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# MY SISTERS MYSELF: EXPLORING THE HEALTH AND WELLNESS PRACTICES OF AFRICAN AMERICAN WOMEN

by Carmen Renée Alexis

### A Dissertation

Submitted to the
Department of Educational Leadership
College of Education
In partial fulfillment of the requirements
For the degree of
Doctor of Education
at
Rowan University
May 2015

Dissertation Chair: James Coaxum, III, Ph.D.

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### **Dedications**

First I thank God for allowing me to complete this process. He is my fortress, my redeemer, and the lifter of my head. Many days I felt like giving up, but God's presence was a constant throughout every step of this journey even in the midst of my human frailties. So, this dissertation and all of the experiences that accompanied it are to the Glory of God my Father, Jesus Christ my Redeemer, and The Holy Spirit my Comforter.

I thank my mother Rev. Ruth Eva Benton for her unconditional love, sacrifice, guidance, and belief in God's ability to see me through. From my earliest beginnings, you instilled in me a love of God and the promises afforded to me through His Word.

Because of you I recognize that I can do all things through Christ who strengthens me (Philippians 4:13). I love you and thank God for blessing me with such an awesome, wise and praying mother.

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#### **Abstract**

### Carmen Renée Alexis

MY SISTERS MYSELF: EXPLORING THE HEALTH AND WELLNESS PRACTICES OF AFRICAN AMERICAN WOMEN 2014/-015

Dr. James Coaxum, III, Ph.D. Doctor of Education

African American women contribute disproportionately to disease in the United States. Researchers have repeatedly turned to issues related to poverty, access to medical care, and stress to explain this syndrome, however studies have shown that the disparities persist even in the absence of poverty and impaired access. Stress remains a constant in every discussion of disease in African American women, but what is it that fuels their particular brand of stress and how does it impact the health of African American women? The purpose of this mixed methods study was to explore the perceptions held by African American women in the areas of health and wellness using the frameworks of Critical Race Theory and Black Feminist Thought. Inherent in this process was an examination of society's treatment of African American Women as a factor in the measure of the allostatic load they endure. This study also incorporated the concepts of making meaning and self-efficacy as a means of conceptualizing the experience of the participants. Observations of wellness support group meetings and the analysis of nine focus group sessions yielded themes suggesting the need for companionship, increased avenues of support and nurturing, as well as the creation of culturally relevant, health assessment standards and tools.

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### Chapter 1

### Introduction

"Now I'm not saying that we are not suffering from the things we die from-that's what the statistics give us. But what causes all this sickness?"

(Avery, 1994, p. 8)

In the United States in 2008, aggregate costs for cardiovascular disease, diabetes, and cancer, including direct medical expenditures, disability, death, and loss of work, exceeded 784 billion dollars (BlueCross BlueShield [BCBS], 2009). Additionally, the Centers for Disease Control and Prevention (CDC) noted that there were 26.6 million Americans living with heart disease in 2012 (CDC, 2015). According to a 2004 CDC report, heart disease, cancer, and stroke combined contributed to 60% of U.S. deaths (CDC, 2004).

Although the impact of disease profoundly affects the entire nation, historically within medical research in the United States, greater importance was assigned to how men, particularly European-American men, displayed symptoms of major diseases (Johnson, Fitzgerald, Salganicoff, Wood, & Goldstein, 2014). Medical complaints from women were often dismissed as frivolous or owing to their status as the *weaker sex*. Female-based research often focused on the reproductive process, neglecting the other major body systems in female patients (Leavitt, 1999; Smith-Rosenberg & Rosenberg, 1999). Consequently, much of the research into major diseases and illnesses was conducted using male subjects and the resultant data related to the disease process in men (Mann, 1995; Taylor, 1994). As medical research began to explore the disease process in women, it became evident that there were, at times, significant differences in the

symptoms experienced by women when compared with those experienced by men (Freemont, Correa-de-Araujo, & Hayes 2007).

The resultant data disclosed a higher tendency to certain diseases than previously believed. While women were found to seek care more often, medical professionals often missed symptoms of major disease because the symptoms displayed by women were uncharacteristic of the symptoms found in men. Accordingly, women seeking health care were not afforded the same level of diagnostic tests, referrals to specialists, or surgical interventions as those provided to men in similar situations (Freemont et al., 2007).

The bias in medical research and treatment has negatively impacted the nation's women. The United States is still largely a patriarchal society, where women are marginalized in many arenas (Collins, 2009; Gilkes, 1981; Leavitt, 1999; White, 2011). The health care system is a microcosm of this marginalization. Societal relegation affects the health of women in several ways. Women still experience lower pay than their male counterparts when performing in equal positions (Nadler & Stockdale, 2012; Whitehouse, 2003). They are also often not afforded the level of respect shown to males at equivalent management levels. Moreover, women are still expected to perform in the traditional roles that were required of stay-at-home moms while working full time jobs outside of the home. Feelings of inadequacy, lower pay, and lack of deserved respect affect economic and emotional health leading to increased stress and decreased wellness (Nadler & Stockdale, 2012; Okechukwu, Souza, Davis, & Butch de Castro, 2014).

This enduring marginalization of women in the healthcare system and the disparate treatment of disease are even more apparent when examining African American women, who are dually marginalized, due to race and gender. The Centers for Disease

Control Office of Minority Health (CDC, 2005a) reported that African American women suffer disease at a higher rate than their European American counterparts. This suffering manifests itself in a greater propensity for African American women to die from breast cancer, diabetes, kidney disease, and heart disease. In fact, African American women are more likely to die from cancer than persons of any other racial or ethnic group (American Cancer Society [ACS], 2010). Although African American women are diagnosed less often with heart disease and cancer than their European American counterparts, they are more likely to die from these diseases (American Heart Association [AHA], 2010; CDC, 2005a; Priest, 2008).

Researchers theorize that these disparities are linked to several factors, including (a) the manner in which healthcare professionals diagnose and treat African American women, (b) the propensity of African American women to forgo diagnostic tests and to neglect medical care, particularly when faced with abnormal test results, (c) the tendency for African American women to be obese and make poor dietary choices (CDC, 2005a, 2010a, 2010b, 2010c; Washington et al., 2007), (d) the lack of access to medical care often linked to poverty, and, (e) the cumulative stress experienced by African American women (Collins, 2009; Priest, 2008; Woods-Giscombè, 2010). Whatever the cause, studies have shown that African American women experience a higher rate of death from breast cancer (ACS, 2010; CDC, 2005a, 2010a), a higher degree of hypertension and the resultant strokes and heart attacks (AHA, 2010; CDC, 2005a), and a higher incidence and severity of diabetes (CDC, 2005a, 2007) than their European American counterparts.

### Oppression as a Path to Disease

The complexities associated with disease in African American women are addressed in Patricia Hill Collin's *Black Feminist Thought* (2009), and Richard Delgado and Jean Stefancic's Critical Race Theory (2001). These theories focus not only on the prevalence and systemic nature of racism, but also the conscious and subconscious response to racism witnessed in the privileged—those in power and the unprivileged those controlled by those in power. Delgado and Stefancic's Critical Race Theory, embraces the concept that race is constructed by society and that the categories of race are created, manipulated, and withdrawn to serve the needs of those in power. Delgado and Stefancic's sentiments are supported by Derek Bell (1992) in Faces at the Bottom of the Well, as he concludes that not only is racism the norm for the United States, but that some notable civil rights victories may be more the result of elitist self-interest than of a desire to help society's disadvantaged. Patricia Hill Collins' Black Feminist Thought (2009) explored the viewpoints of African American women as they grappled with their existence in a society that has attempted to define them and speak for them without understanding them. In the course of the development of these viewpoints they have created methods to counter the images created by society to categorize, dehumanize, and control them. These controlling images have been central to most discussions on Black Feminist Thought. Through this theory, Collins addresses the manner in which African American women have assessed their place in society and formed ideas and responses to their treatment by American society, both during and after slavery. African American women are often depicted as Mammy—the faithful maidservant who recognizes her subservient place and teaches her family to do so as well; Matriarch—the unfeminine,

overly aggressive, emasculating source of cultural deficiency; Welfare Mother—
"updated version of the breeder woman image created during slavery"; Sapphires—
assertive women; Jezebels—highly sexed, insatiable, aggressive; Mules—asexual,
subhuman, workhorses; and more recently, the Black Lady—well-educated, middle-class,
ultra-assertive, lacking femininity, women who do not know how to love men, women
who take the jobs that should be reserved for men (Collins, 2009; Davis, 1981).

Black Feminist Thought and Critical Race theories combined create a framework for considering the impact of racism on health and for establishing the need for cultural exchanges on the prevalence of disease in African American women. Additionally, these theories serve as frameworks for the lack of equitable care received in the presence of disease (National Cancer Institute, 2001; Delgado & Stefancic, 2001). Collins (2009) details the oppression that depicts African American women as inferior, as objects to be controlled and manipulated by whatever context society ascribes to them. African American women, fighting to disaffirm negative stereotypes work to be all things to all people while neglecting themselves (Collins, 2009; Jones & Shorter-Gooden, 2003; White, 1994; Woods-Giscombè, 2010). Priest (2008) asserts, "Racial, gender, and economic disparities are playing themselves out on the bodies of black women, manifesting themselves as fatal disease and chronic illness" (p. 121).

While African American women have demonstrated resilience within an unremitting system of oppression, their resolve is not without consequence (Collins, 2009; Davis, 1981; Jones & Shorter-Gooden, 2003; Priest, 2008; White, 1994; Woods-Giscombè, 2010). Statistical data from the major disease databases clearly reveal the dismal facts of disease and mortality among African American women (AHA, 2010;

CDC, 2005a). The stress created by the need to continuously adapt to a society that incessantly attempts to define them without substantive attempts to understand them: to meet the demands of family expectations, to battle discrimination often rendered as nonexistent or greatly decreased (Carlson & Chamberlain, 2005), has created an unbearable load that is literally breaking the hearts as well as the physical and mental constitutions of African American women (Collins, 2009; Priest, 2008; White, 1994).

African American women must find a way to assuage the damaging effects of unrelenting stress if they are to achieve optimal health. Assessing the root causes of their stress in a culturally sensitive matter is a key step in this process. Until African American women are willing to tap into their deepest emotions and fears they will continue to compromise their health and future (Avery, 1994; Hooks, 1994; Priest, 2008; White, 1994).

### Context of the Study

The weight of societal oppression is manifested in African American women I have encountered in my experience as a Holistic Health Coach and a licensed Massage Therapist. While the women often appeared positive and ready to make healthy changes in their lives in the areas of food choices and exercise, at the root of each encounter were issues that revealed their marginalized status as African American women. This status makes them more prone to the ravages of stress due to a lifetime filled with working hard in and for a system that consistently negates their value to society and their aesthetic worth (Boyd, 1994; Collins, 2009; Jones & Shorter-Gooden, 2003); a lifetime filled with searching for a suitable mate and finding that the education that they earnestly pursued may actually place them among the group of African American women least likely to marry (Wiley, 2008); a lifetime of choices, to wear that natural hairstyle to a job

interview or straighten out the tight curls because it may place the prospective employer at ease (Boyd, 1994; Jones & Shorter-Gooden, 2003); a lifetime of being mistaken for the hired help and carefully watched by the store clerk as they purchase overpriced items from a too small paycheck (Jones & Shorter-Gooden, 2003). This type of oppression has impacted African American women to the point that even when the anticipated discrimination is not present, their health is still impacted by the perception or expectation of discrimination based on past experiences (Carlson & Chamberlain, 2005; McEwen, 2000; McEwen & Stellar, 1993).

**Factoring in the stress**. This level of persistent stress is often taken for granted in African American women and they bear the load without ever putting a name to the perpetual heaviness. Many attribute risk factors and health problems to a family history of a particular disease, some never consider the root causes of their stress and compromised health. This understanding intensified my desire to research some of the issues associated with the health and wellness practices of African American women. The diseases endured by African American women are due in part to a greater prevalence of the risk factors associated with disease. Obesity is a risk factor indicated in many diseases and African American women are not only more likely to be obese than their European American counterparts (CDC, 2009), but often do not perceive themselves as such (Bennett, 2006; Kuchler & Variyam, 2003). Another factor contributing to the obesity, in itself a risk factor, is the lack of physical exercise among African American women. According to the National Institutes for Health (NIH, 2009), 55% of African American women do not exercise. Developing an understanding of the choices (and reasons for the choices) that impact dietary and exercise habits was a critical component of this study.

Although initially a simplified solution of reducing the controllable risk factors surfaced, through research and observation it became clear that it was crucial to examine the most significant risk factor for African American women, unrelenting stress (Adisa, 1994; Carlson & Chamberlain, 2005; Collins, 2009; Geronomise, Hicken, Keene, & Bound, 2006; Priest, 2008). A framework for exploring this phenomenon was also critical to this study. The model of stress and coping employed by African American women is rooted in a history of neglecting health and personal well-being to deal with the issues of survival in an oppressive society. Overburdened by the need to constantly address basic survival issues, they are less likely to take time for physical and emotional nourishment, to accomplish suggested diagnostic medical tests, and to obtain suggested follow-up care (Hooks, 1994; Press, Carrasquillo, Sciacca, Elsa-Grace, & Giardina, 2008). The coping model employed by African American women is often based upon their lived experiences coupled with the fact that they are often reared, either by precept or example, to believe that they should handle all stressful situations on their own without regard to their need for self-care. The demands placed on them cause them to be considered, at once, superhuman and subhuman (Collins, 1986, 2009; Hooks, 1994; Geronomise et al., 2006; Woods-Giscombè, 2010). Geronomise et al. (2006) contend that the cumulative stressors imposed on African American women increase the likelihood of disease in this group. These stressors are linked to racism, inferior jobs, and family burdens endured continuously without reprieve. The systems and processes that have led to this cumulative stress can be explained through the theories of Critical Race and Black Feminist Thought as previously noted. Jointly, these theories explain the pervasiveness of racism and the often-detrimental response of African American women to racism and oppression.

While African American women cannot obliterate the societal inequities that have led to, and continue to fuel, their oppression and consequently their increased prevalence to disease, they are able to mitigate the influence of these elements through a system of education, self-care, and culturally-based therapeutic discourse (Adisa, 1994; Collins, 2009; Hooks, 1994; Neal-Barnett et al., 2010). Controlling these influences through increased awareness and incremental changes to diet and lifestyle may reduce the prevalence of health issues in African American women while simultaneously compelling a greater degree of responsiveness from healthcare institutions and practitioners.

### **Purpose of the Study**

There is a significant amount of research on the role of controlling images in the level of stress endured by African American women. However, there is a dearth of information on how the self-imposed imagery, created as a response to society's portrayal, has exacted a toll on the wellness of African American women and contributed to the disease imbalances.

As a means of addressing the health disparities experienced by African American women, I conducted a mixed methods study designed to explore the perceptions held by African American women in the areas of stress, exercise, diet, and the health care system. The study examined the healthcare, lifestyle practices, and the experiences of the participants in order to explore the choices that contribute to the disease process.

This study also attempted to examine the research on allostatic load, the cumulative biological load endured by an individual (Seeman, McEwen, Rowe, & Singer,

2001; Sterling & Eyer, 1988), through the lens of Black Feminist Thought and Critical Race Theory. Another goal of the study was to address the concepts of self-efficacy (Bandura, 1995, 1997, 2004); personal mastery (Senge et al., 2000); making meaning, and mental models (Mezirow, 1991; Senge et al., 2000) in the context of African American women's culture. Personal mastery in this sense is the ability to fully comprehend the current situation while simultaneously creating a vision of optimal health and wellness. Self-efficacy addresses an individual's belief in her ability to make the necessary lifestyle changes to improve health. Additionally making meaning and mental models refer to the ability to honestly reflect on the elements of one's upbringing and life experiences that impact thoughts and decision-making processes. Critical Race Theory and Black Feminist thought provided a means of exploring the impact of marginalization on each of these areas.

Mezirow (1991) emphasized the need for individuals to confer meaning critically and reflectively as opposed to merely accepting inherited meanings from our socialization experiences. He also addressed the conflict that arises when the traditional understanding intersects with this critical assessment. Observing this type of reflective practice was crucial as participants addressed self-defeating norms and behaviors and moved towards the creation of new meanings that support healthy lifestyle decisions and wellness.

Mezirow's (1991) concept of making meaning is closely aligned with the mental models principle espoused by Senge et al. (2000). Meaning is often derived from the assumptions made about the world around us. The mental model discipline involves

extensive self-reflection as well as a willingness to expose our methods of thinking and making decisions to others.

The health promotion aspect of the self-efficacy tenet of Bandura's (2004) Social Cognitive Theory centers on the role of an individual's belief in their ability to influence their own behavior in effecting change. This is of particular importance given the marginalized status of African American women. His research addressed the positive psychological benefits gained when individuals recognized and exercised their innate capability to increase self-motivation and achieve goals.

By commissioning this innate power, individuals are able to realign their at-risk behavior in a way that supports the process of self-definition as opposed to continued acceptance of images imposed by society (Adisa, 1994; Collins, 1986, 2009; White, 2011). This new vision has the potential of fostering new behaviors designed to decrease the prominent health status of African American women as objects of financial liability to society while asserting their position as assets to society. This study has the added potential of providing an opportunity to observe the support needs of African American women as they seek to improve their level of wellness.

### **Research Questions**

This study afforded the opportunity to observe the women as they participated in a wellness support group. This study attempted to answer the following questions:

- 1. What were the perceived factors that impacted the health of African American women?
- 2. How did self-efficacy and mental models impact the health and wellness of African American women?

3. How did Black Feminist Thought and Critical Race Theory provide a framework for understanding the health and wellness of African American women?

These questions guided my observations of the participants in the support group and also formed the framework for the design of this study. It was my hope that this study would yield answers to these questions and eventually formulate a medium for improving the health and wellness of African American women thereby reducing the prevalence of disease.

### Significance of the Study

While reducing the prevalence of disease is important for African American women, it is also important for the economic health of the nation. As noted previously, the direct and indirect costs of disease is staggering, exceeding 700 billion dollars in 2008 for cardiovascular disease, diabetes, and cancer (BCBS, 2009). African American women comprise a significant percentage of those diagnosed with these diseases. Heart disease, cancer, stroke, and diabetes place a considerable financial burden on the nation. These diseases were also the top four killers of African American women in 2006 (CDC, 2010b).

The death rate (age adjusted) for African American women in the state of New Jersey was reported at 30% higher than that of European American women (New Jersey Department of Health and Senior Services, [NJHSS], 2010). Each death is associated with direct and indirect costs. Considering the human suffering and the financial costs associated with disease and dying, action is needed to create sustained change in this

area. A forum to address the issues impacting the health of African American women will potentially decrease the financial burden of these diseases at the state and national levels.

In addition to the fiscal benefits to society, this study was needed to address the debilitating effects of societal marginalization on African American women (Seeman et al., 2001). Most often the health issues of African American women are ascribed to improper diet and lack of exercise (Daroszewski, 2004; Myers, Kagawa-Singer, Kumanyika, Lex, & Markides, 1995) without contemplating the impact of oppression on dietary choices and other at-risk behaviors. We essentially blame the victim without significant efforts to consider the disparate treatment that promotes disease. The stress associated with this marginalization is known to increase allostatic load and impact wellness (Carlson & Chamberlain, 2005; Seeman et al., 2001; Sterling & Eyer, 1988).

This study also communicated the need to educate health professionals about disease and treatment disparities (Happe, 2006; Miller et al., 2005; Morris & Mitchell, 2008). This is particularly true given the systemic nature of racism and sexism. Bias is often woven into society's established systems and almost rendered invisible by privileged members of society (Bell, 1992; Delgado & Stefancic, 2001; McIntosh, 1988). Educating health care professionals will expose the practices that intentionally or unintentionally discriminate against African American women while permitting the establishment of culturally sensitive procedures that meet the needs of all members of society.

Lastly, this study is significant as a gateway for African American women to create individual and collective avenues for improved wellness. African American women demonstrate inconsistent medical follow-up and a lack of awareness about

disease (Williams, 2009). The disciplines of personal mastery and mental models espoused by Senge et al. (2000), as well as the concept of making meaning as espoused by Mezirow (1991), acted as conduits to healing for the women in this study. These principles were referred to throughout the study as a means for generating an environment for the deep self-reflection needed to evaluate and release self-defeating habits (Field Note, November 12, 2011).

### Summary

Decreasing the prevalence of disease among African American women requires an examination of the history, perceptions, and support needs of this group. This study was designed to explore the perceptions of African American women as they reflected on the path to disease as a critical aspect of the journey to wellness.

This study provided a means of examining historical barriers to wellness as perceived by African American women. Simultaneously, it provided an opportunity to examine the methods used by the women to manage stress and to address the controllable risk factors related to disease. Marginalization places an extreme burden on African American women, just as disease and death create a tremendous financial burden on the nation. Exploring the issues that cause African American women to contribute disproportionately to this burden will illuminate the societal deficiencies that have fueled the disease disparities. This in turn may create the potential for change in the very systems that have fashioned the inequities. "We have to address and *change* the dismal predictions about our lives because we've got glorious contributions to make to society" (White, 1994, p. xv).

### Chapter 2

#### Literature Review

The level and severity of disease experienced by African American women is not only relevant to the African American population, but considering the costs of disease, it is an economic and social justice issue for this country. The disparities illustrate the premise that injustice in a society affects all of the society (King, 1986; Thoreau, 2012). Inequality cannot be quarantined to limit its impact to a specific segment of society.

While African American women remain central to the process of reclaiming their health, it is also crucial to address the complexity of this issue. The inherent power of African American women to better their plight aside, African American women also experience unequal treatment at the hands of medical practitioners and healthcare institutions (Delvecchio-Good, James, Good, & Becker, 2003). To exacerbate this situation, some are not even aware of the disproportionate treatment because they often lack the knowledge to ask relevant questions in order to make informed decisions (Lorde, 1994; Williams, 2009). Still, this unequal treatment as it relates to health care represents just a microcosm of the daily living experiences of African American women; experiences that cause stress and anxiety that are often pushed to the deepest recesses of their minds so they can carry on the business of life (Adisa, 1994; Hooks, 1994; Lorde, 1994). African American women will need to look within themselves and within their community of women to find ways to insulate themselves from the detrimental effects of lives too full of socially constructed stressors (Collins, 2009; Lorde, 1994; Priest, 2008).

This review examines literature that documents the specific disease disparities from various perspectives including the treatment, prevalence, and awareness of disease.

It also serves as a review of the literature that addresses the common factors related to the prevalence of disease in African American women. These factors include poverty and access, obesity, exercise, and allostatic load, which is a measure of the pervasive stress experienced by African American women. Additionally, this section addresses Black Feminist Thought and Critical Race Theory as frameworks for exploring the ways in which the lived experiences of African American women may illuminate the root causes of disease. Lastly, I consider the issue of powerlessness as an outgrowth of persistent oppression and the concepts of making meaning, mental models, personal mastery, and self-efficacy as a means of restoring power.

### **Documenting Disease Disparities**

As a preface to addressing the reasons for the prevalence of disease in African American women, it is essential to first document the existence of the disparity through the literature. While the statistics from the various databases provide the quantitative measurement of the issue, the literature examined in this section provides a more comprehensive view of the problem as it relates to cardiovascular disease, breast cancer, osteoporosis, and diabetes.

Cardiovascular disease. The existence of disparity in the occurrence, severity, and treatment of disease is well documented (Carlson & Chamberlain, 2005; Priest, 2008; Williams, 2009). According to Williams (2009), cardiovascular disease is the greatest killer of African American women in the United States (p. 536). Cardiovascular disease is a term used to describe many problems of the circulatory system. Many of these conditions are related to a build up of plaque in the arteries and include: heart attacks, strokes, heart failure, and heart valve problems (AHA, 2012). Williams (2009) found that

45% of African American women have some form of cardiovascular disease compared to 32% of European American women. He noted that there is also a disparity in the awareness of the disease. Referencing a 2006 American Heart Association (AHA) survey, he stated that "...while 77% of Caucasian women knew that heart disease was the biggest killer of women, only 38% of African American and 34% of Hispanic women were aware of this" (pp. 536-537). Williams focused on 4 categories of cardiovascular disease: coronary artery disease, defined by the growth of plaque in the coronary arteries resulting in decreased flow to the heart muscle (AHA, 2015a); hypertension, a measure of two forces, one of blood as it pushes out of the heart and through the arteries, and the other of the heart muscle as it rests between beats - hypertension exists when these forces are excessive enough to damage the walls of the arteries (AHA, 2015b); stroke, a blockage or rupture of the blood vessels that carry oxygen and nutrients to the brain (AHA, 2015c); and congestive heart failure, a condition where the heart is too weak to supply the cells with oxygen and nutrient-rich blood resulting in fatigue and shortness of breath (AHA, 2015d). Williams addressed the differences in the manner in which African Americans present with these conditions and the disparity associated with each category. African American women were found to have the highest incidence and mortality rate in all categories when compared to European American women. Some of the concerns raised by Williams (2009) were the level of awareness about the disease, age at onset of disease, and the different manner in which African American women present with these diseases. A greater degree of emphasis on cardiovascular disease in African American women is needed in order to address the unique manner in which this disease manifests itself in this group.

Breast cancer. Williams' (2009) study is one of many focused on increasing awareness of race related health disparities. Other researchers have explored this phenomenon from various aspects for several years. Press et al. (2008) note that African American women present with breast cancer less often than European American women, but are less likely to survive the disease. According to the American Cancer Society, "breast cancer is a malignant tumor that starts in the cells of the breast. A malignant tumor is a group of cancer cells that can grow into (invade) surrounding tissues or spread (metastasize) to distant areas of the body" (2011, para. 1). Press et al. (2008) suggest that the poor survival among African American women may be linked to delayed follow-up care after the initial breast cancer diagnosis. The median number of days to follow-up for African American women was 20 days, compared to 14 days for European American women. The authors acknowledge, however, that there is no consensus as to what constitutes a reasonable follow-up period, but reference studies have found that even a 30-day delay can increase the risk of recurrence or death.

Morris and Mitchell (2008) also note the tendency to delay treatment and the tendency for African American women to die from the disease. This disparity is credited to lower utilization of mammography, less access to care, and the all too familiar socioeconomic factors. Additionally, they state that African American women present with more aggressive forms of the disease. The follow-up habits of African American women were also associated with an elevated risk of death. African American women were found to receive less treatment cycles of chemotherapy and radiation than European American women (Geronomise et al., 2006; Morris & Mitchell, 2008; Press et al., 2008; Woods-Giscombè, 2010). They were also found to terminate treatment more often. This

highly technical research clearly delineated some of the biological and external risk factors that caused the mortality rate to be higher in African American women than in European American women. Race was substantiated as a risk factor in the development of the most deadly forms of this disease. Since Critical Race Theory posits that race is socially constructed (Bell, 1992; Delgado & Stefancic, 2001) as opposed to genetically formed, the impact of racial marginalization must be contemplated as a factor in the prevalence and severity of disease (Carlson & Chamberlain, 2005, Seeman et al., 2001; Sterling & Eyer, 1988).

While Morris and Mitchell (2008) contended that more focus should be given to the racial disparity in the diagnosis and treatment of breast cancer, Happe (2006) felt that identifying breast cancer as a racial disease was not only erroneous, but possibly an attempt to realign resources and designate privilege based on race. Happe also felt that by categorizing the disparities on the basis of race alone, opportunities to draw other correlations are missed. She preferred an approach that addressed prevalence to breast cancer in terms of ancestry as opposed to race.

Happe (2006) engaged in a scientific discussion concerning the gene mutations possibly responsible for the aggressive forms of breast cancer in African American women. In spite of the evidence supporting the fact that African American women are known to present with the more aggressive forms of cancer, Happe maintained that some research into ancestry was needed before attributing this phenomenon entirely to race. Happe makes a reasonable argument since individuals who are classified as black or African American often represent many ancestries. Research into the ancestry or combination of ancestries that result in the more aggressive form of breast cancer may

yield data that are valuable in detecting vulnerability to the disease in all races. Focusing exclusively on race may cause some individuals of other races to go undetected.

Nonetheless a concentration on race is bound to occur when the data consistently reveal a heightened proclivity to disease within a particular race. Perhaps it is the construct of race as used by society that has increased stress and disease within a particular race, as opposed to an inherent predisposition toward disease. Nevertheless, while the data cannot be ignored, they should not be viewed in isolation. Maintaining a flexible approach to assessing causes of disease disparities may ultimately yield more accurate data than a rigid focus on race alone.

Osteoporosis. The focus on race is also a factor in osteoporosis screening.

European American women are more readily screened for osteoporosis than African American women (Miller et al., 2005). According to the NIH's National Institute of Arthritis and Musculoskeletal and Skin Diseases, "Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures, or broken bones. Bone strength has two main features: bone mass (amount of bone) and bone quality" (NIH, 2014, para. 2). European American women are considered most at risk for osteoporosis. As Happe (2008), suggested this focus on race creates a tendency for health professionals to overlook the risk of osteoporosis in African American women, resulting in less referrals for osteoporosis screening than for European American women. In a study based in two outpatient clinics, one in an urban area and the other in a suburban area, Miller et al. (2005) noted that African American women were less likely to be referred for a dualenergy x-ray absorptionmetry (DEXA) scan, a bone density screening, than European American women of similar risk.

Miller et al. (2005) also found that 1 to 1.5 million African American women have low bone mineral density (BMD), a risk factor for osteoporosis. They also found that despite the lower prevalence of osteoporosis, African American women in this group were almost twice as likely to die from a hip fracture than their European American counterparts. Miller et al. raised an awareness issue for consideration by medical professionals and African American women. Neither group should assume a lesser degree of risk for this disease based on race. Instead, attention to risk factors in African American women should be treated with the same degree of precaution and urgency as for European American women.

A study by Mudano et al. (2003) reported similar findings—postmenopausal African American women were found to suffer greater post-fracture disability, longer hospital stays, and higher mortality when compared with European American women. The African American women in this study were two-thirds less likely to receive BMD testing and were also less likely to receive prescriptive therapy for osteoporosis. Although the African American women in this study presented with fractures at an older age than the European American women in the study, they were found to experience more complications. African American women need to know the facts about this disease so they are able to ask appropriate questions of their healthcare professionals. There is also a need for educating health care professionals in order to prevent erroneous prognoses, diagnoses, inequitable screening practices, and improper treatment.

**Diabetes.** Educating health care professionals and patients is crucial to decreasing disease disparities. African American women must be informed of the lifestyle choices that pose additional risks, and healthcare professionals must develop an awareness of the

distinctions in the manner in which African American women present with disease and respond to treatment. One distinction that appears to warrant further study is that African American women are more likely to be deficient in vitamin D (Alvarez et al., 2010). This vitamin D deficiency has been shown to be responsible for a lower level of insulin sensitivity in African American women. Vitamin D levels do not appear to affect insulin sensitivity in European American women (Alvarez et al., 2010). Since African American women present with Type 2 Diabetes, a condition where abnormally high glucose levels exist within the body, more often than European American women (ADA, 2011), it is critical for medical professionals to understand the dynamics that produce increased risks for African American women

While there is no conclusive evidence to substantiate vitamin D deficiency as the primary causal factor for the tendency toward diabetes in African American women, it is noted that women in this group are more likely to suffer complications related to diabetes and to die from the disease (CDC, 2005b, 2007). Health care professionals must not accept the likelihood of diabetes as a norm for African American women, but continue to examine coexisting and preexisting factors that might contribute to the prevalence and severity of the disease in African American women.

#### **Risk Factors for Disease**

Other causal factors related to disease disparities are poverty, access to medical care, and the perceptions held by African American women about stress, diet, exercise, and weight. Literature related to these perceptions is addressed within this section.

**Poverty and access.** This review would be incomplete without the mention of poverty and access. All of the major health databases and several research studies link

these elements to the heightened disease in African American women (ACS, 2010; AHA, 2010; CDC, 2005a, 2010a; Miller et al., 2005). Access denotes the lack of availability of quality medical care often due to the individual's underinsured or uninsured status (Bolton & Wilson, 2005; Perry, Harp, & Oser, 2013; Ward et al., 2004). Access may also relate to the availability of medical providers within the community as well as transportation considerations. Factors related to poverty include residing in neighborhoods with elevated violence and crowded unsanitary living conditions (Bolton & Wilson, 2005; Perry et al., 2013; Ward et al., 2004). These neighborhoods are often characterized by excessive advertisements for alcohol and tobacco products with local stores offering an abundance of junk food and an insufficient variety and quantity of fresh produce (Bolton & Wilson, 2005; Perry et al., 2013; Ward et al., 2004).

The line between the issues of poverty and access are blurred in the African American community. There exists a cause and effect relationship between the two. While the unsanitary crowded conditions of poverty may promote the spread of disease, access issues related to the inability to afford quality health care contribute to the failure to seek preventive healthcare and follow-up care in a timely manner (Geronomise et al., 2006; Press et al., 2008; Woods-Giscombè, 2010).

**Obesity.** Another prevalent risk factor for African American women is obesity. Research on body size perceptions held by African American women suggests that overweight or obese African American women often do not view themselves as such (Bennett, 2006; Kuchler & Variyam, 2003; Schuler et al., 2008). Obesity is not an isolated risk factor. It is most often a consequence of poor dietary choices and lack of exercise (Daroszewski, 2004; Myers et al., 1995). While some African American women

are attempting to change unhealthy traditional eating habits that include fried foods, heavy starches, and sweets, there remains a inclination towards diets high in calories and fat and low in nutritional value. These diets are normally steeped in tradition and associated with joyful occasions despite evidence to suggest that these eating patterns have not served African American families well (Hargreaves, Schlundt, & Buchowski, 2002; Harris, 1994). Moreover, these diets are often used as a means of exercising control over an otherwise defenseless existence and as a means of anesthetizing the wounds of oppression and powerlessness (Arnold, 1994; Avery, 1994; Harris, 1994).

The stress connection. The use of food is just one means of survival employed by African American women. They have also created a system of repressing their needs in order to cope with a marginalized existence (Hooks, 1994). The Woods-Giscombè (2010) study on the coping strategies of African American women addressed the model of stress and coping used by African American women and its role in the prevalence of disease. She suggested that the cumulative stressful experiences, the allostatic load, of African American women might account for their predisposition to disease and premature death. The cumulative experiences noted by Woods-Giscombè (2010) included efforts to counteract negative stereotypes, and the need to survive in an environment of oppression, the *Superwoman Schema*.

This devaluation of the bodies of African American women is rooted in their historical societal devaluation, and its effects on wellness can be explained by the concepts of allostasis and allostatic load (Carlson & Chamberlain, 2005; Seeman et al., 2001; Sterling & Eyer, 1988). Allostatic load is used to describe the measure of unrelenting stress on the body. While homeostasis represents the body's ability to self-

correct and maintain physiological stability in reaction to stressors (Selye, 1984), allostasis refers to the body's ability to successfully maintain stability by making physiological adaptations to combat stressors. It represents the body's ability to override homeostasis to meet the demands of stressful situations (Carlson & Chamberlain, 2005; Sterling & Eyer, 1988).

Under normal circumstances these systems help the body to maintain functionality in moments of excessive stress. The problem occurs when the systems are engaged frequently or for prolonged periods as in the case of chronic stress. When chronic stress causes the stress response system to engage continually or without cessation this results in accelerated aging and degeneration of the body. In fact, this type of stress has been shown to cause shrinkage of organs in studies using laboratory rats (Selye, 1984). While the body's internal systems are designed to counter the physiological changes produced by excessive stress, the entire body is compromised when the stress is prolonged.

This concept of allostatic load has been implicated in studies involving cognitive and physical performance and the incidence of disease (Carlson & Chamberlain, 2005; Seeman et al., 2001; Sterling and Eyer, 1988; Woods-Giscombè, 2010). In fact, a body functioning at an excessive level of stress can become addicted to conditions, such as high blood pressure, generated by the prolonged excessive stress (Sterling & Eyer, 1988). African American women, by virtue of their historical and present marginalized existence, are subjected to excessive and pervasive stress. This stress exacts a toll on their physical and emotional health and creates the opportunity for dis-ease. Moreover, because of the desire to combat the negative stereotypes attributed to them, they rarely

take the time to nourish their struggling health because they expend excessive amounts of energy either countering racism and sexism, or resisting stereotypical images (Adisa, 1994; Collins, 2009; Hooks, 1994; Lorde, 1994; Priest, 2008; Jones & Shorter-Gooden, 2003). African American women live as a dually marginalized group by virtue of their gender and race, therefore experiencing the stress of both groups (Collins, 2009; Perry et al., 2013). They are also quite adept at survival, albeit at the expense of their health.

As a means of examining the basis for the pervasive stress experienced by African American women, I explored the frameworks of Critical Race Theory and Black Feminist Thought. These theories combine to unearth the relationship between the historical experience of the African American Woman and her present day dis-ease.

Happe (2006) aptly stated that a focus on race may create a missed opportunity to explore other correlations that impact the tendency toward disease; however, it is also this focus on race that must be explored as a precursor to stress related disease in African American women. The root of disease is entrenched in a history of racism, slavery, and sexism. A history that has forced African American women to nurture the children of their European American master and mistress while witnessing their own children sold into slavery, a history that created a need for the separation of emotion and strength, because to feel was weakness and a threat to survival (Hooks, 1994). Additionally, this system rendered African American woman as objects of the master's needs, whether sexual conquest or physical labor, while simultaneously labeling them as sexually promiscuous or animal-like. African American women were forced to have unnatural relationships with their slave masters and not permitted to develop healthy relationships and lasting bonds with their children or their husbands (Collins, 2009; Hooks, 1994). It is

the daily contention with the vestiges and consequences of this oppression that has caused the accelerated depreciation of their bodies (Adisa, 1994; Hooks, 1994; Lorde, 1994; Priest, 2008).

### **Critical Race Theory**

Existence in this system of oppression is an outgrowth of the construct of race created by a dominant culture as of means of distributing and withholding power (Bell, 1992; Delgado & Stefancic, 2001). This tool remains an effective means of control even when not explicitly intended, because the basis for the control is woven into the rudimentary elements of this society. Critical Race Theory proposes that racism is pervasive, rooted in the laws and systems established by a dominant culture, and has permanence (Bell, 1992; Delgado & Stefancic, 2001). Critical Race Theory also holds that society chooses to focus on the limited divisive component of race and neglects areas of greater commonality. Society's creation and fixation on race is used to ascribe traits to specific races even though there is no valid basis for this practice (Delgado & Stefancic, 2001). This practice permits the dominant culture to use race for whatever needs deemed expedient at any given time (Bell, 1992; Delgado & Stefanic, 2001). It is this practice that allowed a dominant culture to make one group subservient to another, as in the context of slavery and oppression in the United States (U.S.). In this manner, race is used to designate entitlement, withhold resources, and promote the use of stereotypes for the purpose of manipulation and control (Bell, 1992; Delgado & Stefancic, 2001). Because of the oppressiveness of a society built on racism, it becomes almost impossible to determine if the prevalence of disease is a manifestation of disease inherent in a particular

race, or the physiological manifestation of the inequities endured from a system of racism.

# **Black Feminist Thought**

While race was used as a determinant for those who would serve as slaves, inherent in the successful establishment and continuance of subjugation in the U.S. was the multilayered oppression of African American women. Black Feminist Thought is the lens through which we can view the particular brand of oppression endured by African American women as a result of the intersections of race, gender, and class; as well as the response of African American women to this oppression (Collins, 1986, 2009). As inhumane as slavery was for African American men, African American women experienced a more complex oppression due to the fact that they were also multiply exploited as women (Jacobs, 2012). African American women, like African American men, were required to labor inside and outside of the slave master's house. Additionally, African American women still had to provide meals for their own families while performing their "wifely" duties and nurturing their children (Davis, 1981; White, 2011).

This complex existence for African American women was far different from the experiences of European American women. Although European American women were also often treated as objects and relegated to a less than human, less than equal member of the slave master's household, their existence was a pampered one. They were neither responsible for the running of the household or the tending of their own children, nor for managing two families and the work of the land (Collins, 2009; Davis; 1981; Jacobs, 2012; White, 2011). The African American slave women were considered subhuman (Jacobs, 2012; White, 2011), yet responsible for nourishing, nurturing, and rearing the

European American children and often for satisfying the sexual needs of the slave master (Davis, 1981; Jacobs, 2012). African American women were required to continuously neglect themselves to promote the comfort and well-being of others. This multilayered oppression created a basis for the present perceptions held by society about African American women and indeed for many of the perceptions African American women hold of themselves. African American women are at once considered inferior and required to perform in a superior, superhuman manner (Collins, 1986, 2009; Hooks, 1994)

The functions of African American women are often seen in isolation as opposed to a composite of the many roles they are required to perform. Additionally, because they are identified by their gender, color, and established roles instead of their humanness, many of those in society and in their own families forget that they too have needs. The result is that African American women attempt to live up to the expectations of loved ones, employers, and society while attempting to rid themselves of negative stereotypes contrived in slavery and nurtured in racism. African American women employ unique methods of surviving this oppression, and while these methods have produced an avenue to cope with the stress of raising children, developing careers, and nurturing others, the physical and mental costs remain significant.

# **Restoring Power to African American Women**

Indeed the effects of racism and oppression, whether overt or covert, remain a consistent theme in studies on health and longevity disparities (Carlson & Chamberlain, 2005; Jones, 2000, 2001; National Cancer Institute, 2001; Priest, 2008). Racism and sexism increases stress, depression, and susceptibility to disease and death. While the concept of allostatic load refers to the cumulative biological load endured by an

individual (Seeman et al., 2001), and is repeatedly noted as a factor in morbidity, the permanence of these stressors over time also has the coincident effect of promoting powerlessness in the individual experiencing the burden. This powerlessness can exact a toll on the individual's self-efficacy, their belief in their ability to effect change (Bandura, 1997, 2004; Thomas & Gonzalez-Prendes, 2009). The challenge for African American women relates to the skilled use of Personal Mastery, the ability to recognize the current reality, while creating strong vision for the future (Senge et al., 2000). In this manner African American women will not despair, but hold tight to a vision of wellness and wholeness even as they endure sickness and disease. If African American women are to mitigate the detrimental societal influences, they will have to redefine themselves on their own terms, adjust their expectations of society and the workforce, and find alternative methods of assessing and neutralizing negative experiences (McEwen, 2000; Mezirow, 1991).

Making meaning and restoration. African American women have a unique way of making meaning out of their experiences. Their thought processes and perceptions are shaped by an upbringing rooted in survival. A survival based on the need to navigate the hazards of racism and sexism, while providing for the needs of those they hold dear (Mezirow, 1991). This survival rarely takes into consideration the personal needs of African American women (Hooks, 1994). While like European American women, they are constantly striving for an identity independent of the one assigned to them through a patriarchal society (Burack, 2004; Collins, 1986), they are also embroiled in a battle against the historical and present impact of oppression at the hands of a society that at once dishonors their hue and assigns them to a permanent underclass. African American

women must evaluate themselves on their own terms. Collaboration and dialogue with other African American women in similar circumstances adds value to this process (Collins, 1986).

While the systemic oppression endured by African American women is costly to their health, it also serves as a catalyst for resistance that is not easily explained (Bell, 1992; Collins, 2009; Davis, 1981). This resistance, as well as the existence on the peripheral of society, provides African American women with a unique perspective that when used effectively and collaboratively can create an opportunity for healing. This same perspective can cause undue harm if not compartmentalized effectively. African American women's culture is a viewpoint formed from the need to survive in this dualistic existence (Collins, 2009). It is an existence that allows them to see what others often cannot, yet causes them to fight oppression others view as nonexistent (Carlson & Chamberlain, 2005).

#### Summary

While documenting specific disease disparities validates the existence of the problem, the tougher work comes with addressing the preventable causes of disease. These preventable causes are associated with equitable care and the reduction of the controllable risk factors associated with disease. An even more difficult undertaking is the creation of an effective channel for the management of the allostatic load endured by African American women.

Because the health status of African American women is rooted in a history of oppression, tradition, and poor personal choices, disease disparities represent a complex problem that requires a multifaceted approach. Educational programs for healthcare

American patient, and the dissimilar ways they may present with disease. However, caution must also be followed to prevent an overemphasis on race that may also cause health issues to go undetected. Additionally, African American women must be informed about the risks of disease and their role in disease prevention. With culturally specific support groups and educational programs, African American women can begin to heal and health care systems can become more responsive to the needs of all people.

This study used literature from the fields of medicine, education, and the social sciences. The literature served to document the disease and treatment disparities and the extensive nature of the problem. This analysis of the literature served to acknowledge how the health of African American women is situated in history and connected to present day disease.

#### Chapter 3

### Methodology

Research documents the fact that African American women suffer from disease more often or to a greater degree than their European American counterparts (American Heart Association [AHA], 2010; CDC, 2005a) and researchers suggest many reasons for this disparity. However, there are three common threads that emerge when examining the health status of African American women: poverty, access to health care, and cumulative stress. It is noted, however, that even when factors of access and poverty are removed, African American women still experience a greater tendency toward disease (Carlson & Chamberlain, 2005; Geronomise et al., 2006). It is therefore critical to explore the concept of allostatic load, the measure of the cumulative stress experienced by an individual, as a fundamental factor in the disease process in African American women (Carlson & Chamberlain, 2005; McEwen, 2000; Priest, 2008; Seeman et al., 2001; Sterling & Eyer, 1988).

A comprehensive understanding of the causes of disease inequity must capture the perceptions held by African American women about their well-being. Their voices must provide the starting point for healing. While poverty and access issues exist, they do not fully account for the level of disease experienced by African American women. The propensity towards disease in African American women exists outside of the spheres of poverty and lack of access to medical care. Unrelenting multilayered stress remains the constant factor in the disease progression in African American women (Carlson & Chamberlain, 2005).

As a means of addressing the health of African American women, I conducted a mixed methods study designed to explore the perceptions held by African American women about factors affecting their wellness. The study examined the lifestyle practices and experiences of the participants as they took part in a wellness support group.

This study also explored the research on allostatic load through the lens of Black Feminist Thought and Critical Race Theory. Another goal of the study was to observe the reflective practices of the participants in relationship to the concepts of personal mastery (Senge et al., 2000), making meaning (Mezirow, 1991), mental models (Senge et al., 2000), and self-efficacy (Bandura, 1997, 2004).

#### **Research Questions**

This study provided the opportunity to observe the women as they participated in a wellness support group. The study attempted to answer the following questions:

- 1. What were the perceived factors that impacted the health of African American women?
- 2. How did self-efficacy and mental models influence the health and wellness of African American women?
- 3. How did Black Feminist Thought and Critical Race Theory provide a framework for understanding the health and wellness of African American women?

This chapter serves as a discussion of the methodology used in conducting the study. Within this chapter, I discuss the conceptual framework that guided the study (see Appendix A), the research design, the participants, and the setting. I also explain the data collection process and data analysis procedures as well as the procedures used to ensure

the reliability of my data. Lastly, I discuss my assumptions and the limitations of the study.

# **Conceptual Framework**

One of the components of wellness centers on responsibility for one's own health and wellness. This concept is a component of the social cognitive theory espoused by Bandura. According to Bandura, an individual's belief in her ability to influence her own behavior is an essential factor of any program designed to improve the health of the participant. Bandura stated:

Current health practices focus heavily on the medical supply side. The growing pressure on health systems is to reduce, ration, and delay health services to contain health costs. The days for the supply-side health system are limited. People are living longer. This creates more time for minor dysfunctions to develop into chronic diseases. Demand is overwhelming supply. Psychosocial factors partly determine whether the extended life is lived efficaciously or with debility, pain, and dependence. Social cognitive approaches focus on the demand side. They promote effective self-management of health habits that keep people healthy through their life span. Aging populations will force societies to redirect their efforts from supply-side practices to demand-side remedies. Otherwise, nations will be swamped with staggering health costs that consume valuable resources needed for national programs. (Bandura, 2004, p. 144)

Much of what is stated by Bandura in this quote embodies the elements noted by this study. A move away from medicating symptoms towards more diligence in self-care is needed to counteract the disease disparities faced by African American women. Too much emphasis is placed on the control of disease rather than the prevention of disease.

Bandura (2004) focused on using social cognitive theory as a means to promote health and wellness. He addressed the need for self-efficacy as a principal factor required for an individual to change detrimental health practices. While awareness of the impact of negative habits is important, little or no lasting change will result if the individual does not believe she possesses the ability to do so.

This concept of self-efficacy for African American women encompasses many elements. Achieving self-efficacy in the pursuit of wellness in spite of systemic marginalization is complex. African American women who express belief in their ability to exercise and obtain solid nutrition often do not do so in spite of a professed desire for wellness. It then becomes a matter of understanding what factors detach the belief in the ability to diligently pursue wellness from the actual development of positive health habits. It was this disconnect that caused me to modify the original design of this study from an action research study to a mixed methods study designed to explore the perceptions held by African American women about health and wellness.

It was the desire to understand the pivotal disease-causing factors that formed the focus of this study. The statistical data described the prevalence of disease, but outside of denoting the risk factors associated with disease, did not address the root of the problem. In order to change the health condition of African American women there was a need to understand the issues that led to their compromised health status. It is easy to list controllable risk factors and the literature offers a myriad of plausible reasons for the disease in African American women. However, it is important for African American women to examine the purported causes in the context of their individually held perceptions and to come together to explore the causes and perceptions as a group (Adisa, 1994; Collins, 2009; Washington et al., 2007). This exploration must include the statistical data, self-assessment data, as well as an examination of the historical context of racism, cultural traditions, and sexism as possible reasons for the degree of stress experienced by African American women.

As noted previously, the prevalence of disease in African American women is evident even in the absence of factors linked to poverty and access (Carlson & Chamberlain, 2005; Geronomise et al., 2006). It is therefore apparent that allostatic load as an indicator of cumulative stress is fundamental to the exploration of disease in African American women.

Conducting this exploration of allostatic load through the theoretical lens of Black Feminist Thought and Critical Race Theory offers an opportunity to examine the significance of the historical context of the issue. African American women experience a three-cord type of enduring oppression due to the intersection of racism, classism, and sexism (Collins, 1986, 2009; White, 2011). This oppression is deeply rooted in the structure of this society and is therefore pervasive (Bell, 1992; Delgado & Stefancic, 2001). One of the key tenets of Critical Race Theory is the pervasiveness of racism. Racism is woven throughout every system in this country and is the normal experience for people of color (Bell, 1992; Delgado & Stefancic, 2001). It is this pervasiveness that explains the inherent bias in the healthcare, political, and legal systems. It is also this bias that has fueled the health disparities experienced by this nation. The prevalence of racism means that it is an unavoidable risk factor for African American women. It will always factor into the level of wellness that they experience even as they make efforts to mitigate its influence.

While much research exists on the unequal contribution of African American women to disease in this country, there is not enough research on how Black Feminist Thought and Critical Race Theory might help us to better understand the concept of allostatic load. Black Feminist Thought permits us to view the basis for the suppression

of emotion as a means of survival and self-neglect as a demonstration of strength (Hooks, 1994). It also offers a declaration of the peculiarity of the struggle of African American women when compared with European American women and African American men. It was born of the recognition that many battles for racial and gender equality left African American women's issues unattended, leaving them at the bottom of the food chain, objectified individuals who were expected to produce, but whose voices were silenced (White, 2011).

Black Feminist Thought was also birthed out of the need to understand how

African American women make sense of their status in this society, how their perceptions
color their actions, and how their response to triangulated oppression varies based on the
particulars of their individual situations and experiences (Collins, 1986; Gilkes, 2001;
Hooks, 1994). It is for this reason I chose to study the perceptions held by African

American women, particularly the perceptions that govern their response to stress and
their self-care. Exploring the roots of prolonged stress is often a complex undertaking.

This is even more the case when the stress response is an outgrowth of hundreds of years
of oppression rooted in racism, classism, and sexism.

While oppression created a foundation for much of the stress response syndrome in African American women, it has also compelled African American women to free themselves from the externally created images used to define them. This process, self-definition, represented a rejection of not only the images, but of the systemic oppression that allowed them into existence. Inherent in this rejection was the creation of new self-defined images, self-valuation, that more positively reflected African American womanhood (Collins, 1986, 2009). Unfortunately, this process is not without

consequences in that new images are often created to address the need to be polar opposites of the negative, externally contrived images. This adds to the stress burden of African American women (Collins, 1986; Jones & Shorter-Gooden, 2003). In this sense an exploration of self-efficacy as it relates to self-valuation may be needed to affirm the strength of African American women independent of the aforementioned negative images.

African American women can achieve improved health, vitality, and longevity. They must feel capable (self-efficacy) of making the changes necessary to mitigate the impact of oppression that has resulted in an unhealthy stress management process. They first must be willing to recognize the cultural responses to oppression that have served them well and also those that have not served them well. Silence has not served African American women well. They often suffer in silence and feel the need to be martyrs. Lorde (1994), who died an untimely death from cancer stated,

Most of all I think of how important it is for us to share with each other the powers buried within the breaking of silence about our bodies and our health, even though we have been schooled to be secret and stoical about pain and disease. But that stoicism and silence do not serve us nor our communities, only the forces of things as they are. (p. 35)

The significance of African American women's culture must be explored as a catalyst to the process of breaking the silence and effectively managing stress and therefore health.

The fact, as Lorde (1994) states, "that we are schooled to be secret and stoical about pain" (p. 35) speaks to the stronghold of our mental models (Senge et al., 2000). We hold on to our established beliefs to avoid the conflict that surfaces when new thinking challenges long held beliefs (Mezirow, 1991). Senge et al. define mental models as a "discipline of reflection and inquiry skills focused around developing awareness of

attitudes and perceptions – your own and those of others around you" (2000, p. 7). Mental models are often protected, sometimes subconsciously. They are closely held perceptions that have served us in some way. Whether it served us as a means for resistance or survival, as in the case of African American women's culture, or as a means of building secure walls around our comfort zone.

As stated earlier, the mental model discipline is very closely aligned with Mezirow's (1991) concept of making meaning. Mezirow speaks of this process as a method of reflecting on the foundations of our beliefs and revising those beliefs into a new context. Another discipline presented by Senge et al. (2000) is personal mastery. Senge et al. discuss personal mastery as the practice of formulating a clear personal vision while simultaneously establishing a concrete understanding of the present reality to create and build personal capacity. This model establishes personal accountability and fits nicely with the self-efficacy tenet of Bandura's Social Cognitive Theory (Bandura, 1995, 1997, 2004). Bandura's self-efficacy tenet is based on the premise that an individual's belief in the amount of control that she has over a situation determines the extent to which she can change that situation. Once this control is exerted it has the effect of reducing or eliminating feelings of powerlessness, in turn improving one's sense of well-being. When applied to health this means that a person who believes she can effect change in her weight or her health will ultimately make the changes necessary to do so.

### **Research Design**

As a means of exploring the barriers to wellness in African American women, this study employed a mixed methods approach to collecting and analyzing data. According to Creswell and Plano Clark (2011), mixed methods research emerged as the result of the

need to address the gaps created by studies that employed either qualitative or quantitative data exclusively. The integration of both types of data enhanced the likelihood of achieving the goals of this study. A mixed methods study allows the researcher to obtain diverse forms of data from various perspectives (Creswell & Plano Clark, 2011; Mason, 2006; Torrance, 2012). This type of design represents multiple ways of seeing, hearing, and making sense of the gathered data (Greene, 2008; Mason, 2006). Mixed methods gives the researcher the flexibility to determine whether the data will be collected concurrently or sequentially and at what point the data will interface (Creswell, 2009; Creswell & Plano Clark, 2011). This research method can also help to provide an imbedded validation process through the triangulation of data (Creswell, 2009; Creswell & Plano Clark, 2011).

In this study the data were collected concurrently to provide a comprehensive view of the perceptions held by the women throughout the entire study. The qualitative data strands allowed me to focus on the richly detailed experiences related by the participants through words and nonverbal clues (Mason, 2006). These data strands entailed the use of purposeful sampling and were collected through video, observations, and semi-structured one to one interviews (Creswell, 2009). The quantitative strands provided the opportunity to determine any relationship between the variables of weight, Body Mass Index (BMI), and level of contentment (Creswell, 2009; Creswell & Plano Clark, 2011). For these data I employed the use of a rating instrument, an online BMI calculator, and a quality digital scale.

Another aspect of mixed methods research is the balance of the data. According to Creswell (2009), in some studies the qualitative and the quantitative are given equal

weight, while other studies emphasize one method over the other. This is largely dependent upon the interest of the researcher and the goals of the study. Mason (2006) suggests that a qualitative analysis of both data strands, qualitative and quantitative, affords access to information that might otherwise be missed. In this study, priority was given to the qualitative data collection and analysis as a means to assess the manner in which the participants make meaning of their well-being and to provide a plausible explanation for any gaps identified between the two strands (Mason, 2006).

According to Mason (2006), "research strategies should be driven by the research questions we seek to answer, and part of this must involve choosing methods that are appropriate to the questions being addressed" (p. 13). In this case a mixed methods strategy was most appropriate for the multidimensional research questions that guided the study. The mixed methods strategy served to enhance the open-ended methods of gathering data and as a means of viewing the reflective process of the participants.

Additionally, it allowed for the continuous comparative analysis of divergent strands of data as a means to the illuminate the subtleties that occurred within and between the participants (Glaser, 1965; Glaser & Strauss, 1967; Mason, 2006).

#### Role of the Researcher

The role of the researcher is that of overt participant observer. The role of the overt participant observer is interactive and not hidden from the participants (Di Domenico & Phillips, 2010). I communicated my role to the participants to ensure that they were aware of the purpose for my presence during the wellness support group sessions. As a participant observer I interacted with the other participants in the support group sessions and participated in the discussions after the sessions ended.

While the overt participant observer's role permits the researcher to closely observe the experiences of the participants and affords the opportunity for informal discussions, the role is not without challenges (Di Domenico & Phillips, 2010). One issue is that the presence of the researcher may alter the dynamics of the group and distort results (Creswell, 2007; Di Domenico & Phillips, 2010). This is particularly true when there exist marked differences between the researcher and the group under observation (Di Domenico & Phillips, 2010). Another conflict is that the researcher must attempt to maintain a sense of objectivity within the natural realm of human subjectivity (Schuetz, 1944). In many cases it is important to bracket personal beliefs and other subjective elements as much as possible in order to preserve the validity of the data (Creswell, 2007; Di Domenico & Phillips, 2010).

The role of overt participant observer aligned with my participatory advocacy worldview. This worldview represents the set of beliefs that guided my actions (Creswell, 2007, p. 19). According to Creswell (2007), research within the participatory advocacy worldview embeds a call for action to effect change in the lives of the participants. As both participant and observer I was able to explore the issues of the participants in light of their marginalized status while also reflecting on my own experience as an African American woman. Inherent in this study was the recognition of the need for the participants to have a voice in addressing and mitigating the core issues related to the prevalence of disease in African American women.

#### **Participants and Setting**

This study employed the use of purposeful sampling. A purposeful sample means that the participants were recruited based on the their ability to provide the data needed to

address the goals of this study (Creswell & Plano Clark, 2011). Although several themes (such as poverty, prevalence of risk factors, and stress) had been identified in the literature, it was important to focus on a group of women who could provide the insight related to the problem. The participants were selected by virtue of their experience as African American women and their desire for improved wellness. Furthermore, I desired to recruit middle-income African American women with private health insurance to eliminate the variables of poverty, lack of insurance, and lack of access emphasized in many disease disparity statistics (CDC, 2005b, 2009). Income was self-reported using the guidelines established by the United States Census Bureau 2011 median income for women (United States Census Bureau, 2015). The women were part of an active wellness support group and met all of the intended criteria.

The final group consisted of nine middle-income African American women between the ages of 37 and 80. This purposeful sampling ensured the collection of data from those central to the issue (Creswell, 2007). One of the participants was married. Two were widowed, three were single, never married, and three were divorced (one previously widowed, remarried, and divorced). All of the women were legally able to provide informed consent to participate in the study.

This study occurred across multiple settings. The observations of the support group meetings were conducted in the living room and dining room at the home of the wellness support group facilitator and the interviews took place in the homes of the participants. The home of the facilitator was a relaxing environment and supported the need for a culturally relevant experience for this population (Adisa, 1994; Collins, 2009; Jones & Shorter-Gooden, 2003; Washington et al., 2007).

This setting created an atmosphere that enhanced the goals of the study and provided the opportunity to view the participants in a natural environment (Creswell, 2007). Participants engaged easily in conversation and provided the researcher with rich data.

#### **Data Collection**

According to Creswell and Plano Clark (2011), "in mixed methods research, data collection procedures consist of several key components: sampling, gaining permissions, collecting data, recording the data, and administering the data collection" (p. 171). In addition to these key components, collection of data involves planning that addresses the timing of the collection of both strands and also the point at which the strands will interact (Creswell, 2009; Creswell & Plano Clark, 2011).

As part of this process I implemented a mixed methods study in which qualitative and quantitative data were collected concurrently. This concurrent design permitted me to collect comprehensive data about the experiences of the participants and to determine if data from one strand supported or contradicted the other strand (Creswell, 2009; Creswell & Plano Clark, 2011). For this study I recorded my observations, experiences, and reflections in a computerized researcher's journal.

Prior to conducting the study, an application was made to the Institutional Review Board for permission to proceed with the study. This permission was obtained within two weeks of application. After receiving the necessary permissions, I met with the wellness support group. During this meeting, I distributed copies of the Letter of Informed Consent (Appendix B) and answered questions. The participants signed the letter and were furnished a copy for their records.

According to Creswell (2007), the collection of qualitative data requires "the use of distinct approaches to inquiry" (p. 37). I accomplished this through a three-tiered process that included observations, focus groups, and interviews. The support group and focus group sessions were videotaped and each interview was audiotaped.

Tier one observations. The first tier consisted of observing the women as they participated in the support group. As part of this process I observed and recorded nine wellness support group sessions. Creswell (2007) suggests the use of an observation protocol to provide the details of the session and to record descriptive and reflective notes. My electronic tablet was used to record my descriptive and reflective notes during the course of each session. I also reviewed the video for additional data and insight into the dynamics of the sessions.

At the start of each support group session the women discussed any challenges encountered since the last session. The women freely related their experiences during this time. After this period of sharing, the support group facilitator presented the women with information on various health concerns. This information session included statistical data as well as the results of the latest health research. The women then commented on the information and made personal reflections about the information conveyed.

Another period of observation was conducted at the close of the meeting when the women shared a meal and often continued with a discussion of the topics introduced during the session. According to Creswell (2007), a general guideline in qualitative research is to collect as much data as possible about the individual being studied.

Although this segment was not recorded, it provided the opportunity to garner more data

on the subjects of my study. Observing the women as they socialized and shared a meal provided rich, and at times unexpected data, which enhanced the study.

**Tier two focus groups.** "Focus groups create data through group interaction on a topic determined by the researcher" (Morgan, 1996, p. 130). Information obtained from focus groups produces a synergistic data result. The information derived comes not only from the individual participants, but also from the dynamics of group interaction and often leads to greater understanding. The focus groups in this study were conducted at the conclusion of the wellness support group sessions and prior to the meal. The discussions concentrated on perceptions held by the participants in the areas of health and wellness. A modified version of Critical Incident Technique was used to elicit stories that detailed the experiences of the women in the areas of health and wellness (Appendix C). Critical Incident Technique is a process used to gather data on meaningful human behaviors. The behaviors (incidents) are considered meaningful when they contribute valuable insight to the area under study (Flanagan, 1954; Norman, Redfern, Tomalin, & Oliver, 1992). Critical incident technique was also used in correlation with Mezirow's making meaning and Senge's Mental Models (Sharoff, 2008). This technique was particularly useful in eliciting foundational beliefs about wellness and healthcare.

Tier three interviews. Tier three consisted of the initial and final interviews. Semi-structured one-on-one interviews were conducted after the first focus group session (Appendix D) and again at the conclusion of the study (Appendix E). As a researcher, I conduct interviews because I am interested in what the participants have to say. I am interested in their stories, their lived experiences, how those experiences impact behavior, and the meaning they make of those experiences (Seidman, 2006).

The semi-structured interview allows the researcher to prepare the questions in advance while also permitting the flexibility to modify the protocol as needed during the interview. The open-ended questions in this protocol were designed to elicit information about present and past lifestyle choices as well as the socialization data that might explain current lifestyle choices. This protocol also created an opportunity for triangulation of data and provided the means for a comparison of data obtained from the similarly designed final interview protocol. Each interview lasted from 30 to 40 minutes and was recorded as explained in the Letter of Informed Consent.

Qualitative data were also collected through the exploration of artifacts and a worksheet during the focus groups sessions. Two artifacts, *The Mayo Clinic Diet* and *The Mayo Clinic Diet Journal* (a copy of each book was purchased and distributed to each participant) were used to prompt discussions on the daily habits of the participants. A worksheet, The Family History Exercise (Appendix F), was also used to generate discussion about family and personal disease history. This instrument yielded some of the richest discussion of the entire study. The use of artifacts served to center the participants' attention on the themes discussed during the focus group sessions (Crilly, Blackwell, & Clarkson, 2006; Kuehne, 2011) and enhanced the quality of the data.

Quantitative data. In addition to the qualitative data collection, four instruments were used to collect quantitative data. These instruments are described in this section. Two identical rating instruments, *My Reality I* and *My Reality II* (Appendix G - one shown), were used comparatively to gauge each participant's level of satisfaction with her life in 12 specific areas. The instruments were identical with the exception that one was launched at the beginning of the study and the other near the end. The *My Reality I* 

and *My Reality II* rating scales coincided with the initial and final interviews respectively. Another quantitative instrument, a digital body weight scale, was used to conduct a weigh-in of all participants during the second focus group session. Lastly, the National Heart, Lung, and Blood Institute's (NHLBI) BMI Calculator was used to calculate the participants' measure of body fat based on their height and weight. (National Heart, Lung, and Blood Institute, n.d.).

### **Data Analysis**

According to Creswell and Plano Clark (2011), an initial step in data analysis involves preparing the raw data. In this study, preparation for data analysis involved transcribing interviews and creating a color code to identify recurring themes across all data sources. This coding was then used to code each interview, each observation, and certain portions of my researcher's journal. Additionally, video recordings were viewed and the resultant observations were also coded.

Data analysis was then conducted using constant comparative analysis (Glaser, 1965; Glaser & Strauss, 1967). This process enabled me to identify the persistent themes through the close examination of data derived from observations, focus groups, interviews, and videos. These data were constantly compared to isolate the most prevalent themes. Data from each source were managed through the use of a structured code map, Figure 1 (Anfara, Brown, & Mangione, 2002). This illustrated the analysis of emergent and enduring themes in relationship to the research questions. It was essential to perform rigorous analysis of data from each strand while also connecting the data for a synergistic effect (Hall & Howard, 2008).

### Validity and Reliability

While there is an advantage to collecting multiple strands of data there are some challenges associated with the process, as noted by Creswell and Plano Clark (2011). Rigorous data collection and data analysis of all strands must be accomplished to ensure that the results are accurately reported. According to Patton (2002), the researcher can build in the triangulation of data by using multiple theories and methods. This study employed the use of Black Feminist Thought and Critical Race theories and used a mixed methods approach to collect and analyze data. Quantitative validity for physiological instruments was addressed through the use of standards from sources external to the researcher and the participants (Creswell & Plano Clark, 2011). Validity was addressed through the process of member-checking (Creswell, 2007). The researcher reviewed the transcribed interview results with the participants to ensure that the results accurately conveyed the meaning expressed by the participants. Meticulous care was also taken to record physiological data accurately.

### **Summary**

This mixed methods study was designed to explore the perceptions of a group of African American women as they participated in a wellness support group. Data for this study were collected from a combination of observations, one-on-one interviews, physiological measurements, and focus groups. Each facet of the study was conducted in a culturally sensitive environment, creating a relaxed, safe atmosphere for participants to express their thoughts and feelings on the issues that impacted their health (Adisa, 1994; Collins, 2009; Hooks, 1994).

This mixed methods approach, although challenging, helped to determine if the qualitative and quantitative data impacted each other and if so in what context or to what extent. When combined with an effective approach to data analysis, this approach embeds validity within the qualitative and reliability within the quantitative aspects of the study. This design also helped to show what relationship existed between the perceptions held by the participants about their ability to make healthy changes and the implementation of the changes.

### Chapter 4

### **Findings**

This study explored the perceptions of African American women as they grappled with the issues of health and wellness. To this end, the study employed Critical Race Theory and Black Feminist Thought as a lens to holistically view the experiences of the participants. The intent of this chapter is to present and discuss the findings of the data analysis process as outlined in Chapter 3.

Black Feminist Thought posits that African American women are impacted by the interlocking oppression of race, class, and gender, as well as society's historical use of controlling images (Collins, 2009). Critical Race Theory advances that racism is enduring and ubiquitous, not an aberration, but part of the usual experience of people of color (Bell, 1992; Delgado & Stefancic, 2001). While both theories have widespread application in research there is dearth of significant data on the use of these frameworks to address the concept of allostatic load. According to Seeman et al. (2001), allostatic load is a measure of the cumulative biological load exacted upon a person as she adapts to the demands of life (p. 4770). Allostatic load represents the wear and tear on the body. It is associated with stress and the stress response particularly as endured by marginalized members of society (Carlson & Chamberlain, 2005; Seeman et al., 2001; Sterling & Eyer, 1988).

As a means to explore the connection between disease disparities and the unique experiences of African American women, this study utilized a mixed methods design to view the multiple realities of the participants. This method provided a foundation for understanding the relationships that existed among the variables associated with disease

in this population. Triangulation was afforded through the use of quantitative data collection as well as three tiers of qualitative data collection comprised of observations, focus groups, and interviews.

In order to provide a framework for continuous data analysis, an adaptation of Anfara, Brown, and Mangione's (2002) structured coding schema, *My Sisters Myself Code Map* (Figure 1), was used. Figure 1 displays the resultant themes, application, and interpretations using a bottom-up format that is described later in this chapter.

This chapter specifically reiterates information about the chosen sample and provides a further description of the participants. This chapter also includes a discussion of the quantitative data collection instruments and presents the quantitative data results. Additionally, the qualitative themes are discussed, as are any relationships between the qualitative and quantitative data.

# **Participants**

The purposeful sample included nine middle-income African American women with private health insurance as an intentional exclusion of the variables of poverty and access. The women in this study were part of a wellness support group that originally included 11 women. Two of the women dropped out of the group, one for health reasons, the other for career endeavors. The nine remaining participants shared their thoughts, feelings, and experiences throughout the study. Each participant was assigned a pseudonym to maintain confidentiality while including relevant responses. While some identifying information is included in this section, care is taken to exclude information that might inadvertently disclose private details. The nine participants were Lorrie, married and 45 years of age; Grace, single and 37; Beth, a widow 80 years of age; Aria,

divorced and 52; Edna, single and 53; Whitney, divorced, previously widowed and 69; Madison, divorced and 56; Gail, single and 63; and Wanda, 52, a widow. Each of the participants resided in New Jersey. Limited details are provided for each participant in order to afford the confidentiality expressed in the Letter of Informed Consent.

Table 1

Participants

Name	Age	Marital Status
Lorrie	45	Married
Grace	37	Single
Beth	80	Widow
Aria	52	Divorced
Edna	53	Single
Whitney	69	Divorced
Madison	56	Divorced
Gail	63	Single
Wanda	52	Widow

## **Quantitative Results**

Each of the participants provided quantitative measurements through the use of four instruments, the *My Reality I* and *My Reality II* life satisfaction rating scales (Tables 2 & 3), weight measurements using a digital scale, and the BMI offered on the National Heart, Lung, and Blood Institute website (Table 4).

Life satisfaction scales. The participants completed the *My Reality I* and *My Reality II* life satisfaction rating instruments on different dates for comparison purposes. *My Reality I* was completed at the start of the study prior to the first focus group session and *My Reality II* was completed near the end of the study, but prior to the final focus group session. This assessment gauged the participants' level of life satisfaction across 12 specific areas: (a) happiness, (b) career, (c) education, (d) spirituality, (e) diet, (f) exercise, (g) finances, (h) social life, (i) relationships, (j) health, (k) home, and (l) hormones. Only the survey results of the women who remained in the study were included in the data results. The participants were asked to rate each of the listed areas from 0 to 100, with 0 representing the least satisfaction and 100 representing the greatest level of satisfaction. This assessment was important because of the need to show any correlation between the degree of overall life satisfaction with other indicators of health or risk factors for disease. It also provided the means to address these correlations during the focus group sessions and to elucidate any relationships between the data sets.

The rating scales revealed lower self-reported scores in the areas of finances, weight, and exercise near the conclusion of the study than those noted at the beginning of the study. As noted in Tables 2 and 3, the difference between the initial survey responses in the areas of diet and exercise dropped from a mean of 56.7 to 47.8 and from 48.9 to 34.4 respectively. The life satisfaction survey results were not surprising in that the lack of contentment in the areas of diet and exercise supported the quantitative measures of overweight and obesity derived from the weight and BMI data. Obesity and the lack of exercise are also identified in the literature as risk factors for disease in this population (Daroszewski, 2004; Myers et al., 1995). The decrease in the rating in these areas may

indicate the impact of increased awareness as opposed to an actual decline in the amount of exercise and the degree of healthy dietary choices.

Despite the overall decrease in the areas of diet and exercise, there was a small increase in the area of health from a mean of 56.7 to 60. This increase was most likely the result of the personal commitment to better health evidenced by the continued participation in the wellness group. Although a strong indication of financial discontent and a slight decrease in contentment with the home surfaced in the *My Reality* II assessment, the qualitative data did not substantiate these findings.

Table 2

My Reality Data I (n=9)

Category	Participants										
	P1	P2	P3	P4	P5	P6	P7	P8	P9	M	SD
Happiness	80	90	55	90	40	60	80	80	80	72.8	17.2
Career	70	30	65	90	40	60	100	80	40	63.9	24.0
Education	70	100	45	90	70	80	80	60	90	76.1	16.9
Spirituality	70	90	80	70	40	50	90	90	70	72.2	17.9
Diet	50	80	60	70	10	50	60	70	60	56.7	20.0
Exercise	50	70	50	70	10	30	60	40	60	48.9	19.6
Finances	70	60	30	70	50	40	80	80	60	60.0	17.3
Social Life	80	80	50	80	40	50	100	80	60	68.9	19.6
Relationships	80	100	80	80	40	50	80	70	90	74.4	18.8
Health	70	90	40	80	10	10	80	60	70	56.7	30.0
Home	70	90	100	80	50	80	100	80	80	81.1	15.4
Hormones	80	100	50	90	50	60	80	80	0	65.6	30.0

*Note.* Self reported level of satisfaction in 12 areas of life. 0 represents no satisfaction and 100 represents complete satisfaction.

Table 3

My Reality Data II (n=9)

Category	Participants										
	P1	P2	Р3	P4	P5	P6	P7	P8	P9	M	SD
Happiness	80	90	55	90	40	60	80	80	80	71.8	17.2
Career	70	30	65	90	40	60	100	80	40	63.9	24.0
Education	70	100	45	90	70	80	80	60	90	76.1	16.9
Spirituality	70	90	80	70	40	50	90	90	70	72.2	17.9
Diet	50	80	60	70	10	50	60	70	60	56.7	20.0
Exercise	50	70	50	70	10	30	60	40	60	48.9	19.6
Finances	70	60	30	70	50	40	80	80	60	60.0	17.3
Social Life	80	80	50	80	40	50	100	80	60	68.9	19.6
Relationships	80	100	80	80	40	50	80	70	90	74.4	18.8
Health	70	90	40	80	10	10	80	60	70	56.7	30.0
Home	70	90	100	80	50	80	100	80	80	81.1	15.4
Hormones	80	100	50	90	50	60	80	80	0	65.6	30.0

*Note.* Self reported level of satisfaction in 12 areas of life. 0 represents no satisfaction and 100 represents complete satisfaction.

Weight and BMI. In addition to the *My Reality* instruments, each of the participants weighed in at the home of the support group facilitator and the results were recorded. The weight and height for each participant was then entered into the BMI calculator. These results were also recorded. This information is shown on Table 4, Weight and Body Mass Index. The BMI categories are: Underweight = <18.5; Normal weight = 18.5–24.9; Overweight = 25–29.9; Obesity = BMI of 30 or greater. The BMI estimates body fat using a calculation of weight and height. While the index is a tool, it is not always an accurate measure for athletes who may have more muscle, and

elderly or bedridden individuals, who may have less muscle according to the National Heart, Lung, and Blood Institute (NHLBI, n.d.).

The results of the BMI calculations for each of the participants fell in the overweight or obese range with a mean BMI of 32.7 and a mean weight of 190.2 (please also note the standard deviations listed in Table 4 as there were wide variances in the weight and height between the participants). The BMI is represented by minute increments that indicate nuanced distinctions in BMI between individuals even when their height and weight reveal substantial differences. This difference can be observed between participants P7 and P8 on Table 4, Weight and Body Mass Index. While participant 7 is 5 feet 8 inches tall and 196.5 pounds with a BMI of 29.9, participant 8 is 5 feet 0 inches tall and 152 pounds with a BMI of 29.7. The BMI measurements also resulted in participant challenges to the validity of the instrument for African American women. These challenges are addressed later in this chapter.

The findings for each of the participants are aligned with the research implicating weight and BMI as factors for disease in African American women (Bennett, 2006; Daroszewski, 2004; Kuchler 7 Variyam, 2003; Myers et al., 1995; Schuler et al., 2008). The data supported the need for change in dietary and lifestyle practices and supported the qualitative findings of the participants' perceptions of their weight.

The quantitative data provided a means to document the presence of three major risk factors associated with disease: elevated BMI, excessive weight, and amount of exercise (self-reported). Each of these risk factors is associated with a greater risk of diabetes, heart disease, and certain cancers (ACS, 2010; AHA, 2010; CDC, 2005a, 2010a; Miller et al., 2005). While there was no comprehensive correlation evident

between life satisfaction and BMI for the group, the two participants with the highest BMI also self-reported the lowest level of contentment on the *My Reality* rating scales. The same individuals were also most receptive of the accuracy of the Body Mass Index as an indicator of the amount of fat in the body (Field Notes, October 22, 2015). This receptiveness was possibly linked to greater degree of acceptance of their current health condition coupled with significant frustration over their perceived ability to change it.

Table 4

Weight and Body Mass Index (n=9)

Measurement	Participants										
	P1	P2	Р3	P4	P5	P6	P7	P8	P9	M	SD
Height	5'2"	5'7"	5'5"	5'2"	5'2'	5'7"	5'8"	5'0"	5'3"	Not Calc	Not Calc
Weight	191	189	226	156.5	261	182	195.5	152	158	190.2	35.4
BMI	34.9	29.6	37.6	28.6	47.7	28.5	29.9	29.7	28.0	32.7	6.5

Note. Weight is calculated in pounds and height in feet and inches.

### My Sisters Myself Code Map

According to Creswell and Plano Clark (2011), the concurrent collection of quantitative and qualitative data affords a holistic view of a situation or problem and can provide an imbedded validation through the triangulation of data (Creswell, 2009; Creswell & Plano Clark, 2011). To this end, Figure 1 was instrumental in collecting and organizing qualitative data and in the analysis of both quantitative and qualitative data. This code map is a graphic representation of the bottom up approach used in analyzing

the data from this study. The research questions are listed at the top of the table and the first iteration section found at the bottom of the table introduces the initial codes derived from the data. Codes represented as 1C and 2C in the first iteration are also supported by the quantitative findings of the *My Reality II* and *My Reality II* rating tools, as well as the BMI and weight results discussed previously in this chapter.

Coding was accomplished using Glaser and Strauss' (1967) constant comparative method. This method is used to constantly analyze and compare data from all sources. It also involves the use of coding structures to identify relevant themes. After exploring the data from the observations, interviews, and focus groups, codes were generated in accordance with each research question. The data were again examined to search for any themes within the codes. The results were used to establish and categorize the themes presented in the second iteration. The third iteration extended a hypothesis based on the thematic categories created in the second iteration. Lastly, the fourth iteration provided a brief interpretation of the data based on the exploration of the themes (see Figure 1, My Sisters Myself Code Map: fourth iteration).

RQ#1 What are the perceived factors that impact the health of African America Women?	RQ#2 How does self-efficacy and mental models influence the health and wellness of African American women?	RQ#3 How does Black Feminist Thought and Critical Race Theory provide a framework for understanding the health and wellness of African American Women?
	Fourth Iteration: Interpretation	ì
alone in raising families and han silence. This aloneness in concer and external environment for dis necessary to adopt behaviors that measures to improve health.	one in corporate America, alone be dling other household obligations. It with racism and unhealthy mental ease. Additionally, the women in a support health, but this assertion.  Third Iteration: Data Application.	They also suffer alone and in al models has created an internal this study assert the self-efficacy does not translate into consistent
health of African American won	m and the response to racism exert nen. Lack of authentic dialogue w rther impairs health and promotes	ith other African American
Se	cond Iteration: Categorized The	mes
1A. Power 1B Aloneness 1C Quality of Sleep	2A. Influence of cultural and traditional beliefs	3A. Racism
First Iteration: Codes		
1A. Medical Test 1A. Medication 1B. Stress 1C. Habits/Lifestyle 1C. Energy 1C. Discipline 1D. Quality of sleep 1E. Boredom and Loneliness	2A. Traditional diets 2B. Perception of Body image 2C. Desire to change 2D. Genetics 2E. Religious Beliefs 2F. Silence	3A. Subjection to standards created with others in mind 3B. Constant need to prove themselves 3C. Learned nature of racism and learned response to racism

*Figure 1.* My Sisters Myself Code Map (to be read from the bottom up). Adapted from V. A. Anfara, K. M. Brown, and T. L. Mangione (2002), Qualitative Analysis on Stage: Making the Research Process More Public. *Educational Researcher*, *31*(2), p. 32.

### **Qualitative Results**

Codes were created from the analysis of observations, focus groups, and interviews. Initially, several explanations for disease emerged from the data obtained from the discussions and interviews with the participants. These explanations included the customary, research-supported issues of dietary and exercise habits. Overeating, poor diets, and lack of exercise represent significant factors for the presence of disease in African American women as noted in Chapter 2 (Daroszewski, 2004; Hargreaves et al., 1994; Myers et al., 1995). Lack of energy was also noted as a by-product of stress and the lack of exercise. Although excessive stress was mentioned often at this point, it was mentioned without a strong connection to overall wellness. Blame for health situations was most often ascribed to a lack of discipline and/or a genetic tendency towards disease (Field Notes, September 10, 2011).

The initial data also revealed the frustration over the perceived comparisons to European American women in the areas of desirable weight and BMI. The women felt the BMI calculators were based on standards that applied to European American women not African American women. They perceived that the inaccuracy of the BMI calculators for African American women caused them to be rated as overweight or in some cases obese due to a heavier bone structure rather than a higher percentage of fat (Field Notes, September 10, 2011). While limitations to the BMI exist, the National Heart, Lung, and Blood Institute (NHLBI, n.d.) relates these limitations to the degree of an individual's muscle as opposed to bone density. Additionally, specific studies conducted to address ethnicity and the BMI suggest that age and gender, not race, exert the greatest impact on BMI results when comparing "black and white adults" (Gallagher et al., 1996, p. 234).

Still, other issues that emerged were the prevalence of divided homes in childhood and the need for authentic discussions to increase awareness and foster healthier choices. While the coding of the initial data provided some insight to the behaviors and assumptions of the participants, further analysis of the data yielded a more comprehensive reality. Each of the participants ultimately connected the lack of discipline in maintaining a healthy diet and exercise regimen to excessive stress (Field Notes, October 8, 2011). This stress directly related to their marginalized status in society and was ultimately categorized into the persistent themes related in this chapter.

Enduring themes. The analysis of the codes through the use of the code map (Figure 1) yielded an overarching theme of stress and included five major categories: (a) aloneness and isolation; (b) power, powerlessness, and control; (c) response to racism; (d) the influence of cultural and traditional values and beliefs; and (e) sleep quality. These themes are discussed in this section.

Stress. According to the *The American Heritage*® *Stedman's Medical Dictionary*, stress is defined as "a physical or psychological stimulus that can produce mental tension or physiological reactions that may lead to illness" (Stress, n.d). In this study, the stress inducing stimuli were discussed through five distinct categories: (a) aloneness and isolation; (b) power, powerlessness, and control; (c) sleep quality; (d) response to racism; and (e) the influence of cultural and traditional values and beliefs. Factors related to each of these areas were found to produce significant levels of stress for the participants.

During the course of this study stress was implicated as a factor in the types and amount of food consumed, the motivation for exercise, and the lack of quality sleep. As

the women began to deconstruct the stress that found its way into every discussion throughout the study, the complexity of the stress also emerged.

Aloneness and isolation. Stress was found to be a result of the aloneness experienced by African American women. Aloneness of itself is not an undesirable state of being. Aloneness is objective and may be therapeutic when it is positive and intentional. At times we desire to be alone to reflect or just enjoy momentary detachment (Galanaki, 2013). However, it is the perpetual aloneness resulting in isolation, loneliness, and feelings of rejection that contributes to the stress in African American women. This aloneness spanned several contexts and included suffering alone, lack of meaningful relationships with a significant other, aloneness in the household, and aloneness on the job. Each of these contexts are explained and supported in this section.

Suffering alone. The context of suffering alone related to the need for dialogue as experienced during the course of the wellness support group and the focus group sessions. This dialogue afforded the opportunity to discuss health issues and wellness challenges. For African American women, culturally relevant interventions offer the greatest opportunity to elicit valuable data (Collins, 2009; Jackson, 2002; Jones & Shorter-Gooden, 2003; Peterson, 2011). Historically, African American women have shared wisdom, problems, and found comfort through the avenue of kitchen talk, generally used to refer to as a relaxed, homey, non-threatening environment in which African American women feel comfortable sharing life stories, detailing their successes, failures, future hopes, and lessons learned. It is in this environment that the women in the study were able to learn and to share challenges and experiences openly and honestly (Collins, 2009; Jackson, 2002; Jones & Shorter-Gooden, 2003; Peterson, 2011).

The support group experience offered the women an opportunity to share their stories and to hear the stories of others. In this setting they expressed concerns and emotions they often felt uncomfortable expressing elsewhere (Field Note, December 10, 2011). This atmosphere helped the women to feel connected to each other as they clarified their thoughts and feelings about their daily existence. The dialogue also provided a means to dissect the health challenges they experienced. "Sometimes it is good to hear that you are not alone," Edna noted, "[we have] a need for conversation to talk out what we are going through diet and health-wise." Wanda also shared:

Through these sessions, as I was listening to the group, although I would share, I didn't share everything. I started looking at everything as a whole. I think if everybody starts talking about it, instead of keeping it all to themself, I believe it helps. Why should your health and other things the way they make you feel be secret? As my mom would always say, why is everything a secret? And then people would realize that what is happening to her may also be happening to me. If you just read about it and don't have actual contact with these people, you may say that is not true, and you have a tendency not to believe it. However, when I was in the circle with the other women, one woman was talking about how all her numbers [test results] were thrown off, and she was frustrated. I was feeling her. And I'm like yes, I understand and I know I am not alone.

Gail also noted, "A partner to exercise with would help to keep you accountable, especially on days when you feel down and are looking for excuses." "Or just having someone to just talk to when you feel beat up and overwhelmed might just stop you from reaching for those potato chips," added Edna. Lorrie, looked pensive as she added, "On the days that my pain is really bad, it would be good to have someone who I could talk to. I mean just knowing that someone even cares enough to say are you ok? Do you need anything?" Aria asked Lorrie, "Have you shared the way you feel with anyone else?" Lorrie replied, "No, everybody is always leaning on me" (Field Notes, November 12, 2011). Lorrie's comments revealed isolation even from those in her household. Suffering

in silence is one of the hallmarks of disease and death in African American women. The need to be stoic causes the women not to speak about troubling issues. They keep it bottled up where it festers into disease. Silence does not serve them well (Lorde, 1994; Priest, 2008). This stoicism is often a learned behavior and is often considered a sign of strength, a perception that the suppression of emotion is tantamount to survival (Hooks, 1994).

The African American women in this study found a therapeutic release in breaking this silence in the company of other African American women. This sharing involved stories detailing their pain. It is in this environment that they found comfort and healing (Collins, 2009; Hooks, 1994; Jackson, 2002; Jones & Shorter-Gooden, 2003; Peterson, 2011). This comfort level elicited rich data from the women and portrayed the multilayered nature of the stress they experienced (Collins, 2009; Priest, 2008). The indescribable heaviness that filled the room as the participants discussed their battles with weight control and mindless eating was common. Lorrie stated, "For me it is a matter of life and death. If I don't change [pause] my health is declining" (Field Notes, November 12, 2011). "I know I should do better, but I get home and it's just me, I start thinking about things and I head for the food," states Gail as she raises her hands and shrugs her shoulders (Field Notes, October 22, 2011). When women discussed the helplessness they felt because of medication or from emotional eating and physical pain, it left no doubt about the need for this type of interaction.

*Need for significant other.* The participants in the study expressed the desire for a relationship with a significant other, but African American women are more likely to find themselves alone. According to the Wiley (2008) documentary, *Soul Mate*, "42.3 percent

of black women have never been married, *and* almost 50 percent of black women between 30 and 34 have never been married compared to 16 percent of white women." The documentary goes on to state that, "the more money and education a black woman has the less likely she is to ever get married or have children."

This particular stressor surfaced during discussions about deepest desires. Of the nine participants in the study, one was married, and one was in a relationship. Two of the women had never been married or had children, three were divorced with grown children, and two were widowed with children. Of the two widowed women, one had been estranged from her husband for over 30 years prior to his death. Grace, 37 years old and never married stated, "I would like to be married and have kids." Wanda, 52, who lost her husband a little over two years ago stated, "I want to move forward, I have a home that I had with my spouse. I would like to leave that home and move forward. Don't make me cry." Madison, 56, a divorced mother, with grown children, stated, "I will be honest with you. I would like to have a relationship, a meaningful relationship [pause] before I am too old to enjoy it." Aria replied, "I have a lot going on right now, but as soon as things settle down, I will be looking for Boaz" (biblical reference to a Kinsman redeemer, a very significant other).

Inherent in this conversation about the search for a significant other was the participants' perception of a shortage of African American males due to incarceration, sexual preference, and what they felt was the outright rejection at the hands of African American men. The women felt that the shortage was linked to the disproportionate incarceration of African American men and the tendency for other African American

males, particularly successful African American males, to prefer to date outside of their race (Field Notes, October 22, 2011). Madison noted:

We [are] more likely to be head of household, also historically our education or experiences often left us in better income situations and even now the educated black men who are not incarcerated are choosing white women as life partners and are not building up the black family.

When exploring the perceived difference in the stress experienced by African American women as opposed to European American women, Edna stated, "That can be many things, it can be African American men. I say that because African American women tend to support African American men, but the support doesn't always come the other way." Whitney, once divorced and once widowed, stated:

Speaking from my experience we are put into situations where so many of us are singles, are widows or we have lost our mates or some of us don't have mates and some of it is also through divorce or not getting along.

Aloneness at home. This absence of a spouse or someone to share household responsibilities significantly impacts African American women on the home front. They are often the only breadwinner in the home and bear total responsibility for the rearing of children and the maintenance of the home. When discussing the lack of help at home Wanda stated, "You know I never had to worry about work that needed to be done on the house, since Gregory's not here anymore, I have to figure everything out by myself." "I know what you mean," replied Beth, "it makes a difference to have a man around the house. These contractors try to cheat you as soon as they know there is no man around." (Field Notes, October 22, 2011).

Even when grown children return home, the burden of running and maintaining the home often remains with the woman. This situation may intensify feelings of aloneness and create resentment. Aria stated:

It is like your home is treated like a hotel. It is bad enough that you are responsible for the bills and the food, but then no one wants to help keep the place clean and orderly. I have more things broken around here than ever. I feel used. (Field Notes, September 10, 2011)

Aloneness in the workplace. This sense of aloneness takes on an additional nuance in the workplace. The aloneness is often linked to race and is marked by the absence of camaraderie with others on the job. Grace illustrated this by stating, "I am the only African American teacher in my building and I find that they have a different level of camaraderie than they might have with me." Edna mentioned, "You are always trying to be on guard, [with] what you do and how you do it. It is not easy to relax." Edna also mentioned the need to try to look and act like the "Caucasians," who comprise the majority of the work staff, in order to fit in.

Indeed the constant need to shift in order to fit in can make the workplace a source of alienation and stress resulting in illness for African American women (Jones & Shorter-Gooden, 2003). The isolation experienced by African American Women in the workplace may be intentional or unintentional, resulting from obvious discrimination, subtle discrimination or based in institutional structures that grant racial privilege. In either case the result is the same, unrelenting stress and increased illness (Okechukwu et al., 2014).

*Power, powerlessness, and control.* While aloneness may account for one facet of the stress endured by African American women, another aspect of stress is explained through the perceptions of power, powerlessness, and control. Power and powerlessness in this sense describe the ability or inability to perform in a given situation. It also relates to the perceived ability to thwart manipulation while exerting greater influence over life situations. Control is described as the use of power to direct outcomes and is related to

the perceived degree of input into wellness and life decisions. This theme relates to sense of power or powerlessness and what the application or non-application of control meant to the women in the study. This notion of power is aligned with the ability to effect change in one's health and wellness, but is also tied to the concept of resistance to perceived external control. For these reasons the related concepts of self-efficacy and resistance are also addressed in this section.

The exertion of power and the feeling of powerlessness appeared throughout the study in the context of healthcare decisions, dietary practices, and the response to racism addressed later in this chapter. Participants felt the need to engage medical professionals in their health and wellness, but acknowledged a sense of relinquished control and powerlessness when placed on excessive medication or given limited influence over treatment plans. Moreover, power was used as an act of resistance even when the effects were detrimental. This resulted in decisions to ignore doctor recommendations and healthy dietary choices as a means to exercise control when feelings of powerlessness surfaced. Some participants refused to allow others to exercise power and control over their health, their diet, or their manner of evaluating their bodies (Field Note, October 8, 2011).

This aspect of control precipitated conversations about body image, motives of the medical profession, and medications. Each of the participants had a medication story, either they avoided medication, were concerned about the amount and frequency of the medications they were taking, or viewed medication as a form of mass treatment for individual conditions. Prescription medication was discussed in several contexts from valuable to villainous. On one hand, some participants viewed medication as something

to be avoided at all cost. Other participants felt that they would not be able to function without it, but even these participants associated dependence on medication with compromised health and powerlessness. This was the case with Gail, who stated, "They put me on Premarin [hormonal control] and I've been on that for about 100 years and I think that I have just been controlled by that for so long that now if I stop taking them I get crazy." Still others recounted the issue of prescription medication with great sorrow, as in the case of Madison. Her statement impacted an entire after meal discussion when she said:

I don't even feel like I am myself, I am on all of these medicines and now I am taking medicine to control the medicines. I didn't really feel bad before all of this, but now they are saying that I have to take medicine to protect my liver from the damage that could be caused by the Lipitor [cholesterol medicine]. I used to feel hopeful that I would be able to change my diet and get off of this stuff, but now I am just fearful of what the medicines do to me and what would happen if I stopped them. (Field Notes, February 11, 2012)

Her statement visibly saddened others in the group. Tears filled the eyes of two of the participants. Aria suggested that she communicate what she felt to her doctor the same way she had communicated it to the group (Field Notes, February 11, 2012). Madison had previously voiced concerns related to the administration schedule of her new diabetes medicine. While she felt she communicated these concerns to her doctor, her doctor advised her to continue with the new medication. Madison felt powerless to change her situation. She was experiencing several incidents of low blood sugar and felt the doctor was undiscerning of her needs. Nevertheless, she continued to follow the doctor's suggestions (Field Notes, February 11, 2012).

Not all of the participants were taking the medication prescribed by their physicians. Some made conscious decisions not to take the medications prescribed, as in

the case of Wanda, who stated, "I don't want to take a lot of medication. Like for my asthma, I definitely don't follow that, but I try to avoid anything that will trigger it before I do the meds." Another participant, Beth, stated:

I've had high blood pressure since I was very young and I very rarely take any medication prescribed for me. When I have attempted to take the medication it has not agreed with me and caused me to have all kinds of problems. I trust God and try to exercise wisdom, although I still need to work on my eating habits and my exercise. I get sick of these doctors who won't even address the issues that I go to see them for because all they see is my high blood pressure. I have more concerns than my blood pressure yet they won't treat anything without trying to put me on medication. (Field Notes, February 11, 2012)

Beth, an anomaly at 80 years of age, persistently indicated a resistance to doctors who prescribed treatment based on her age or treated her as a statistic rather than as an individual. She refuses to take any medication with the exception of an antibiotic if absolutely necessary. Each of the participants verbalized the need to feel empowered to influence the decisions about medical health, particularly in relationship to the treatment of disease.

In some cases, the need for control is closely associated with a need to battle oppression through the use of resistance (Bell, 1992). The discussion of this type of resistance surfaced during a family history activity (Appendix F). During the activity participants were asked to use a chart to explore any family history of disease in the context of their personal disease history. This required them to reflect on personal habits that were either associated with the risk factors for disease or supported better health through a move away from negative traditional habits. This process initiated a conversation about family gatherings and good tasting high fat food. For some participants the issue of food was related to recouping a sense of control. Beth commented, "As my mother used to say, I don't have control over much else in my life,

but I'm going to eat what I want to eat. I am not going to get stressed over my diet. I will do what I can, but I have enough stress in other areas." Edna also commented, "The more I focus on weight and what I supposedly should weigh the stress actually causes me to gain weight" (Field Note, November 12, 2011).

With the comments by Beth and Edna, the issues of control and power resurfaced. This time it related to how the lack of control over other life situations prompted the exercise of control wherever possible. Derrick Bell describes this type of attitude as a determination to resist oppression (Bell, 1992). In this sense, the victims of oppression become triumphant over oppression when they make a deliberate decision to resist domination at all costs.

This resistance-based control may be partially responsible for the challenge to the BMI and weight standards noted during the study. African American women, incensed by the constant comparisons to European American women, feel the need to have standards and images created with them in mind. The participants vocalized the rejection of the body size standards as an attempt to devalue the appearance and body characteristics of African American women by using European American women as the standard. "Our bodies are made different," stated Madison. Grace added that her orthodontist addressed the larger jaw structure of African American women when she was fitted for braces. Beth contributed a recent conversation with a dressmaker who insisted that her clothes fit African American women so well because she used an "African woman's' cut" when creating her designs (Field Note, October 8, 2011). Power and control are factors for African American women, not because of a desire to dominate others, but because of a

desire to feel empowered as opposed to manipulated, to be viewed and valued as individuals as opposed to the other.

The participants demonstrated an inconsistent use of power and control. Some participants were rendered helpless by the need for medicine or the dependence on medical practitioners, while others refused to place any element of control in the hands of their physicians as an assertion of power and resistance. This use of power did not translate into self-efficacious behaviors in the areas of diet and exercise for these women. Instead, self-efficacy is verbalized, but did not materialize. According to Bandura (1997), self-efficacy not only influences the actions an individual takes, but also the time and effort expended to create change even in the face of adversity. During the support group sessions the woman consistently reported that they were unable to follow the healthy suggestions provided at each meeting even while asserting the ability to make the healthy changes.

This inability to make even minor changes was observed during an individual review of each participants *Mayo Clinic Journal*. Participants were asked to make healthy changes by adopting five healthy habits, dropping five unhealthy habits, and adding five bonus healthy habits. The participants were unable to adopt or maintain even five of the healthy habits during a two-week period (Field Notes, November 2, 2011). The inability to sustain healthy lifestyle changes is often equated with self-worth, which further exacerbates a marginalized existence. Each of the participants also indicated dissatisfaction with their current weight and their failed attempts to develop healthy habits (Field Notes, November 2, 2011).

Quality of sleep. The sense of powerlessness also preempted the ability to obtain proper rest. Sleep quality was viewed as a response to stress and eventually a stressor in its own right. The problems and issues experienced during the course of the day lead to poor sleep quality, and the resultant exhaustion produces additional stress on the body. Stress, whether from aloneness, powerlessness, racism, or cultural resistance to oppression, can considerably impact the quality and duration of sleep. Six of the nine participants noted significantly reduced sleep or interrupted sleep as an issue associated with wellness. The women linked the inability to sleep as a manifestation of excessive stress. Lorrie stated,

I think I'm having panic attacks at night. I think I'm so stressed out and I'm running doing all kinds of stuff during the day. So when I lay down to go to sleep or try to relax or whatever, I feel like my body is still running and racing and my mind is going a mile a minute. So, it is kind of hard for me to calm down and be still. You know, I stay up, and I don't go to sleep, so my sleep [is not good]. I'm going to get some Tylenol PM tonight and try that.

Beth noted that her first few hours of sleep were fine, but then she awakens about every one and one half to two hours during the night. Wanda described her sleep, "I don't, I don't sleep. I am one of the ones who sleep 2 hours and I'm up." Whitney also addressed her sleep:

Last night I didn't do too good but surprisingly the week before I've been sleeping every night well, but before that that's the first week I slept good and have really gotten rest, I felt like my body was rested because the weeks before that I sleep for an hour or two and I wake up and I go back to sleep maybe for another hour or two so I am really having a problem sleeping at the moment.

While quality sleep is restorative and healing (Sleep, 2007), sleep deprivation is a factor in heart disease and increased BMI (Sepahvand, Jalai, Mirzaei, & Jahrom, 2015).

Moreover, a lack of sleep increases anxiety and can lead to depression (Colten &

Altevogt, 2006). With six of the nine participants interviewed indicating poor sleep quality, sleep represents a significant factor in wellness for these women.

Racism, culture, and tradition. The type of stress that makes sleep so elusive for African American women is deeply rooted in racism and further ingrained through learned, even cultivated, responses to racism. The marginalized status of African American women in American society is an outgrowth of racism in society. African American women attest to the common nature of racist incidents (Jones & Shorter-Gooden, 2003). Moreover, racist incidents are associated with stress and compromised health for minorities (Okechukwu et al., 2014). Aria illustrated this as she spoke of her routine trip to the grocery store:

I love shopping at Wegmans, but I can't believe the rudeness of some of the women. I stand in front of the grocery store shelf making a selection and a woman comes along and practically steps on my feet to get in front of me. It is like I am not there. What's worse is that she looks at me like I did something wrong. I try to tell myself that it is just a rude person, but when the same woman says excuse me to a white women on the same aisle what should I think? (Field Notes, September 24, 2011)

Other participants readily agreed, Gail stated, "They do make you feel like you're not even there." While Wanda stated, "I make sure that I say, don't you see me, I am not going to let them just act like I'm not there" (September 24, 2011). Wanda, a retired General Motors employee, feels that she was treated like a donkey at work and related the following experience:

We can all do the same job and we get our workload and the workloads of others. I used to use the expression that I felt like a donkey. Don't ask no questions just do the job. Then they ask you why are you so hostile? They try to push your buttons to prove that black women naturally have a bad attitude. They do not even want to acknowledge you as female. Treat you like a dog. This black woman knocked in the air by another piece of equipment hits the concrete, and was made to come to work. A white woman twisted her ankle and was allowed to sit in the office and answer phones. The black woman was eventually fired and then sued

the company ... White woman will say my package is too heavy to lift ...then my supervisor comes to me and tells me to pick it up. I state that I am having problems with my back and he says I don't want to hear it pick it up. They quickly add that you are not a team player...they want you to put on a show.

#### Beth stated:

We are African Americans in a white controlled society, which makes us a minority trying to achieve success in life, which becomes a very stressful challenge. In many cases if we are married our husbands don't make the same salary as our white counterparts so therefore we are in a struggle economically. And of course with so many separations and divorces, and if we are not educated, which has changed somewhat, we are in the lower economic strata of earnings so managing money to reach a budget, to maintain a sensible budget is very stressful...even in seeking employment you have to have the mindset to be the best of the best to even have a chance. And I might say that even racism within the race [identified as colorism] because if you are of a darker hue than your chances of being employed are diminished from those of someone who is fair [in complexion] and less qualified and I certainly have experienced this first-hand.

Inherent in the issue of racism is society's use of images to control and dehumanize African American women as well as the response of African American women to racism and the controlling images (Collins, 1986,2009; King, 1982). Methods used to process racist encounters are rooted in historical marginalization and in our mental models and contribute to or detract from the level of stress endured from each incident.

Our mental models are engaged as we attempt to make meaning of our beliefs and socialization experiences and apply them to new circumstances. Positive uses of mental models include the appropriate transfer of information, which assists with assessing new situations (Mezirow, 1991; Senge et al., 2000). When we are taught that a hot stove can be dangerous and this teaching is reinforced with the personal experience of touching the hot stove, we easily transfer that learning and experience to a new situation for our safety. Less positive uses of mental models include the socialization experiences that teach us to stereotype others. Unfortunately, stereotypes are then reinforced when we encounter

individuals who fit the stereotypical images and thus reinforce our beliefs. These beliefs tend to cause us to expect racism as a part of every day life, however these same beliefs can initiate protective behaviors in racist situations. This expectation and the need for protective behaviors have been shown to increase stress even when the racism does not materialize (Carlson & Chamberlain, 2005). This same type of conditioning is also found in those privileged members of society who are bombarded with negative images of African American women, which become ingrained in their mental models. Each African American woman they encounter that supports the negative images provides reinforcement for faulty beliefs and creates an expectation of certain behaviors.

This relates to African American women on multiple levels. They are socialized through the norms and beliefs provided by family traditions and cultural exchanges, and they are also socialized by the manner in which they are viewed by society. Society's portrayal of African American women promotes disrespect of African American women, generates invalid feelings of inadequacy, and exacts a potentially unhealthy counterresponse. Collins (1986) identified this counter-response as self-definition, which is expressed as a challenge to society's externally created images, and self-valuation, which is the replacement of society's images with representations of authentic black womanhood. Politically and socially the controlling images are purposed to frustrate the African American woman's fight against oppression and therefore maintain the status quo (Collins, 1986; Gilkes, 1981; King, 1982).

The counter-response to these images may appear positive on the surface, but create an increased level of stress for African American women by producing an ever present need to struggle. As mentioned previously, the response to racism varied among

the participants. This difference is addressed through the means of socialization experienced by the women. Wanda was socialized by her upbringing to confront racism directly while Aria was taught to address it through formal channels, to write letters, or register complaints. Grace and Aria also mentioned that they were taught at home to pray for those that perpetrated racist acts as opposed to becoming confrontational (Field Notes, February 11, 2012). Beth noted that in her home, she and her siblings were trained to be better than those that discriminated against them. She stated, "We were taught to be better behaved and to work harder than the others. We were already stereotyped to be lazy when we were the ones that had to do the work" (Field Notes, February 11, 2012).

Sometimes the culture of the home is not just verbalized, but demonstrated through example as well. Edna noted, "My mother [a cancer survivor] never complained even when she was diagnosed with cancer. She did not really discuss her pain and emotions while she was going through her illness" (November 12, 2011). Aria noted, "My grandmother just kept going even when she was in pain. So many people leaned on her and then one morning she stood up and drop to the floor from a massive stroke. She died that day" (Field Notes November 12, 2011).

Nonetheless, African American women continue to battle society's attempt to control them. The fight is costly. African American women are taught by precept or example, to ensure that whatever they do is the polar opposite of the negative images society has imposed on them. To this end, they felt a constant need to prove themselves. This is characterized by a need to be careful to not display anger, even when warranted, to speak more quietly, to ensure that clothing is not suggestive or form fitting, lest someone reaffirm the stereotypes as truth for all African American women (Jones &

Shorter-Gooden, 2003). Edna, as noted previously, addressed the need to fit into a predominately "Caucasian" work setting; this meant watching her dress and the manner in which she styled her hair (Field Notes, February 11, 2012). This constant pressure represents a significant stressor for African American women. It is imposed by society and nurtured by mothers as they teach their children how to survive as a marginalized member of society.

### Summary

The data derived from this study served to substantiate the risk factors associated with disease in African American women through the use of quantitative and qualitative measures. The Code Map (Figure 1) was used as a tool to constantly analyze and categorize information throughout each tier of data collection. The data analyzed throughout this study disclosed an overarching theme of excessive stress categorized in five contexts: (a) aloneness and isolation; (b) power, powerlessness, and control; (e) sleep quality; (d) response to racism; and (e) the influence of cultural and traditional values and beliefs. These areas were responsible for the multilayered stress endured by the participants. Aloneness, powerlessness, and racism are part of the daily experience of the women in the study and encompassed the workplace, social life, and home life.

Moreover, the women were reared in a manner that prepared them for racism and taught them how to respond to racist acts. The participants expressed a need for consistent dialogue as a means to offer mutual support and to increase awareness while addressing these life challenges.

Critical Race Theory and Black Feminist Thought facilitated an understanding of the multifaceted stress experienced by African American women. This stress is often a result of oppression founded in racism and intensified by self-imposed standards developed as a response to society's controlling images (Collins, 1986, 2009). The self-imposed standards then become an additional source of stress for African American women.

It is impossible to view the allostatic load endured by African American women outside of the context of recurrent acts of racism and the intense struggle to make sense of a dually marginalized existence. Combining the theories of Critical Race and Black Feminist Thought illuminates the impact of the collective experiences responsible for the measure of allostatic load experienced by African American women.

Critical Race Theory explains the significance of the stress endured by African American women by asserting the permanence and the frequency of the racism they experience. Critical Race Theory also helps to explain how deeply entrenched racism is in our society. It accounts for well-established systems of privilege that set the standards for beauty, success, justice, and access to power and control (Bell, 1992; Delgado & Stefancic, 2001). Because of racism, parents find the need to instruct their children in methods of managing racism or the possibility of racism. This exacts an additional level of stress as it creates an internal monitoring system resulting in a guarded existence, an inability to relax.

Black Feminist Thought addresses the nature of the oppression endured by

African American women through the viewpoints produced by the African American

women as they grapple with their status in society. To this end, the women, as an answer
to constant subjugation, must redefine themselves on their own terms and create

culturally relevant means to do so (Collins, 1986, 2009). Resistance to systems created to control African American women is a natural and necessary part of this expression.

Although African American women communicate common experiences, the expression and processing of these experiences may vary greatly. To this end, while the women communicated like experiences, their handling and processing of the experiences varied. One example of this was the vocal response to racism communicated by Wanda and the prayer response communicated by Grace. The importance for the women to come together as a group to share the commonality and the differences in expression is a noted aspect of Black Feminist Thought and is associated with need for culturally relevant dialogue and support systems (Collins, 2009; Priest, 2008).

The group, through the rejection of the standardized assessments of acceptable weight and BMI, also expressed the need for culturally relevant health standards and assessments. The data also revealed a significant need for the participants to form a personal definition of wellness that supports their beliefs and attitudes about health. Many of them were unable to conceptualize what good health meant to them and instead resorted to commonly accepted measures of health to describe their level of wellness. Developing a clear picture of what health and wellness looks like for them will help the participants to sustain the needed changes for quality and longevity of life (Senge et al., 2000, pp. 59-65).

Although the life of African American women is fraught with unrelenting stress associated with aloneness, powerlessness, racism, faulty mental models, and impaired sleep, the load endured by African American Women is not easily communicated. They often lay blame upon themselves in an effort to explain the struggle to thrive in an

oppressive society and to combat situations outside of their control. Nevertheless, they must bear the responsibility for confronting the issues that have led to the levels of disease noted among African American women and for making the changes needed for optimum wellness.

According to Mezirow (1991), culturally based learned behaviors are rewarded. This is true of learning in the home and learning in society. If societal norms are followed, behavior is rewarded. If parental teaching is demonstrated, behavior is rewarded. Lorrie recalled a racially mixed coworker, "They loved her because she wore her hair like them and was more quiet than the rest of us, she didn't do much work but she fit in, she fit the mode" (Field Notes, October 22, 2011). Lorrie suggests that individuals are rewarded when they conform to societal norms. This expectation of conformation exerts undue stress on African American women as they attempt to fit into society while simultaneously fighting stereotypes.

While African American women experience stress due to the need to conform to society's standards, they are also constantly torn between the cultural teachings related to identifying and responding to racism and lifestyle choices. Traditional behaviors must be challenged in order to stem the disease process in African American women.

Senge et al. (2000) addressed the concept of mental models as the process of exploring and understanding the source of our thinking and the thinking of others. This permits an exploration of the thoughts that precipitate damaging cycles of negative behavior. Both Mezirow (1991) and Senge et al. (2000) addressed the significance of critical reflection, the need to examine our value systems and our thought processes. This examination facilitates awareness and precipitates changed behavior.

Change involves a clear understanding of current circumstances and desired circumstances. According to Senge et al. (2000), "Personal Mastery" is the practice of clarifying personal vision along with an honest assessment of current reality to create a change producing tension (Senge et al., 2000, p. 7). This aligns with Bell (1992), who while addressing the need to understand the permanence of racism, also noted the possible undesired effect of despair. African American women must be able to develop a coherent assessment of their current health while establishing a clear vision for optimal wellness. This is not to create an avenue for despair, but instead to build the ability for consistent healthy lifestyle choices.

## Chapter 5

## **Summary, Conclusions, and Recommendations**

Achieving wellness as a marginalized member of society is a challenging but necessary undertaking. This even more so when the marginalized members are so accustomed to the oppressive existence that they place the experiences in the recesses of their minds as of means of survival (Hooks, 1994). A system of marginalization impacts the health and wellness of the less privileged. Moreover, it teaches acceptance of the oppression as a way of life while disaffirming the existence of the experience. How those less privileged individuals make meaning of the status imposed upon them is a critical element in understanding and reducing disease disparities in African American women (Carlson & Chamberlain, 2005; McEwen & Stellar, 1993).

African American Women exhibit a greater tendency toward disease than European American women. This is often attributed to issues related to poverty, access, stress, and discriminatory treatment provided by healthcare professionals. This study attempted to explore the factors associated with compromised health from the women central to the issue (Creswell, 2009).

This study sought to discover the meaning African American women attributed to their health status and their status in society. The experiences and the perceptions detailed by the participants were viewed through the lens of Critical Race Theory and Black Feminist Thought to determine if the frameworks would provide insight to the problem and disclose any gaps in previous research. The study also utilized these theoretical frameworks to examine the concept of allostatic load as a factor in the disease experienced by African American Women. Lastly, the study addressed the role of self-

efficacy (Bandura, 1997), making meaning (Mezirow, 1991), Mental Models, and Personal Mastery (Senge et al., 2000) in the disease and healing process for the participants.

### **Research Ouestions Answered**

The goal of this study was to explore the perceptions held by African American women in the areas of health and wellness and to address the roles of making meaning and self-efficacy in the health status of the participants. The study attempted to answer three research questions. The answers to the questions are presented in this section.

**Research question 1.** What were the perceived factors that impact the health of African American women? African American women in this study described their health using the most common indicators of health such as weight, diet, and the absence or presence of disease. They initially described their health as either good, fair, terrible, or better than what it was. Some then added additional information to clarify these perceptions. For instance, Lorrie stated, "Terrible right now, not exercising or eating right." Beth replied, "fair," but added that her stress level was extreme. Madison stated, "Right now, fair, now a couple of months ago I would say good; but now because of the heart disease, I would say fair." Whitney's statement was extremely revealing, as she stated, "I would say it is good because I don't have a terminal illness or anything." These answers were provided early in the study, but it is interesting to note that towards the end of the study, some of the participants expressed a different, possibly deeper, understanding of their health. This also correlated with a lower mean score in the areas of diet and exercise on the My Reality rating scale as noted in Table 3. While the women in this study equated diet, weight, and the absence of disease with wellness, it is important

to add that when the women reflected on the risk factors associated with disease they each implicated stress as a factor. This stress was rooted in aloneness, powerlessness, cultural beliefs, and racism and exacerbated by disturbed sleep. Hooks (1994) addressed the ineffective management of this type of stress as a remnant of slavery, allowing no time for healing, no time for feeling. Survival during slavery, Hooks contended, did not allow the luxury of emotions; you had to continue with the business of life even if you just experienced the lynching of your husband or your child being sold away (p. 333). Unfortunately, this training, received in African American families by precept or example, causes women to neglect emotional and physical well-being in an effort to contend with basic existence. In this case stress, though ever-present, was not addressed, but pushed to the side in order to handle issues of daily survival. Neglecting self-care in the face of unrelenting multifaceted stress fosters disease and illness in African American women.

Research question 2. How did self-efficacy and mental models impact the health and wellness of African American women? Mental models impact self-efficacy as they limit a person's ability to change (Senge et al., 2000). The women in the study found it difficult to take the time to nurture themselves. They also witnessed the same behavior in their mothers and their grandmothers (Field Note, November 12, 2011). Some long held beliefs represented barriers to sustaining a commitment to a wellness program. These barriers to change were observed in the participants who chose to follow the beliefs of parents who exercised control through unhealthy food choices. It is also noted in the participants who determine to counter society's images by proving they are better than the women depicted by the images. An authentic assessment of mental models represents

a first step in acknowledging the long held beliefs and assumptions that hinder selfefficacy and render healthy lifestyle change initiatives ineffective.

Despite verbalizing sentiments to the contrary, the African American women in this study were unable to establish and maintain a healthy lifestyle. Of the nine participants, eight claimed to have the ability to make the necessary changes to improve their health, but seven of them consistently failed to do so. Lorrie, however, noted this powerlessness as she admitted to a need for outside assistance. She stated that her current weight terrified her. She acknowledged that she feared her weight would lead to other health conditions. Her test results had already shown that she was nearing levels considered borderline for diabetes and she had started to have trouble with her pancreas. She was desperate for change. Other participants in the group who were diagnosed with diabetes admitted to monitoring what they ate, but still seemed unable to manage their weight, a critical element in the control of diabetes (ADA, 2011). Any failures related to deficient self-efficacy were explained away. Gail voiced the sentiments shared by many in the group when she stated, "I think if I could just grab hold of whatever it is that I am letting slide through my hands. I think everything could be changed. I think a lot of my problem is because I am not pushing myself." Many of the women felt they could make the changes if they just had the right amount of time to plan and prepare meals, the right amount of peace so they were not constantly worrying, and the right amount of money so they did not have to work so hard; then they could really focus on their health and wellbeing. For right now they are comforted by the perception that self-efficacy is not an issue for them. After all, they have been trained to place self-care on the back burner while they sacrifice for others and negotiate life (Gilkes, 2001).

Research question 3. How does Black Feminist Thought and Critical Race

Theory provide a framework for understanding the health and wellness of African

American women? There is a need to understand the level of stress associated with

consistent exposure to racist acts. There is also the need to understand that the

expectation of these acts and the past experiences of racism create an undeniable level of

stress in African American women. Racist experiences live on in our minds and foster the

expectation of racism. A framework for understanding the debilitating stress experienced

by African American women is impossible without understanding the destructive

debilitating nature, prevalence, and permanence of racism in American society.

In African American women, the debilitating nature of racism does not occur in isolation. It occurs within a gang of oppressions that suffocate and often consume. African American women fight to battle this multifaceted oppression in many ways and this battle creates a culture critical to the survival of African American women. Black Feminist Thought is a comprehensive framework for exploring the health concerns of African American women. It provides the means for understanding the nature of the stress encountered in this country as a result of being black and woman. It addresses the issues of the twofold rejection by society based on color and gender. It also addresses the rejection experienced at the hands of African American men and explains the need African American women have to prove themselves to others as a way to counter negative stereotypes and images.

African American women have been conditioned to believe that they exist for the use of others. Therefore they should not think to nurture themselves, others come first.

This is not to say that there are not African American women who think of themselves

first and may even selfishly attend to themselves, but these women often still battle with the guilt of nurturing themselves. So even in their battle to achieve self-definition and self-valuation as a means of defeating negative stereotypes, African American women create their own stereotypes (controlling images) of the superhuman woman, who exists to soothe all hurts, calm all fears, and protect her family (Collins, 2009; Gilkes, 2001; Woods-Giscombè, 2010).

The health concerns of African American women must be understood in the context of their historical existence in this society. The existence that caused them to be at once undesirable yet critical to the growth of this nation. This existence was addressed by one of the participants in the study who felt used at her job. "They can't stand to look at me, but they come looking for me when they need some heavy work done." Another participant described the perception of unreciprocated support provided to African American men, stating, "... African American women tend to support African American men, but the support doesn't always come the other way." Any effort to transform the health status of African American women must also address the journey from their historical reality to their current reality. This can be done by providing an understanding of the impact of the relationships and mental models formed in slavery that continue to impact present-day circumstances for African American women. Oppression of the magnitude experienced in slavery may no longer directly impact the stress level of African American women, but has contributed to the creation of cultural norms and coping behaviors that nurture unrelenting stress even in the absence of the former degree of oppression.

# **Leadership Reflection**

As part of this program I created and maintained a journal of my reflections on the process and my progress. This enabled me to see my points of growth, my points of stagnation, and my epiphanies along the way. This practice afforded me the opportunity for deep reflection on my leadership, my mission, my beliefs, and my self-efficacy. Each of these areas came into question throughout this journey.

Initially, I started out extremely optimistic. My goal was to create an Action Research project that would leave the participants in better health and eager to continue with positive changes. I had worked with women in the past and assisted them with making healthy changes, so I did not view these goals as overly ambitious. Unfortunately, fairly early in the study I perceived the women were not committed to the process. This impacted me and I grew disheartened as they did not complete the agreed upon activities, did not check their email, and seemed not to take the study seriously. This was one of my first epiphanies. I recognized that my desires and their desires were not the same. Even though achievement of my goals would benefit them, I had to realize they were my goals, totally separate from the goals and the priorities of the participants.

This caused me to really reflect on my leadership, my mission, and my beliefs. My mission was and is to use my skills to help others achieve health and wellness through education and activities that encourage and support. I believe that the Power that created the body is able to heal the body and that this healing is achieved through the balance of body, mind, and spirit. My leadership, as espoused early in this program, is a combination of Situational Leadership and Servant Leadership. Situational Leadership was not appropriate for this study, as it is based on modifying the style of leadership in

relationship to the maturity level of the employees (Hershey & Blanchard, 1995). The participants were grown women in a setting outside of the workplace over which I had no authority.

Since Servant Leadership, which addresses the profound needs of others, was the natural driving force behind this study, my reflections of my leadership are within this framework. Once I realized the varied priorities of the participants, I realized that by interjecting my personal feelings I obscured the reality of the situation. This realization permitted me to really hear what the women were saying and at this point I was able to perceive that the women desired to be healthy, but underlying hindrances needed to be exposed. As a servant leader what matters is that the highest priority needs of others are served (Greenleaf, 1995). Therefore, it was more important to ensure that the participants were given the time and space to communicate their most pressing needs. Providing this opportunity allowed me to understand that an Action Research study was not the best and highest good for this group. What was needed was an opportunity to speak on the issues that prevented them from achieving the level of wholeness that they desired. They were not ready for the between session activities that actually increased their stress levels by giving them another thing to do. This discovery not only caused me to reassess my course of action, but allowed me to design a study that garnered the perceptions held by the group and elicited valuable information for future interventions.

Following the redesign of the study, my reflections addressed my perceptions of my ability to complete the program. When I started this program, I had no doubt that as long as God spared my life I would complete it. Interesting enough as I reviewed my journal, I came across an entry that related to self-efficacy. This entry was written just

after the completion of the capstone project, which was for me a time of reflection. I reflected on the cohort members who had dropped out of the program and wondered why they had been unable to see it through. At this time I also wrote "there is a certain degree of self-efficacy required to start this program and another level required to complete it. Those with the lowest level are easily broken and can be sidetracked by those who question their ability and their right to be part of a doctoral program" (C. R. Alexis, Personal Communications 6-1-2011).

At the time I wrote this entry, I felt capable of completing the program; in fact, I firmly believed that I would complete the program in the 3-year time frame originally asserted by the University. What I soon discovered was that the very foundations of my beliefs would be challenged within the coming months and years. This challenge would leave me doubting both my ability and my resolve to complete the program. I found myself increasingly stressed due to factors related to the program and life situations external to the program. This placed me in an interesting situation in that what I espoused to the participants was that we needed to make healthy choices regardless of our stress level. Yet, I began to make increasing unhealthy choices as a means to survive the program. My dissertation title was even more relevant: My Sisters Myself: Exploring the Health and Wellness Practices of African American Women. While exploring the practices of my sisters, I was also exploring myself, my own health practices, and learning just how much stress had impacted my own level of wellness.

These unhealthy changes provided a greater insight into what the participants had expressed throughout the study about the incapacitating effects of stress. My level of stress greatly impacted my ability to exercise and plan healthy meals. The stress I

experienced was inescapable. The more stressed I felt the more I found myself unable to make sound dietary choices and the more I began to feel overwhelmed and incapable of turning my situation around. During this time I continued to assert that I could make the change, because I felt that my level of self-efficacy was the same, yet I continued with detrimental eating habits and a lack of exercise. I also neglected my prayer and meditation, which left me in distress.

This disconnect between what I espoused and what I practiced also left me disconnected from my theoretical Servant Leadership Framework as I found myself once again focused on my issues, which led to a compromised ability to give the highest priorities of the participants the proper place as required by servant leadership. However, I also came to understand, that as Argyris and Shön (1974) state, it is the directly observable behaviors that either confirm or deny a person's leadership in use. In this respect, the internal conflict of attending to and focusing on my own needs represented little more than necessary reflection. In most cases, my observable behaviors were consistent with my professed leadership style and demonstrated my genuine interest in the wellness of the participants.

# Implications and Recommendations for African American Women's Health

So what happens to the women who give up? Those intelligent, hard-working professionals who are no longer contributing to the growth of this nation because they are made sick by society's constant harassment of their skin color, their hairstyles, and their assertiveness. Those that choose to marinate in negative controlling images because they decide not to fight anymore. Those who become benefactors of public assistance, not because of a temporary need, but because they have chosen to stop fighting and then lead

generations of others into this same acceptance. What cost to their families and society? What cost to the future of the nation?

It is a cost we cannot afford. We cannot afford the monetary costs associated with the loss of productivity and loss of income generated by African American women. We also cannot afford the constant erosion of financial assets associated with rising medical costs.

We cannot afford to lose the unfinished contributions of talented women like Audre Lorde [cancer] and Zora Neal Hurston [heart disease], Sylvia Boone [heart failure], or most recently, Tamiko Youngblood [cancer] (Hassell, 2015; Priest, 2008). Priest (2008) notes, "death is becoming an occupational hazard for the female intellectual" (p. 116). The cost to our survival as a nation is great and inaction impacts all of society, not isolated segments.

#### **Recommendations for Future Research**

This study expands the research on allostatic load as a factor in the level of disease in African American women. It also supports the need to further explore allostatic load in the context of Critical Race Theory and Black Feminist Thought. This will provide the opportunity to generate meaningful solutions to the compromised health status of African American women.

Recommendations for further research include an action research study to create culturally specific health assessment tools designed by African American women for African American women. In this way the women would empower themselves to define their health and wellness in a way that is meaningful to them, without feeling subjected to the perception of otherness noted in this study. Another recommendation includes a study to explore the impact of mental models on the intensity of the stress response to racist

and treatment noted in past research (Morris & Mitchell, 2008). One last recommendation would be to extend the research comparing the allostatic load and health of minorities born and raised in the United States with those who immigrated to the country as adults. This would permit an analysis between those exposed to racism in the United States since birth and those exposed for shorter durations (Doamekpor & Dinwiddie, 2015).

#### Validity and Reliability

This study utilized multiple theories and methods to collect, analyze, and triangulate data (Patton, 2002). Viewing the health of African American women through the theories of Black Feminist Thought and Critical Race Theory highlighted the areas of racism and the unique response to racism fashioned by African American women. Combining these theories also helped to reveal the correlation between resistance to racism and marginalization and self-defeating dietary choices, as noted when food was used as a means of exerting control. The combination of these theories and the use of qualitative and quantitative data collection imbedded the triangulation of data and facilitated data analysis.

Member checking was an additional layer of validity as participants were asked to verify the accuracy of the statements collected by the researcher (Creswell, 2007).

Quantitative validity for physiological instruments was addressed through the use of the established standards for weight and BMI using a calibrated body weight scale and the Body Mass Index provided through the National Hearth, Lung, and Blood Institute (NHLBI) (Creswell & Plano Clark, 2011).

#### **Limitations of the Study**

There were several limitations inherent in this study. First, the small sample size may not be generalizable. The study began with 11 women and two of the women were unable to continue with the group. Among the women that continued, not all attended every session. Second, the *My Reality Rating Scales* represent self-reported information and is subject to bias. An additional limitation of the study was the lack of income diversity. A more heterogeneous income group may produce different outcomes.

#### Conclusions

The initial data revealed the tendency for the women to view their health status in isolation without regard to the plight of African American women as a whole. In this sense, the group suffered alone, but eventually welcomed the opportunity to share their experiences with other women. The need for dialogue as a path to healing is supported in the literature (Collins, 2009; Lorde, 1994) and by the women in the study. The women readily identified the value of the support group and the focus group sessions as an opportunity for making meaning of their experiences in a safe environment.

As the study expanded, the issue of stressors and stress management became more pronounced. The stress experienced by the women in the study revealed a need to defend their position or rights in society, while caring for the needs of others often at the expense of self-care. The women often associated the care of others with a lack of gratitude for the efforts they expended and correlated this to occasional feelings of resentment, linked to feeling unappreciated and taken for granted. The women also felt that the nature of their stress could not be compared to European American women, because they did not

experience the degree of aloneness and other complexities attributed to the dual marginalization experienced by African American women.

Stress represented an overwhelming barrier to wellness for this group. This stress is truly represented in layers. I do not think that I really comprehended multilayered stress before this study. With this type of stress, one layer of stress is actually built upon the previous layer, creating an intersecting oppression (Collins, 1986). While the women did not always directly connect the stressors to racism, the stressors were ultimately defined as byproducts of racism. These byproducts included, but were not limited to, splintered families, the unavailability of mates, and discrimination.

Another factor noted during the study was that the perception of health seemed to decline in some participants the more health issues were discussed. Did the discussions increase stress or increase awareness to issues that already existed? Another premise is that discussions increased the level of urgency to make needed changes, thereby causing the participants to be more critical of their current lifestyle. This type of dissatisfaction often precipitates change (Evans, 1996). Grace, who stated during one of the sessions, "I remember attending a conference where one of speakers stated that when you get sick and tired of being sick and tired you will make the necessary changes." Evans (1996) addresses this as the critical point when fear of staying the same outweighs the fear of making the needed change. In this sense, perhaps support groups function not just as an avenue for sharing and comfort, but also as a catalyst for change.

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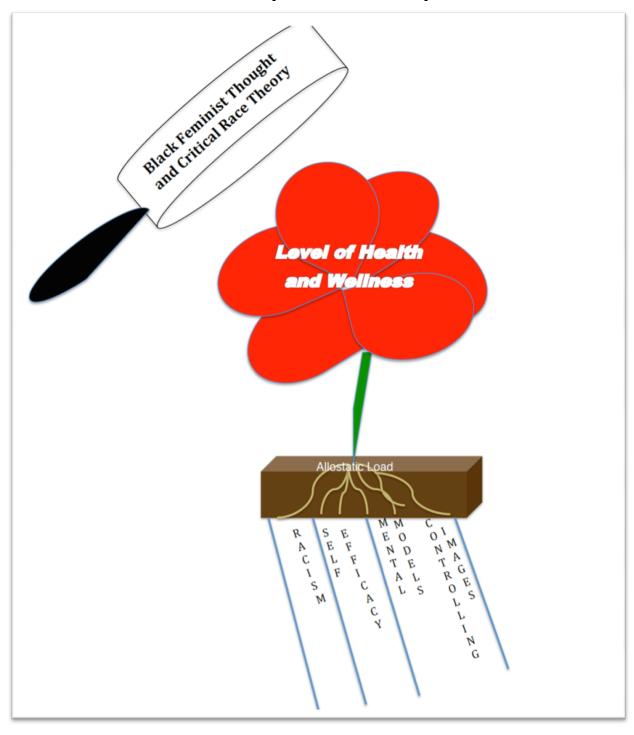
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Appendix A

Conceptual Framework Graphic



#### Appendix B

#### **Letter of Informed Consent**

<u>Project</u>: My sisters myself: Exploring the health and wellness practices of African American Women

<u>Investigators</u>: Carmen R. Alexis Ed.D. Candidate

<u>Purpose</u>: This is mixed-methods research study. The researcher will facilitate an educational forum to inform the participants of the disease disparities that exist between African American Women and European American Women. The study will explore the controllable risk factors associated with disease and provide support for participants as they create a personalized plan for improved health and wellness.

<u>Description and Procedures:</u> This study will provide participants with current information on disease prevalence and the associated risk factors. Additionally participants will utilize health and self-assessment instruments to examine their current health and wellness practices.

During this project, Carmen R. Alexis will be interviewing you to find out about your	r
current health and wellness practices and your perceptions of the health care system.	
Additionally Ms. Alexis will conduct focus groups. In these focus groups participants	S
will engage ingroup discussions about their experiences with the healthcare system as	nd
general health and wellness. The focus group sessions may be videotaped*	_and
interviews will be audiotaped * for data analysis purposes only.	

\*Participant Initials

<u>Risks:</u> Your data will be kept secure and confidential. You can withdraw from this study at any time. There are minimal risks involved with your participation. You will need to see your primary care physician to obtain accurate blood pressure and cholesterol readings as well as accurate height and weight measures. No identifiable information – name, identification number, etc. will be used when describing the results, in order to reduce any risks.

<u>Benefits</u>: The information you provide will contribute to the advancement of the knowledge of causes of disease disparities and will provide you with the opportunity to assess and improve your own level of health. This research may also contribute to policy changes and reduced expenditures in the healthcare and insurance industries.

Extent of Anonymity and Confidentiality: All of your responses, writings, or other materials will be kept confidential. This research data will also be developed into a

dissertation, published articles and conference presentations. Please note all identifying responses will be concealed to keep your identity confidential.

<u>Freedom to Withdraw</u>: Participation is completely voluntary. Should you decide to participate, you may withdraw at any time without penalty.

You will be reimbursed transportation costs to and from the focus group sessions. Your participation in the study should not exceed 20 hours over the course of seven months.

Your participation does not imply employment with the state of New Jersey, Rowan University, the principal investigator, or any other project facilitator.

Your signature below gives us permission to use the data collected from you during the project (You will also receive a copy of this form for your records). Any further questions about this study can be answered by the principal investigator, Carmen R. Alexis, at <a href="mailto:alexis60@students.rowan.edu">alexis60@students.rowan.edu</a>, or Dr. James Coaxum at (856) 256- 4779. Additionally for any questions about your rights as a research subject you may contact the Associate Provost for Research at:

Rowan University Institutional Review Board for the Protection of Human Subjects Office of Research

201 Mullica Hill Road Glassboro, NJ 08028-1701

Tel: 856-256-5150

I have read and understand the information included in this document and I agree to participate in the study entitled "My sisters myself: Exploring the health and wellness of African American Women," that is being conducted by Carmen R. Alexis a doctoral candidate at Rowan University.

Participant Name	 	 
Date		
Researcher Name		

#### **Appendix C**

#### **Focus Group Guide**

# Increasing Awareness, Building Self-Efficacy Reclaiming our health, our wellness and our future My sisters myself

# <u>Title of Project</u>: My sisters myself: Improving the health and wellness practices of African American Women

The purpose of each focus group session is to examine the participants' perspectives on various aspects of health and wellness. Additionally the focus groups are designed to uncover and address any barriers that might hinder the development of positive health practices. Each focus group session will inform subsequent meetings. The discourse generated by each session will provide meaningful data on the disease process in African American Women while also assisting the researcher with planning awareness activities for all participants.

# Session 1 - Purpose - Examine perceptions of habits needed to obtain/sustain good health

**Procedure**: This is the first of seven focus group/Educational sessions. As you were previously informed, each session will be video or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session I will ask you to complete a survey entitled My Reality to explore your level of satisfaction with your current lifestyle. I will also ask you some questions to find out what things you feel contribute to your health and wellness. The discussion is informal so please feel free to respond whenever you desire. Only one person should speak at a time. Please keep all information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

**Introductions** - As we go around the room, please state your first name and at least one goal you hope to accomplish by the end of this project.

Now for our questions:

How would you describe your present level of health? Why?

How much attention do you pay to what and how you eat?

What activities do you engage in that improve your health?

#### Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during our session today?

Thought/Action for next meeting - Keep a diary of what you eat and drink for 7 days.

Thank you for your participation today. Are there any questions or comments?

#### Session 2 – Purpose - Perceptions about Weight and Cravings

**Procedure:** As you were previously informed, each session will be video and or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session I will ask you about your perceptions of your current weight. I will also ask you questions about the things you feel trigger your cravings for unhealthy foods or drinks. The discussion is informal so please feel free to respond whenever you desire. Only one person should speak at a time. Please keep all information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

It has been a few weeks since our last meeting so please state your name as we go around the room and tell us one thing that you discovered by keeping a food diary (allow some brief discussion and then move into this week's discussion).

How often do you experience food cravings?

What were some of your favorite childhood treats?

Do you consider yourself overweight?

What is your BMI (iPad passed around the room for online Calculation by each participant)?

#### Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during our session today?

Thought/Action for next meeting – Using your food diary, write down each time you have a strong craving for unhealthy foods or drinks over the next two weeks then answer the following questions:

Were you hungry at the times you experienced the cravings? Were you tired? Were you stressed?

Thank you for your participation today. Are there any questions or comments?

#### **Session 3 - Purpose: Perceptions on Exercise**

**Procedures:** As you were previously informed, each session will be video and or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session I will ask you some questions to find out about your current level of exercise and how you feel about exercising. The discussion is informal so please feel free to respond whenever you desire. Only one person should speak at a time. Please keep all information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

In our last session you were asked to pay particular attention to your cravings, what were some of the things you discovered (allow for some brief discussion on the topic of cravings then move into this week's discussion)?

This week we explore your beliefs about exercise. Let us begin by answering this week's questions.

Do you exercise? If not, why not?

For those of you who answered yes, how often do you exercise and for how long?

What are the benefits of exercise?

Have any of you been told by a doctor or health care practitioner that you cannot exercise?

#### Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during our session today?

Thought/Action for next meeting - Keep a log of each time you exercise between now and our next session. Be sure to include the type of exercise the time of exercise and the

duration of your exercise session. Remember to only exercise if permitted by your physician or other health care practitioner and to only perform exercises at a level that is comfortable to you.

Thank you for your participation today. Are there any questions or comments?

Session 4 – Purpose: Perceptions on Risk factors for Disease in African American Women

**Procedures:** As you were previously informed, each session will be video and or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session we will explore the significant risk factors associated with disease in African American Women. Please keep all information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

In the last session we focused on exercise. As we go around the room please share your experiences with increasing movement (allow for some brief discussion on the topic of exercise then move into this week's discussion).

Now that we discussed our experiences since our previous session, Let's view some information on current disease statistics and risk factors associated with disease (After viewing the statistical data, present questions for discussion).

Now that we have viewed the data on disease and risk factors let's answer the following questions:

What are the reasons for the obesity/overweight conditions?

Where does the reluctance to exercise come from?

#### Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during our session today?

Thought/Action for next meeting – Add at least one new vegetable to your diet. Using your food diary write down each time you eat a vegetable. Be sure to note how you prepared the vegetable and whether it was fresh, frozen or canned.

Thank you for your participation today. Are there any questions or comments?

Session 5 – Perception of challenges to wellness – Excuses versus valid barriers

**Procedures:** As you were previously informed, each session will be video and or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session I will ask you some questions to find out about your perception of the stress and stressors in your life. The discussion is informal so please feel free to respond whenever you desire. Only one person should speak at a time. Please keep all information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

In the last session we focused the risk factors associated with disease in African American women. You identified stress as a catalyst toward disease as well as a barrier to good health. This session will focus on the impact of stress in your daily life. We will also address any self-imposed barriers.

What stresses you?

How do you deal with stress?

What are some the physical and mental signs that appear when you are stressed?

How do you protect what you value (this begins with a discussion of material things and progresses to self-care)?

How can we remove excuses and address legitimate barriers?

#### Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during our session today?

Thank you for your participation today. Are there any questions or comments?

#### Session 6 – Purpose: Perceptions on Family History and Family Disease

**Procedures:** As you were previously informed, each session will be video and or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session I will ask you some questions to find out what diseases have been experienced by members of your family history and to assess your perceptions on any correlation between their diseases and their dietary choices. I also would like you reflect on the extent which your lifestyle practices mimic or deviate from those in your family who experienced the diseases. Only one person should speak at a time. Please keep all

information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

In our last session we talked about several diseases that plague African American Women. We also discussed the risk factors associated with disease. In this session I would like you to complete a family history activity and then we will discuss the results.

#### Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during our session today?

Thought/Action for next meeting – Take a moment to write the next time you feel stressed. Record your thoughts, your physical and mental signs (forgetfulness, fatigue, wringing hands etc.). Practice the deep breathing exercises covered today when you feel stressed and monitor any changes that you observe after performing the exercises.

Thank you for your participation today. Are there any questions or comments?

**Session 7 – Purpose: Maintaining Health** 

**Procedures:** As you were previously informed, each session will be video and or audio taped for research purposes. The digital recordings will be maintained in a locked cabinet and your information will be kept confidential.

During this session we will talk about maintaining healthy habits for optimal wellness. The discussion is informal so please feel free to respond whenever you desire. Only one person should speak at a time. Please keep all information from this session private. If you do not understand a question or a comment please ask for clarification.

Are there any questions before we begin?

During our last two sessions we focused on stress and stressors. We also addressed our family disease history. Please take a moment to share your experiences since our last session (allow for some brief discussion on stress and stressors then move into this week's discussion).

Now we will delve into the questions for this session.

Do you feel capable of sustaining a healthy life style?

What support do you think you might need to stay well?

What are you struggling with?

What comes easy for you?

## Wrap Up

Common Thoughts/perspectives – What were some of the common perspectives or thoughts that emerged during this project?

Thank you for your participation in this study. Do you have any additional comments or question?

# Appendix D

# **My Sisters Myself Initial Interview Protocol**



My Sisters Myself Initial Interview Protocol

1.	Name
2.	Email Address_
3.	Height and Weight
4.	Date of Birth
5.	Place of Birth
6.	Marital/Relationship Status
7.	Please Rate your Average Menstrual Cycle (if Applicable):
	Asymptomatic
	Symptomatic
8.	Please rate you menopausal Experience:
	Asymptomatic
	Symptomatic
9.	Is there a family or personal history of any of the following diseases?
	Heart Disease
	Hypertension

	Diabetes
	Obesity
	Cancer
	Digestive Disorders (Colitis, GERD, IBS etc.)
10.	Are you Currently taking any medications or dietary supplements?
11.	Tell me about your most recent visit to the doctor?
12.	Do you accomplish the routine screenings, physicals and follow-up care suggested by
	your doctor(s)?
13.	What is your current Blood Pressure?
14.	What is your current Cholesterol Level?
15.	How do you sleep at night?
16.	How do you feel when you wake up in the morning?
17.	Do you exercise regularly ?
18.	How do you feel about your present weight?
19.	How would you describe your current level of health?,

20. Describe your average Breakfast
21. Describe your average lunch_
22. Describe your average Dinner
23. Describe some of the traditional meals you remember as a child  Breakfast
Lunch
Dinner
24. How often do you eat out?
25. If you could change one thing about your life right now what would you change?

# Appendix E

### **My Sisters Myself Final Interview Protocol**



My Sisters Myself Final Interview Protocol

1.	Name
	Email Address
	Height and Weight
4.	Date of Birth_
5.	Place of Birth
6.	Marital/Relationship Status
7.	Please Rate your Average Menstrual Cycle (if Applicable):
	Asymptomatic
	Symptomatic
8.	Please rate you menopausal Experience:
	Asymptomatic
	Symptomatic
9.	What did you gain from your participation in this study?

10.	Are you Currently taking any medications or dietary supplements?
11.	Did journaling work for you?
12.	What do you think about the health care issues facing African American Women?
	How can this situation be changed?
13.	What is your current Blood Pressure?
14.	What is your current Cholesterol Level?
15.	How do you sleep at night?
16.	How do you feel when you wake up in the morning?
17.	Do you exercise regularly ?
18.	How do you feel about your present weight?
19.	How would you describe your current level of health?,
20.	Describe your average Breakfast

21. Describe your average lunch_
22. Describe your average Dinner
23. How often do you eat out?
24. If you could change one thing about your life right now what would you change?
25. What causes the stress experienced by African American Women?
26. Does Racism or Discrimination play a role in the stress experienced by African American Women?

# Appendix F

## My Sisters Myself Family Health History Activity



My Sisters Myself Family Health History Activity

Disease/Condition	Family History	Your Difference	Your Similarities

# Appendix G

# My Reality I

#### My Reality 1

Happiness	Career	Education	Spirituality	Diet	Exercise	Finances	Social Life	Relationships	Health	Home	Hormones
											Balanced/Not
100	100	100	100	100	100	100	100	100	100	100	100
90	90	90	90	90	90	90	90	90	90	90	90
80	80	80	80	80	80	80	80	80	80	80	80
70	70	70	70	70	70	70	70	70	70	70	70
60	60	60	60	60	60	60	60	60	60	60	60
50	50	50	50	50	50	50	50	50	50	50	50
40	40	40	40	40	40	40	40	40	40	40	40
30	30	30	30	30	30	30	30	30	30	30	30
20	20	20	20	20	20	20	20	20	20	20	20
10	10	10	10	10	10	10	10	10	10	10	10
0	0	0	0	0	0	0	0	0	0	0	0