the results.***	**Confirmed**	
34. **Does the consent form describe any thank you gifts[45], compensation, or reimbursement (for travel costs, etc.) or lack thereof?**	***Yes. The consent form states: Payment: The researcher will email a $25 Visa gift card to the first 20 volunteers once they complete the interview.***	**Confirmed**	
35. **Does the consent form describe how privacy will be maintained[46] and state that that the data will not be used for any purposes other than research?** For this item, we strongly recommend using the	***Yes. Consent form states: Privacy: The researcher is required to protect your privacy. Your identity will be kept confidential, within the limits of the law. The researcher will not ask for your name at any time or link your***	**Please remove the following sentence as it is not accurate:** The researcher will not ask for your name at any time or link your responses to your contact info.	**Both of these sentences have been removed from the document.**

[43] The consent form should state that the minimal risks are similar to those encountered in daily life, in addition to describing any risks that are substantial.
[44] For most social science studies, it is appropriate to state that there are no particular direct benefits to the individual. In this case, just present the benefits to society and/or benefits to the group to which the participant belongs (i.e., teachers).
[45] Offering a modest gift card (between $5 and $20) is common for interview studies and questionnaires that are not anonymous. Note that raffles are not permitted.
[46] The consent form should explain any coding system that will permit the researcher to not use names in the research report; how names,contact info, and research data will be secured and eventually destroyed; and that the data will not be used for any purposes other than research. It is not always clear to participants how a research interview is different from a journalistic interview, in which informants might be named. So the consent form should make this distinction clear. For sensitive interviews, the researcher might also want to assure participants that recordings will be destroyed immediately after transcription.

language in Walden's consent form template.	***responses to your contact info. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining informed consent. Data will be kept secure by being password protected or stored in locked compartments, only to be accesses by the researcher. The audiotaped discussion parts of the session will be transcribed, and all identifying information will be removed. Final data that is reported will be drawn from the transcriptions without identifiers. Audiotapes will be destroyed immediately after they are transcribed.*** ***Data will be kept for a period of at least 5 years, as required by the university.***	**Please also remove the following sentence as it is not compliant with Walden's requirement that all data (including recordings) be retained for at least 5 years:** Audiotapes will be destroyed immediately after they are transcribed.	
36. **Does the consent form disclose all potential[47] conflicts of interest?**	***N/A***	**Confirmed**	
37. **Does the consent document preserve the participant's legal[48] rights?**	***Yes. Supporting details:*** ***The consent form does not include any language asking participants to waive rights and is based on the Walden University consent form.***	**Confirmed**	
38. **Does the consent form explain how the participant can contact the researcher (for general questions about the study) and the university's Research Participant Advocate (if they have questions about their rights as participants)?** Contact info	***Yes. Consent form states:*** ***Contacts and Questions:*** ***You can ask questions of the researcher by email at sanam.sarahbi@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at***	**Confirmed**	

[47] Only applicable if the researcher has a dual role in relation to the participant (i.e., is known to the participant as a teacher, nurse, or similar professional role).
[48] In some settings, consent forms include exculpatory language and/or ask the signer to waive rights. Walden does not permit that. The Walden consent form template does not ask participants to waive any rights.

is 612-312-1210 or irb@mail.waldenu.edu). Provide international code if outside the USA.	***612-312-1210. Walden University's approval number for this study is IRB will enter approval number here. It expires on IRB will enter expiration date.***		
39. **Does the consent form include a statement that the participant should consider keeping a copy of the consent form?**	***Yes. Consent form states: You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.***	**Confirmed**	
40. **If any aspect of the study is experimental (unproven), is that stated in the consent form?**	***N/A***	**N/A**	

General comments from the IRB reviewer(s) that might not be directly related to research ethics:
(Note: the comments above are offered collegially in the interest of promoting top quality research, and are NOT stipulations for IRB app

SECTION II: RESEARCHER'S ELECTRONIC SIGNATURE By placing an X next to each of the following boxes and submitting this document from my official Walden email address, I (the research statements below is true.	
X	The information provided in this application form is correct, and was completed after reading all relevant instructions.
X	I understand that I am requesting the university's ethics approval to conduct the exact procedures described above. I understand t ensuring that this form fully reflects the final set of procedures.
X	I understand that any deviation from the participant recruitment and data collection procedures referenced in this form can result
X	I will request IRB approval before making any modification to the participant recruitment and data collection procedures or form Web site.
X	I will report any unexpected or otherwise significant adverse events and general problems within one week using the Adverse Ev
X	Neither recruitment nor data collection will be initiated until notification of approval to conduct research is received from IRB@
X	I understand that this research, once approved, is subject to continuing review and approval by the Committee Chair and the IRB
X	I will maintain complete and accurate records of all research activities (including consent forms and collected data, as per the Do student handbook) and I will be prepared to submit them upon request to the IRB.
X	I understand that if any of the conditions above are not met, this research could be suspended and/or not recognized by Walden U
X	I understand that my data and research activities are subject to audit at any time by the university's compliance office within the
X	I have conducted my own inquiries to ensure that I am aware of any applicable state or international regulations that might apply protection of minors or other vulnerable populations). *Note to researcher: State-level professional organizations and licensing entities for your field are a good source of this informat found at this link:* http://www.hhs.gov/ohrp/international/intlcompilation/intlcompilation.html
To electronically* sign this document, the researcher must enter his or her official Walden email address below and send the materials fro	
Sanam.sarahbi@waldenu.edu	
Please enter the title of the study:	
Exploring the Phenomenology of How the Doctor-Patient Relationship Plays a Role in Cardiovascular Disease Patient Resiliency	

Students must also provide their student number:
A00175198

SECTION III: SUPERVISING FACULTY MEMBER ELECTRONIC SIGNATURE	
As the faculty member supervising this research, I assume responsibility for ensuring that the student complies with University requireme in research. By placing an X in each of these boxes and asking the student to CC my official Walden email address when submitting this the statements below is true.	
kmm	I have reviewed the researcher's entries on this form as well as the supporting documents (e.g., consent form) and I confirm tha
kmm	I will ensure that the researcher properly requests any protocol changes using the Request for Change in Procedures Form on th
kmm	I will ensure that the student promptly reports any unexpected or otherwise significant adverse events and general problems wit Web site.
kmm	I will report any noncompliance on the part of the researcher by emailing notification to IRB@mail.waldenu.edu.
To electronically* sign this document, the supervising faculty member must enter his or her official Walden email address below and ther materials from his/her Walden account. A faculty member should notify IRB@mail.waldenu.edu if a student submits any documents that	
Kimberly.mccann@mail.waldenu.edu - Kimberly McCann, PhD	

***IRB Policy on Electronic Signatures**

Electronic signatures are only accepted when the signer is either (a) the sender of the email, or (b) copied on the email containing the signed document. Electronic signatures are regulated by the Uniform Electronic Transactions Act.