

Omu, O., & Reynolds, F. (2012). Health professionals' perceptions of cultural influences on stroke experiences and rehabilitation in Kuwait. *Disability and Rehabilitation*, 34(2), 119-127.

Abstract

Purpose:- The aim of this study was to investigate the perceptions of health professionals who treat stroke patients in Kuwait regarding cultural influences on the experience of stroke and rehabilitation in Kuwait. Health professionals interviewed were from a variety of cultural backgrounds thus providing an opportunity to investigate how they perceived the influence of culture on stroke recovery and rehabilitation in Kuwait.

Method:- Semi-structured interviews were carried out with 12 health professionals with current/ recent stroke rehabilitation experience in Kuwait, followed by thematic analysis of the verbatim transcripts.

Results:- The health professionals identified several features of the Kuwaiti culture that they believed affected the experiences of stroke patients. These were religious beliefs, family involvement, limited education and public information about stroke, prevailing negative attitudes towards stroke, access to finances for private treatment, social stigma and the public invisibility of disabled people, difficulties identifying meaningful goals for rehabilitation, and an acceptance of dependency linked with the widespread presence of maids and other paid assistants in most Kuwaiti homes.

Conclusion:- To offer culturally sensitive care, these issues should be taken into account during the rehabilitation of Kuwaiti stroke patients in their home country and elsewhere.

Introduction

It is thought that individuals interpret ill-health and disability through cultural 'lenses' (Gard et al, 2005). Culture has been defined as: "a tradition of knowledge and practice that is shared, albeit imperfectly, across the members of a society and across its generations" (Zou, et al 2009: 579). It shapes people's experiences and their emotional reactions (Gard et al 2005), including their understandings of what it means to be healthy, the meanings of symptoms, attitudes towards disability and treatment, and coping strategies (Dean et al 2006; Gallaher and Hough, 2001).

The study reported here offers new insights by exploring how culture shapes the experience of stroke and stroke rehabilitation through the perceptions of health professionals working in the Arabic state of Kuwait. Kuwait is one of the wealthiest countries in the world, with a per capita income of around \$54,000 (UNdata, 2011). In common with other Arabian Gulf States, the culture reveals the modernising influences associated with oil exploration and technological advances whilst preserving collective traditions (Al-Krenawi & Graham 2000; Dean et al 2006; Gallagher and Stratton 2001). The state provides extensive financial support for its own citizens including generous pensions and access to healthcare. However, in common with other Gulf states, the majority of the population are migrant or expatriate workers (Shah et al, 1990; 7Gallagher and Stratton 2001), requiring insurance to access healthcare. Nearly all of the indigenous Kuwaiti population are Muslim, and since 1981, citizenship has been restricted to those of this faith (Kuwait, 2011). The Islamic faith plays a central role in government legislation and everyday life. This is a unique culture, as in Kuwait, strong commitment to the Muslim religion, collective values, and generous financial support to purchase rehabilitation services abroad, may result in an experience of stroke and rehabilitation that is different from that reported in other parts of the world. Despite the

distinctiveness of the Kuwaiti culture, the findings may be regarded as not only relevant to health professionals in Kuwait, but to those who work in multi-cultural contexts in the UK, the US and elsewhere, contributing to cultural sensitivity and competence.

Physiotherapists and other health professionals require not only cultural sensitivity (the capacity to recognise and care about cultural differences) but cultural competency, which is “the ability to honor, understand, and respect the beliefs, lifestyles, attitudes and behaviors demonstrated by diverse groups of people, and to diligently act on that understanding” (Coyne, 2001; p45). Culturally competent care invites maximal cooperation with patients and their family members with the aim of promoting better outcomes (Niemeier & Arango-Lasprilla 2007; Balcazar et al 2010).

There is some evidence that culture influences how individuals report experiences of illness and injury, how their families react and provide support, and the patterns of interaction among individuals, family members and health professions. In cultures where there is an emphasis on collective obligations rather than individual rights and autonomy, families have a greater involvement in the lives of disabled people. This increases support, but also has the potential of raising levels of tension and conflict (Haggstrum 1995; Simpson, Mohr and Redman, 2000). Although stigma is a common experience among disabled people living in Western cultures, this may be even more marked in certain non-Western cultures. For example, Vietnamese people living in Australia were found to judge that a relative affected by traumatic brain injury brought shame on the whole family (Simpson, Mohr and Redman, 2000). Japanese families expressed more embarrassment in relation to family members with a traumatic brain injury than British families (Watanabe et al 2001). In Arabic countries, conditions that affect mental functioning are readily stigmatised (Dean et al 2006; Endrawes et al 2007).

Cultures also influence understandings of rehabilitation. For example, Matheson (2009) observed that Angolans may not fully engage with stroke rehabilitation, associated with non-Western cultural beliefs about the body and its functioning, a collective ethos in which families tend to take decisions rather than individual patients, an acceptance of an authoritarian rather than patient-centred practice of medicine, and sometimes distrust and misunderstanding of Western medicine. As a physiotherapist, she suggested that these cultural differences pose challenges to culturally competent stroke rehabilitation.

Religious beliefs and rituals form part of culture, and influence the ways in which people cope with adversity, such as illness and disability. Positive support may be derived when God and religious figures are seen as benevolent (Pargament, Koenig, Tarakeshwar, & Hahn, 2001). Differences have been noted in the reported coping strategies of Muslim, Christian and other religious groups in the UK in relation to mental distress, with Muslims more likely to regard religious coping as helpful (Loewenthal and Cinnirella, 1999; Loewenthal, Cinnirella, Evdoka, & Murphy, 2001; Bhui et al 2008). In Iran, disabled Muslim war veterans who endorsed more positive religious coping reported better mental health and less post-traumatic stress disorder (Aflakseir & Coleman 2009).

Little is known about the ways in which cultural differences in religious beliefs and practices influence the experience of stroke and stroke rehabilitation. The stroke experience has largely been studied in Western countries, with predominantly Christian or secular belief systems. The practice of rehabilitation is understood to incorporate taken-for-granted Western assumptions that people value autonomy, active engagement and independence (Cardol et al 2002; Norris & Allotey 2008). Stroke rehabilitation is not necessarily viewed as culturally appropriate outside of these belief systems, as shown by the negative views of carers from the Indian Muslim community in South Africa (Bham & Ross 2005), and the non-attendance of

Angolan out-patients (Matheson 2009). In Kuwait, stroke rehabilitation (in line with other forms of treatment and therapy) is provided by both Kuwaiti and expatriate therapists and nurses. There has been no previous research into its cultural appropriateness and acceptability.

Study Aim

The aim of this study was to explore health professionals' perceptions of the influence of culture on patients' experience of stroke and stroke rehabilitation in Kuwait.

Method

Design: Qualitative methods are particularly appropriate for understanding complex experiences that are under-researched and not easily quantifiable (Mason 2002). Like Dressler and Pils (2009), this study explored cultural issues through the perspectives of health professionals. Single semi-structured interviews were conducted with health professionals with current experience of working in stroke rehabilitation in Kuwait.

Recruitment: Participants were recruited through the technique of snowballing, a method of sampling that is considered adequate when there is no clear sampling route or frame (Mason, 2002). The first author was a physiotherapist who had worked for several years in stroke rehabilitation in Kuwait. As a person from an ethnic minority migrant background, who had received her physiotherapy training in Kuwait, she experienced the advantage of being both an 'insider' and 'outsider' in cultural terms. Following management permission, health professionals working at a local rehabilitation centre were informed about the study verbally, and were given full written information (including the main interview questions) if interested in participating. They gave written consent. Some participants informed other colleagues who were sent information and consent forms if interested.

Sample: Twelve health professionals were recruited, comprising seven physical therapists, three nurses, one occupational therapist and one speech and language therapist. All had more than one year's experience working in neurological rehabilitation in Kuwait. Sample features can be viewed in Table 1. The participants disclosed a wide variety of national, religious and ethnic backgrounds, which was considered an advantage for considering the complex culture of Kuwait. The high proportion of expatriates in this sample of health professionals broadly reflects the national pattern (Al-Jarallah et al 2009).

Procedure: Semi-structured interviews allow for flexible responses to the interviewees' explanations and understandings. The interviews took place in a quiet room at the local rehabilitation centre or at a suitable public location (for anyone working outside of the centre). Interviews were conducted in English and took 45 minutes to one hour, and were audio-recorded. The main questions/ topic were as follows:

- a) In your experience, what are the most significant challenges faced by stroke patients in Kuwait (exploring physical/ functional, psychological and social changes)
- b) How have you addressed psychosocial issues during stroke rehabilitation?
- c) In your experience, does culture have any influence on the stroke experience and rehabilitation process in Kuwait (if so, why and how?)

Ethics: The project received ethical approval from the host university. All participants were informed of their right to withdraw at any time, and that all interviews would be audio-recorded and confidential. Pseudonyms have been used to preserve confidentiality.

Data Analysis: Thematic analysis was used to identify recurring issues within the accounts (Braun and Clarke, 2006). Trustworthiness was established through strategies such as keeping an audit trail of coding decisions, having the second author independently analyse a subset of transcripts, and making use of a reflective account.

Findings

The participants found the question about cultural influences very meaningful. They focused largely on the Kuwaiti experience rather than the experiences of migrants to Kuwait, which were judged far more variable (linked with having much lower incomes and endorsing a wide range of cultural beliefs and religious faiths).

The following themes were identified:

1. Religious beliefs
2. Family involvement
3. Limited education and public information about stroke
4. Prevailing negative attitudes towards stroke
5. Access to finances for private treatment
6. Social stigma and the public invisibility of disabled people
7. Difficulties identifying meaningful goals for rehabilitation
8. Acceptance of dependency linked with the widespread presence of maids

Religious beliefs

Commitment to the Muslim religion was considered to be an important aspect of most Kuwaiti people's lives, with profound effects on the experience of stroke and rehabilitation. Participants regarded Kuwaiti patients as placing more responsibility on God than patients in some other cultures in which they had worked.

“Yeah, in some ways, there is more responsibility to God here than there is at home. ... I mean they [believe they are] are going to recover or not, Insha'Allah. ...if there is that sense of, God dictates everything so much so that I don't even have to try, or that nothing I do is going to matter, then there could be a bit of a more lax approach to the therapy whereas in North America most people would feel like God helps those who help themselves kind of an attitude.” (Matt, Canadian physiotherapist)

Matt connected Kuwaiti patients' strong religious belief, and preparedness to surrender control to God, to demonstrating limited responsibility for progress in rehabilitation. Western patients were thought to be more willing to take an active role in rehabilitation. Fatalism among patients in Kuwait, associated with religious belief, was also described by a Canadian physiotherapist:

“Because [they think] “life is meant to be this way so why should I aspire to anything else” ... “God wanted it this way so I don't have to do it”. So therapy is a huge deal for some of these people, to actually work toward the goal, so that's the different way of life.” (Andrea, Canadian)

Another participant explained how therapy might be difficult for some patients due to the belief that their disability is God's will for them, the stroke being seen as a challenge sent by God.

“Some people say that it's not like a punishment, but it's the challenge for you. This is some sort of challenge for you from God and then that's how you take it.” (Helen, Malaysian)

Religion was deemed to be an important factor influencing the experience of stroke and rehabilitation in Kuwait, according to both the foreign and Kuwaiti health professionals, influencing the meanings of stroke, fatalism and surrender. Some of these beliefs were thought to influence engagement in rehabilitation in positive ways (e.g. seeing stroke as a challenge sent from God) but others discouraged active engagement in rehabilitation. This issue will be returned to in a connected theme below.

Family Involvement

Family involvement was described by all participants as highly characteristic of Kuwaiti culture. Extended family is practised in Kuwait with children, parents, grandparents and in-

laws typically living in the same house. A North American occupational therapist described this issue in largely positive terms:

“The family is around them and very often they live in a household with extended family. So they don’t feel estranged from the family because they are not in a separate location and getting to the family or having the family come to them is not an issue. So in the Kuwaiti culture I actually see that very much as positive that they have extended family, not only very often right in the same household but they are for support and they are for interaction ... it’s part of their daily life motivation.” (Katie, American)

The advantages of family support and encouragement were described by other participants, such as Aylne, a nurse originally from the Philippines.

“They practise extended family, you know, they are supportive with one another, I guess, as we have seen them coming in and they are always there beside them [the patients], and yeah, they are good family.” (Aylne, Philippines).

Another perceived advantage of having family support was that it could aid in carry-over of therapy gains:

“Really the support of the family, especially daughters or the son being there for their parents, is a blessing and it really affect the parents....So if that daughter believes in what you are doing, its importance for her mother, she will go back and tell her, “no mom, you have to cycle, no mom we have to walk, no mom we have to do this sit-to-stand 20 times a day” so she will do it. But imagine if that person didn’t believe in this, who will encourage like this? **You** have to do it”. (Khadeja, Kuwaiti)

This participant highlighted the importance of family members to *believe* in the therapist and the programme prescribed, as otherwise there would be no commitment to engage in the activities suggested outside of the structured therapy times. Despite these various advantages, the close involvement of the extended family was also thought to pose difficulties, such as slowing down progress by helping stroke patients too much and removing the opportunity and motivation to learn:

“In Kuwaiti culture, the family get involved too much and they sometime restrict the therapy, sometimes you teach the client to do something and the family are like “...no that’s wrong”. They get involved like too much, and support is good but if it’s more than normal - it’s not good for the patient because he will become totally dependent.”
(Ahmed, Kuwaiti)

Ahmed emphasised that family involvement can infantilise the patient and discourage independence. A similar idea about the dangers of helping too much was expressed by Matt, a Canadian physiotherapist:

“Occasionally people will overprotect after an injury in general, certainly with the stroke there is a scenario where often people will want help too much. For example with getting a cup to drink from and just like with the child we can often do everything for them. So if they don’t spill or something that looks easier for them, but then by doing so you are never giving them the opportunity to practise or the opportunity to learn something.” (Matt, Canadian)

Perceptions of extended family involvement were mostly positive. Extended families were perceived as being a source of support, encouragement and motivation. The disadvantages primarily related to over-helping the patient hence increasing their dependency, although some physiotherapists also mentioned that they had experienced a lack of respect from

families when they worked in the community. Perceptions about family involvement were shared amongst the various culturally diverse health professionals who participated.

Limited education and public information about stroke

Both Kuwaiti and Non Kuwaiti health professionals perceived that lack of public education about stroke influenced the stroke experience in Kuwait. People tended to interpret any cognitive or language deficits following stroke as signs of mental illness, and these brought alarm and shame to families. Ahmed, for example, commented:

“Because some of them [families] they are not well educated, they feel that if you get stroke and ...your cognition gets impaired, they think that he is psycho or crazy or something, so that’s why they hide them from others and they don’t want to do anything about it.” (Ahmed, Kuwait)

The participants linked the lack of public education about stroke and its associated problems, to families’ and patients’ tendency to withdraw from the public (a theme that will be further explored when stigma is discussed). Lack of education about stroke was also perceived to be the reason for the limited emphasis on rehabilitation in the wider society. The need for medical and nursing professionals was widely accepted in the Kuwaiti society but rehabilitation was deemed to be relatively unfamiliar.

“So I think particularly with the stroke patients it seems there is not a very great awareness for the need of rehabilitation, it almost seems like there is more of an acceptance of “We need the critical medical people, you have to nurse them back to health so that they can breathe and they can move and they are not sick”, but when it comes to the more physical functional aspects there doesn’t seem to be a great awareness or emphasis on that.” (Katie, American).

Some of the participants had encountered patients with unrealistic expectations of making a total recovery, especially young stroke patients. Some commented that conflicts existed between their own views of recovery, based largely on Western training courses, and those of patients who believe that money can *buy* recovery.

“You get some of these younger stroke [patients] who say well I would finance you, everything is going to be okay and I am going to be a 100% again and then [you are] sort of saying, well, you are not, because you plateau and so this is the most *we can get you to* and again it doesn’t matter if you have all the money in the world to access the equipment, this is all I can do for you, so making them realize their condition.”

(Andrea, Canadian)

A few participants linked limited public understanding of stroke with widespread misunderstandings about rehabilitation. For example, some patients believed that all they needed from therapy was massage. This could indicate expectations of having a passive rather than active involvement in rehabilitation.

“They are just lying on the bed and... will tell the physiotherapist to do some massage. Of course, massage is contraindicated, I feel so in stroke, but they want to do some massage for them, they want to feel relaxed.” (Smitha, Indian)

The need to educate and explain more to patients during the course of rehabilitation was identified as being important in Kuwait.

“I’m explaining more here to patients that I had to do at home, yeah, explaining more, convincing more.” (Anna, German)

Participants linked the lack of education about stroke and rehabilitation within Kuwaiti society to the limited public appreciation of rehabilitation services and, in some cases, patients' and families' unrealistic expectations about recovery.

Prevailing negative attitudes towards stroke

Linked with the perceived lack of education about stroke, participants also reported negative (fatalistic) attitudes regarding stroke amongst Kuwaiti stroke patients and their families. A common attitude was that the stroke survivor was sick and should remain at home and rest.

“It’s end of life over here... In the West, it’s kind of ... you can still get a pretty good quality of life. That’s how I see most of my patients in the West. Here, it’s like ‘Oh no, they are sick, they need to stay in bed’.....whereas when you see stroke as an event and actually we have this window of time where we want to really work and get her up in moving, you know, they ask, “Why does she have to be mobilized? She is so old, let her be”. (Andrea, Canadian)

An Indian physiotherapist considered that older patients are not familiar with the concept of taking responsibility for their rehabilitation:

“Only the young [patients] ...are really cooperative and they are doing their level best. But the people who are really very old, they are just lying on the bed and they would tell the nurse to do some work for them.” (Smitha, Indian)

Health professionals perceived that the prevailing attitude of many older Kuwaiti stroke patients was that stroke was the final end of life with no recovery possible. Such patients, at best, valued passive forms of treatment, and were perceived to have little motivation to engage actively. The participants also believed that there was a widespread notion among older patients that increased age meant that they were not obliged to work hard during

therapy, as they could accept a dependent role in the family. Some of the statements by the health professions could be regarded as prejudiced, implying that patients are to blame for their poor attitude to rehabilitation, however most understood that the whole social context is one that separates the sick from the well, and that reinforces the dependence of older people within the larger family.

Access to finances for private treatment

High levels of personal income and government support for indigenous Kuwaiti stroke patients were thought to help some patients to access better rehabilitation abroad, forming a distinctive feature of the culture:

“Yes everybody [Kuwaitis] goes abroad ... they immediately go to London and of course the government is helping them.” (Smitha, Indian)

A Kuwaiti therapist shared this view, contrasting the financial resources available to Kuwaiti patients and people of other nationalities living in Kuwait who were not so advantaged.

“Like I said, foreigners they usually come and stay alone or they have limited resources. But here in our country, between family and government supports paying for them, so many things are being done for them. But the foreigners, they have limited resources.” (Khadeja, Kuwaiti)

However, ready access to more expensive, perhaps better resourced, treatments was not thought to encourage patients and families to involve themselves actively in the process of rehabilitation.

Social stigma and the public invisibility of disabled people

Isolation due to social stigma associated with disability was expressed as another cultural influence on the stroke experience in Kuwait.

“For some, they become ashamed of the problem... like they want to hide it, they don’t want to tell anyone about... I don’t know, it’s a cultural thing.” (Ahmed, Kuwaiti)

“Just, you know, they had the stroke so they look different and some, they want to cut themselves off socially. It could be either way ... they want to cut themselves socially or they want to have everyone visit.” (Andrea, Canadian)

There is the indication from the above quotations that because of visible effects of the stroke, patients and families may feel ashamed and thus choose to hide the patient from public view. The stroke survivor is not necessarily isolated but is enveloped and hidden *within* the family.

In addition to social stigma associated with stroke disability, depression associated with stroke was also described as a socially undesirable topic.

“Assessing someone for depression or even suggesting depression is such a taboo topic.” (Andrea, Canadian)

Religious coping was thought to be used by many patients, and this also made the subject of depression unacceptable or culturally unfamiliar:

“No, I find, I can’t ask outright if they are depressed ... so I put it into different terms. Have you thought about the medical management? “Ah no, no, she’s got her faith, she prays, she reads the Koran, everything will be fine”. That’s how they deal with depression”. (Andrea, Canadian)

A Kuwaiti therapist mentioned that in Kuwait disabled people do not go out due to negative public reaction and lack of assistance to help them go outside.

“For example, suppose that you are a hemiplegic patient and you are not going [to the] community, not living in the community. If, for example, in our culture we are not seeing people with disabilities going through life, okay... nobody is willing to take care of him and because, you know, if he has to go to the market to buy something from the supermarket, he needs somebody with him.” (Mohammed, Kuwait)

Some implied that disabled people’s lack of visibility in the wider society limits public awareness of disability issues. Family members were thought to require a lot of encouragement to take the stroke survivor outdoors. A community therapist explained:

“The family here they want to hide mummy in the closet with all her care. They want the best care, but they don’t want to take her out. So even if we get the equipment, even if we get a custom wheelchair which is meant to go outside of the house, they need encouragement to do that. A lot of time they do come around, they take them in the garden, take her down the street ... so that’s huge for the patient”. (Andrea, Canadian)

Limited facilities for older and disabled people were thought to discourage social outings of stroke survivors.

“Many times, here we don’t, for example, [have] places where these elderly people with these kinds of disabilities like the stroke, where they are getting together and talking to each other. If they were talking to each other they can say, “Yes, yesterday I went to that place and I have done this, and the other person tell yes, yes” and they will talk to each other and they will push the patient and he will be more independent

in his life, even if the function, level of function is the same, but now he is coming to the community, he is living; he is enjoying his life with various aspects, but [instead he is] all the time in the house” (Mohammed, Kuwait)

In this quotation, the therapist described how a social facility like a stroke club would enable stroke survivors to share experiences and encourage each other. However, without this facility, stroke survivors stay at home. In addition to this, the therapist offered two other reasons for patients’ limited social outings, namely physiotherapists not practising mobilising in a real setting, and lack of preparation of the environment (e.g. lack of ramps and doors for wheel chairs) in both homes and public places.

“Other things [difficulties] could be related to the environment. Are we preparing the community, the environment, outside environment to receive these patients or not? ...If the environment was prepared for them, they can go.” (Mohammed, Kuwaiti)

Participants linked reduced social participation by stroke survivors to the social stigma of disability. In addition to this, limited public awareness, lack of facilities, lack of rehabilitation in real settings, and limited access to equipment and buildings were also mentioned.

Difficulties identifying meaningful goals for rehabilitation

Many participants made comparisons between stroke patients in Western countries and in Kuwait, perceiving the latter group as less likely to have personal goals for activities that they would like to achieve with rehabilitation.

“They don’t, and I am not talking only about the stroke patient ... they don’t have anything...[no] examples of goals: “I want to walk again, I want to go skiing, I want to travel, or I want to do this and that”. It’s very difficult to get something from them what they want to reach.” (Anna, German)

“So in that respect they don’t seem to be as bothered by not being able to, for example, cleaning their house or go shopping because there is someone to do that for them, whereas in the States, people do that for themselves for the most part. So many of their basic life needs are met by someone else, so there is not as deep or a compelling reason to be functional” (Katie, American)

In the above quotations, the therapists compared Kuwaiti patients with those in Germany or the US who seemed to be more eager to return to their leisure and self-care activities. In Kuwait, however due to the almost universal presence of maids, many patients appear to be content with an inability to function independently. The issue of dependency and presence of maids will be discussed in more detail in the next section. Several interviewees believed that their patients mostly had a restricted repertoire of activities, particularly concerning leisure.

“I think more people in my experience in the States, for example, seem to be more affected by their inability to participate in certain activities, whereas extracurricular activities here in Kuwait among locals do not seem to be high on their list of priorities.” (Katie, American)

Several participants perceived that there was greater acceptance of disability among stroke patients in Kuwait, leading to reduced motivation to reach goals and return to pre-stroke roles and activities:

“Technically, I would say that people are okay with some loss in Kuwait, easier [with it] than they would be in North America. Most people in North America will not quit until I can get this absolutely close to perfect as possible. Here there seems to be a ... greater contentment with some loss and being okay with that.” (Matt, Canadian)

Views about limited patient goals were mostly expressed by Western therapists from the US, Canada and Germany as a cultural difference that had to be acknowledged when working with patients in Kuwait. These therapists perceived that the drive to overcome disability did not appear to be as strong as they had experienced in their own country.

Acceptance of dependency linked with the widespread presence of maids

Dependency, linked not only with family involvement but with the near-universal presence of maids among indigenous Kuwaitis, was identified by both Kuwaiti and Non Kuwaiti health professionals as a cultural feature that affected the stroke experience of patients in Kuwait. The therapists thought that dependency in self-care and other activities was not viewed as a problem amongst native Kuwaitis. Familial duty of care, religious beliefs and collective values were thought to make independence less attractive than for Westerners:

“So when a person gets a stroke, the whole family, even friends, have to be involved in the problem...They are surrounding all the time ... and dependency is not a big deal for him because whether or not he recovers, the whole family will be with him.”

(Ahmed, Kuwaiti)

“Here it’s okay to be dependent on someone else. For example, I told you our religion focuses on taking care of our parents. The more you take care of them the more you have better chance to go to Heaven, it is related. Since you believe in God in order to get his satisfaction you have to care for your parents. The main thing He (God) always asks us to do, take care of our parents. So here, the family ... they will try to help them. So here, it’s okay for the patient to be dependent, not the other way, independent, but in the foreign country because they don’t have this, they have to work very hard to reach to the independency.” (Khadeja, Kuwait)

In the quotation above, the physiotherapist attributed the acceptance of dependency not only with the practice of extended family living arrangements but with Muslim religious beliefs. Caring for relatives is viewed as offering better chances of salvation/ afterlife.

Dependency was also thought to be culturally acceptable, as nearly all Kuwaiti families employ staff in the home. Such staff offer care for children, perform domestic chores, driving, and other duties. Helped by maids and other paid assistants, participants considered that stroke survivors encountered daily life as continuing in its familiar way:

“Here in Kuwait people are more familiar with dependent relationships. [There are] people that clean for you, people that cook for you, people that can look after your children for you and that certainly plays a big role ... that people here probably experience less loss than if they were – say - a female that had a stroke with young kids. If the nanny could bring the baby to them, then they could hold them still and the nanny gets their food ready and helps them feed.” (Matt, Canadian)

A Kuwaiti physiotherapist agreed that the presence of maids encourages dependence and made the point that paid assistance does not help the stroke survivor to recover.

“ Like foreigners, she knows that she has to depend on herself to do her stuff, her children won't help her, she doesn't have a maid or, you know, assistance to come home and do things for her so she has to depend on herself.” (Khadeja, Kuwaiti)

A social acceptance of dependency and the taken-for-granted presence of maids were identified by all the health professionals interviewed as a difference between Kuwaiti and non- Kuwaiti patients. Among the Kuwaiti population, widespread access to funds to hire nurses, and domestic helpers was thought to contribute to this lack of need to recover

independence, in addition to prevailing attitudes such as accepting aging and disability, religious coping and fatalism, and extended family support.

Discussion

The health professionals interviewed expressed certain perceived cultural differences in the stroke experience between patients in Kuwait and those they had worked with in other countries. Eight aspects of the Kuwaiti culture were widely discussed by the participants: religious beliefs, extended family involvement, limited education and public information about stroke, prevailing negative attitudes towards stroke, ready access to finances for private treatment, social stigma and the public invisibility of disabled people, difficulties identifying meaningful goals for rehabilitation, and acceptance of dependency, linked with the near-universal presence of maids in Kuwaiti homes.

The central role of religious belief resonates with some previous studies of people who follow the Muslim faith. Previous studies have shown that very high proportions of Muslims profess trust in God and use positive religious coping for physical conditions and mental distress. Studies have focused on disabled people in Afghanistan (Wickford et al 2008), Iranian injured war veterans (Aflakseir & Coleman 2009), as well as young people in the UK who described how they might cope with depression (Loewenthal et al 1999, 2001). Participants in the current study thought that some patients regarded their stroke as a *challenge* set by God, rather than a punishment (as interpreted by a substantial minority of religious rehabilitation patients in a previous study by Anderson et al (1993). The notion that illness is a test or challenge from God has also been described by a Muslim informant in a qualitative study in the UK (Yamey & Greenwood 2004). South African Indian Muslims providing care

to a people affected by stroke also implicated God in the aetiology of the condition (Bham & Ross 2005).

The profound involvement of the extended family was represented a major feature of the stroke experience in Kuwait. Advantages were described as the provision of support, encouragement and motivation. Being in a familiar environment, with familiar people, was also thought to enhance recovery and well-being. However, excessive help from family members was thought to encourage further dependency, through reinforcing the sick role. The importance of family involvement in the care of disabled people in non-Western cultures has been documented in previous studies (Bham & Ross 2005; Haggstrum & Norberg 1995; Subgranon & Lund 2000; Wickford et al 2008), and linked with the Islamic duty of care to parents and other relatives who are in need of support (Aflakseir & Coleman 2009; Subgranon & Lund 2000;). The degree of involvement of the extended family in non-Western cultures has been thought to pose challenges to individualised Western models of rehabilitation (Matheseon 2009; Norris & Allotey 2008). Further illustrating these challenges, in the current study therapists working within the community (i.e. visiting patients at home) mentioned encountering disputes between themselves and family members about appropriate therapeutic goals and the style of therapy. The therapists expected patients to take active responsibility for doing exercises, for example, whereas families did not always agree, expecting stroke patients to be passive recipients of medical treatment and massage.

These issues were closely related to the further theme arising in this study, namely that patients found difficulty in identifying meaningful goals for therapy. Dressner & Pils (2009) offered similar observations of ethnic minority patients in Vienna, linking patients' reluctance to engage in relearning self-care skills to fatalistic beliefs, the reinforcement of the sick role by the family, less cultural emphasis on independence, and an expectation that treatment

would be received in a passive way from expert health professionals. Passivity in the rehabilitation process has also been described among Middle Eastern patients (Dean et al 2006). It is interesting that the health professionals interviewed shared many of the perceptions of health professionals in previous studies who were working with patients in an impoverished, war-torn Muslim country (Wickford et al 2008), or migrants to a Western country, who are subject to further stresses associated with dislocation and economic disadvantage (Dressler and Pils 2009).

Limited public education about stroke and rehabilitation was cited by the Western health professionals as a difference between stroke patients in Kuwait when compared to the Western countries in which they had previously worked. This encouraged, in their views, pessimistic views of recovery, passivity, and limited use of rehabilitation services, despite their availability and lack of cost to Kuwaiti service users. However, a study in Australia (O'Connell et al 2002) also found a marked lack of understanding about stroke among the general public so this problem may not be specific to Kuwait. It is unclear whether better education about stroke in Kuwait would be helpful without addressing the wider cultural beliefs and practices which are not aligned with Western values, as discussed previously.

Stigmatising social attitudes and limited access to public facilities were cited as negative aspects of the stroke experience in Kuwait. Disabilities were seen as “abnormal”, leading to staring by members of the public, and social withdrawal. This view resonates with Goffman's (1963) view of stigma as leading to avoidance or passing strategies in order to protect identity. Other studies have also described social stigma associated with disability and mental health problems in a variety of cultures, and its role in people's withdrawal from community activities (Crabtree 2007; Simpson et al, 2000; Murray and Harrison, 2004; Endrawes et al 2007; Rhodes et al 2008). Interestingly, some of the health professionals also betrayed quite

negative attitudes themselves, and sometimes used the word 'abnormal' when contrasting patients with their pre-stroke state, or referred to clients in slightly disparaging terms. It may be thought that some of the health professionals showed signs of being socialised into the prevailing cultural attitude towards disability. Nevertheless, complex social responses to disability were identified, encompassing profound obligations towards the care of disabled people by the family, alongside perceptions of shame and stigma leading to social withdrawal and public invisibility.

Dependency was reported to be socially acceptable in Kuwait according to both Kuwaiti and non-Kuwaiti health professionals. In part, this may reflect the collective culture which does not prize autonomy in the same way as Western cultures. But the social acceptance of paid helpers in the home was also thought to reinforce dependency. Receiving help from paid maids is not seen as demeaning in any way in the wider culture but as an everyday resource for a comfortable life. Nevertheless, whilst increasing the physical and emotional comfort of stroke survivors, reliance on paid help was considered by participants to be a hindrance to rehabilitation aims, encouraging passivity, and difficulties identifying meaningful occupational goals. Having the financial means to pay for assistance has been recognised as increasing the autonomy of disabled people (Cardol et al 2002). However, in Western countries, the disabled person may have to manage complex power dynamics when paid helpers come into the home (Meyer et al 2007). In Kuwait, authoritarian dynamics within the home may mean that maids continue to have a subservient role, meeting the stroke survivors' needs. This finding has not been reported in other studies involving stroke survivors, and seems to indicate a potentially important, culturally-specific influence on the stroke experience, posing challenges to rehabilitation specialists.

Critical evaluation: The study is inevitably limited by the sample size which meant that differences in the views and values of Western and Kuwaiti health professionals could not be

examined thoroughly. Clearly, the participants were reporting on their own perceptions which may differ from those of stroke patients and their families. It might be thought surprising that the participants did not consider gender issues, but the segregation of men and women occurs in rehabilitation, and may have been taken-for-granted as a feature of the Kuwaiti culture. The first researcher's position as both an 'insider' and 'outsider' to Kuwaiti culture (from having many years of residence, physiotherapy education and work in the country yet being of different nationality, ethnicity and religion) was considered helpful for building trusting relationships with the interviewees, and for sensitising her to emergent themes.

Conclusions

These findings suggest that health professionals and patients (and their families) in Kuwait might be inhabiting different 'cultures', with therapists embracing a Western biopsychosocial model of stroke, whereas the patients and families retain traditional biomedical and maybe religious models. While health professionals understood the importance of physical, psychological and social aspects of rehabilitation, patients and family members were thought to embrace a traditional understanding of the sick role, offering care within the family, accepting the need for medical and nursing assistance and rest, but resisting active involvement in stroke rehabilitation. Family involvement was viewed as being more intense than the health professionals had encountered in Western countries and led, they argued, both to increased support and yet also to increased dependency. The presence of house maids and privately hired nursing staff was perceived as further contributing to dependency although patients themselves were unlikely to regard such paid-for support in these terms.

These findings suggest that it is vital to build a good relationship with family members to work effectively across cultures. Health professionals need to tailor therapy to the patient's and family's model of rehabilitation as far as possible, whilst also seeking to educate them

about the importance of active involvement. Cultural sensitivity requires health professionals to engage with the family of the stroke survivor and to appreciate their world view, as well as offering more education about the principles behind therapeutic strategies. Nevertheless, individual therapists have limited power to counteract societal factors such as the enclosure of disabled people within the family, stigmatising social attitudes, the limited accessibility of community resources, and the widespread acceptance of paid help within the home.

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Table 1: Profile of Health Professionals who took part in this study

Pseudonyms	Age	Nationality	Profession
Katie (HP01)	45	American	Occupational Therapist
Anna (HP02)	28	German	Physical Therapist
Andrea (HP03)	40	Canadian	Physical Therapist
Smitha (HP04)	30	Indian	Physical Therapist
Aylne (HP05)	47	Philippine	Nurse
Matt (HP06)	40	Canadian	Physical Therapist
Ahmed (HP07)	27	Kuwaiti	Speech and Language Therapist
Khadeja (HP08)	45	Kuwaiti	Physical Therapist
Helen (HP09)	38	Malaysian	Nurse
Mohammed(HP10)	42	Kuwaiti	Physical therapist
Deepa (HP11)	45	Indian	Nurse
Grandesa (HP12)	29	Philippine	Physical Therapist