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Associations Between Health-Seeking Behaviors and Social Support for Adult Black Women in the United States

Patricia Saint Cyr-Hager
Walden University

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Walden University

College of Health Sciences & Public Policy

This is to certify that the doctoral study by

Patricia Leonne Naomi Saint Cyr-Hager

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Berthline Isma, Committee Chairperson, Public Health Faculty

Dr. Brieah Hudson, Committee Member, Public Health Faculty

Chief Academic Officer and Provost

Sue Subocz, Ph.D.

Walden University

2025

Abstract

Associations Between Health-Seeking Behaviors and Social Support for Adult Black

Women in the United States

by

Patricia Leonne Naomi Saint Cyr-Hager

MA, Rider University, 1999

BA, Arcadia University, 1991

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Health

Walden University

February 2026

Abstract

A persistent gap exists involving health outcomes for Black women in the United States, regardless of socioeconomic status when compared to Black men and White women. This qualitative case study involved exploring the influence of social support on health-seeking behaviors among Black women. Sixteen participants, between ages 22 to 49 from nine states, were recruited. Data was collected using semi-structured interviews based on the social support theory. An analysis of the network composition showed that family members (including mothers, fathers, sisters, and partners), friends, community support groups not connected to social media, and online community support groups were the most frequently prioritized stakeholders in health-seeking behaviors and decision-making. Thematic analysis further revealed four health-seeking behavior central themes: social support network empowers being in charge of one's health as a persona, social support network acting as a safety net, health information triangulation, and umbrella medical advisory status. These findings highlight the critical role of social support networks in terms of motivating health behaviors, providing dependable safety nets, facilitating informed decision-making, and fostering trusted relationships with healthcare providers. Results suggest leveraging social support systems for this population may remove barriers and contribute to improved health outcomes that inform the design of public health interventions, with implications for professional practice and positive social change.

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Dedication

This study is dedicated to God for direction and perseverance in completing the research, this was COVID birthed moment, though long desired personal goal. It is also dedicated to the many women who face unprecedented challenges to progress professionally, physically, and socially around the world due to continued disparities in treatment in our society. It is dedicated to my mother, Lucienne, and sister, Marie Jose, who died too young due to health challenges that went unmanaged until it was too late to change the course of their short journeys on this earth. Their social support network, family, church, friends were immensely involved in making their health journey as palatable as possible.

This work is dedicated to my husband, daughter, and family, whose unwavering support and encouragement sustained me throughout this journey. To my parents, who instilled in me the value of education and perseverance, and to my siblings, who cheered me on at every stage. Your belief in my dreams inspired me to reach higher and never give up. I am also deeply grateful to my friends, mentors and colleagues, whose wisdom, patience, and kindness guided me through the challenges and triumphs of this academic pursuit.

Finally, I dedicated this to my father Joseph, who decided in the early 1960's to bring my mother and siblings to the United States which created a new door of possibilities for our family and made my life possible, the one American born child.

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To my daughter Annelise, you are my north star. All of my growth through this program, I do to inspire you and to set an example for you as an up-and-coming professional looking to make an impact socially in our world. I know you will.

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Section 1: Foundation of the Study and Literature Review

Foundation of the Study

As a result of systematic racism and weathering in the United States as well as slavery and segregation, challenges involving diversifying the U.S. population to have equitable health outcomes have been longstanding. Black women, despite concerted efforts and progress involving antidiscrimination healthcare policies, still rank among the lowest in terms of positive health outcomes (Brown et al., 2019; Chinn et al., 2021). Black women make up 7.1% of the United States population and 52% of the Black population, and they are the third largest female population in the country (Arispe et al., 2021; National Center for Health Statistics, 2023; Reynolds, 2020).

A continued gap exists involving health outcomes for Black women in the United States regardless of socioeconomic level compared to comparative Black men and White women. As a result, individual, interpersonal, and community interventions to improve health decision-making and health outcomes are not sustained. Social support has been shown to positively influence the health decision process and health behaviors, however its role in influencing health decision process for Black women has not been fully explored (Ehsan et al., 2019; Spivey et al., 2024). A qualitative case study with semi-structured interviews was used to examine the influence of social support on health-seeking behaviors for Black women in the United States and their impacts on addressing health disparities.

I explored the topic with the aim of contributing new insights to health decision-making outcomes for this population. This chapter includes a discussion of the

background of the problem, problem statement, purpose of the study, research questions, theoretical framework, nature of the study, definitions, assumptions, scope and delimitations, and significance before concluding with a summary.

Background of the Problem

Structural racism linked with health inequities has been documented. The intersectionality of structural racism and health inequities and its impact on minorities including Black women continues to be uncovered until today (Brown, Mirand, et al., 2019). Cross-sectional studies for example have shown the impact of structural racism on morbidity and mortality occurring at higher rates in minority groups, specific social groups and specific populations in the United States (Bailey et al., 2021). Various determinants of health drivers have become part of the rationale for why improvement in outcomes are not realized over time. Slavery and segregation have been maintained as two determinants which drove gaps for Black populations (Bailey et al., 2021; Hummer et al., 2011). Additionally, race-based immigration policies and employment practices reinforcing social isolation encouraged the spread of disease and poor health practices for these populations (Hummer, 2011; Scott-Jones & Kamara, 2020). Lastly, socioeconomic movements that advanced policies to remove access barriers in the 1700 and 1800's for immigrants and other minorities such as the Naturalization Acts, were not realized by Black men and women until much later as a result of continued structural racism practices (Bailey et al., 2021; Ellick, 2019). The overall impact on Black people has become known as weathering (Geronimus, 2006). First coined in early 2000 by Geronimus, weathering empirical observation studies demonstrated how Black men and

women and disproportionately so Black women, had worse impaired health outcomes. Further research of weathering uncovered physiological and biological attributes that are negatively impacted over time for populations that are subject to socially and racially-charged environments (Geronimus, 2006; Sandoui, 2021; Tipre & Carson, 2022). The sustained impact on this population resulted from policies and laws that maintained racial divides affecting employment, housing, banking, and access to care. This created a system of socially and legally-supported dividing practices in the United States that drive health disparities for Black populations (Brown et al., 2019; Hudson et al., 2020; Hummer & Chinn, 2011). The impact of these disparities faced by Black women has shown to be even worse both economically and from a health perspective (James & Grzywacz, 2019; National Center for Health Statistics, 2020-2021). Black women statistically have worse health, higher rates of perceived workplace stress, as well as higher rates of infant mortality compared to reference groups (Chinn et al., 2021; Giaquinto et al., 2022; Sandoui, 2021; Yamini-Benjamin, 2006). The collective effects of weathering has a profound and enduring influence on a population's ability to manage their health, sustain social systems and achieve economic growth, all of which are essential tenants to addressing health disparities (Preston, Bronner et al., 2022). Additionally, the process of weathering left Black women disproportionately disadvantage in terms of health and economics outcomes.

The direct effect of social support on health includes benefits to improve or maintain one's health status (Cohen et al., 1988). Resistance to stressful events, for example, is a protective factor associated with the positive benefits of social support.

Protective factors can predict illness and impact physical wellbeing positively and negatively. Schwarzer & Leppin (1989) first established the theoretical framework for social support associated with pathogenic factors by assessing the influence of social relationships on health. Between the late 1970's and 1980's, research outcomes in this area were inconsistent as a result of varying methodology utilized to categorize social support domains. The ongoing debate over theoretical frameworks and ways to measure relational causality between variables contributed to heterogeneity in research outcomes on social supports impact on health (Cobb, 1976; Cohen, 1988; Gangster & Victor, 1988; Tardy, 1985). This research continued to evolve despite limitations to the empirical evidence generated during this period. Through literature, it is generally accepted that the theory of social support is framed within the context of social relationships. Social relationships incorporate two main components: social networks and social support.

Social networks include the number and types of relationships with people, and social support involves the function and nature of social relationships (House et al., 1982). Research by House et al. (1982), established that social support enables "...regulation and control of demands and conflict..." that relationships face in various relational contexts, with multiple stakeholders (e.g., spouse, friends, colleagues). House (1982) and Schwarzer & Leppin (1991) further explain that social support acts as a protective factor, helping individuals manage relationship demands. Key attributes of social networks involve density of relationships, composition of sources, durability, and reciprocity. Social support can both promote and impair health by providing stress buffering, which is essential for responding to environmental stressors (Cohen, 1988;

Gangster & Victor, 1988; House et al., 1982; Schwarzer & Leppin, 1991). Emotional and instrumental support are important dimensions of social support, and these can be measured both qualitatively and quantitatively. Both perceived and received social support can work to counter stressors. They serve as measures of social support in qualitative research and health influence. Perceived support refers to an individual's general sense of wellbeing and aptitude to cope with anticipated stress, while receiving support is the activation of support when stress is experienced. These offer a framework for assessing the impact of social support on health outcomes and disparities.

Since 2020, the U.S. Office of Disease Prevention and Health Promotion has categorized discrimination and residential segregation as social determinants of health. It recognizes the disproportionate impact of racially based policies and practices on minority groups including Black women. Further research is needed to identify and understand the mechanisms that can address these disparities relative to social support. Understanding the levers that can change this paradigm and mitigate the impact of stressors affecting Black women may contribute new insights in the field of public health. This study aims to contribute insights specifically to designing interventional programs to improve this population's health in the United States.

Problem Statement

The situation or issue that prompted me to search literature is a continued gap exists involving health outcomes for Black women in the United States regardless of socioeconomic level. Disparities persist due to systemic racism and weathering, which have impacted Black Americans and in particular women who have worse mental and

physiological health outcomes in terms of cancer, heart disease, and or rheumatoid disease, depression, and overall health status (Brown et al., 2019; Chinn et al., 2021). Despite various health intervention initiatives, other potential influencers can positively impact health decision-making. Social support positively influences health decisions, but the role of social support for Black women involving health-seeking behaviors has yet to be examined. The specific research problem that was addressed through this study is there is a lack of information on the influence of social support on health decision-making for Black women and its impacts on addressing health disparities.

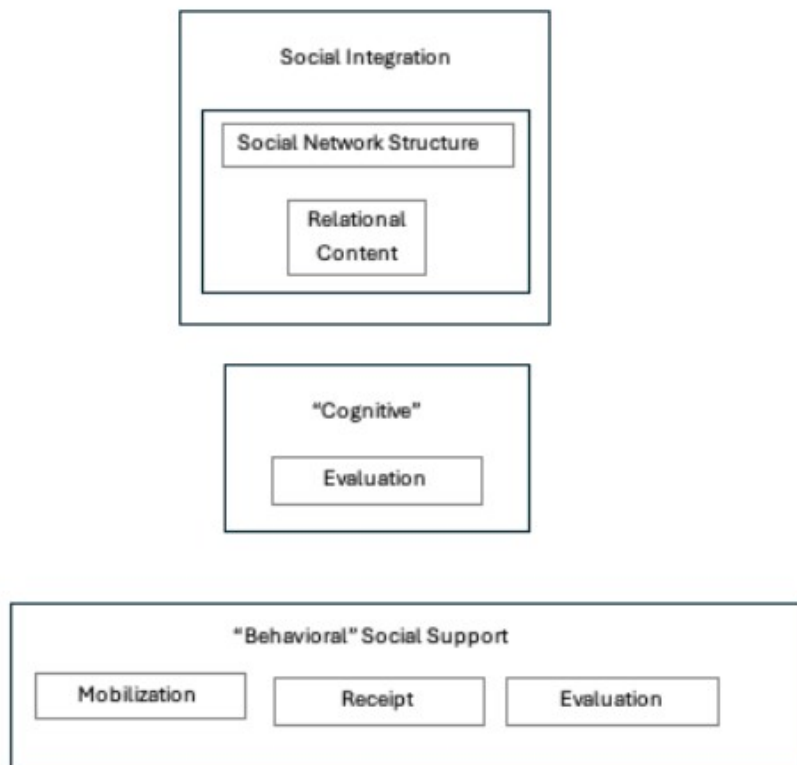
Research Questions

RQ1: How does social support influence health-seeking behaviors for Black women?

RQ2: What were perceived and received support types for Black women that influenced their health decision processes?

Theoretical Framework

Social support is used extensively to evaluate health behaviors with a focus on cognitive and behavioral factors as depicted in Figure 1. The theoretical framework for social support related to health was established by Leppin and Schwarzer in the 1980s. The researchers categorized a taxonomy of social relationships and pathogenic processes and concluded social factors can predict illness.

Figure 1*Social Integration and Social Support Taxonomy*

The framework includes protective factors that impact various levels of socialization, including social integration, cognitive social support, and behavioral social support. Social integration contains social networks, which include all relational content within the network such as marital status, family associations or social groups. Cognitive support includes evaluation of individual support and behavioral social support including the ability to mobilize support, receipt of support, and assessment of support after mobilization. This study is grounded in the concept of social support and social network

constructs which are aspects of social capital theory. Integrating aspects of both concepts will enable an understanding of effects on behavior changes and health-seeking behavior influencers. I focused on Black women and impacts on health-seeking decision making. Emotional, informational, esteem, tangible, and perceived and received support domains were used to inform semi-structured interview question development, thematic analysis, and qualitative analysis.

Nature of the Study

To address research questions in this qualitative study, I used a case study qualitative approach with interviews of adult Black women covering social support types and domains effecting health outcomes including emotional, informational, esteem support, tangible support as well as domains of perceived and received support as outlined by Drageset. I aimed to examine the potential influence of social support on health decisions for the target population. The research design included thematic analysis of interviews. Interview questions were grounded in social support theory. For my planned research design, I will use in-depth semi structured interviews with a sampling of the target population (10-15 black women), as the primary data collection tool (Drageset, 2021; Glanz et al., 2008). I recruited interview candidates for this study. An interview protocol was developed to address the problem and purpose of the study. Data points assessed included those related to social support construct based on responses to the interview questions (Drageset, 2021). Social support was defined qualitatively. The analysis allowed for identification of central themes that correlate to support types and

degree of perceived or received support domains. Change in health benefits was assessed based on interview thematic analysis outcomes.

Definitions and Assumptions

Definitions of terms that were relevant to this study are as follows:

Black Woman: A female who identifies as African American or Black and is born the United States (Christo-Baker et al., 2012, p. 14). Culturally, these women can come from diverse backgrounds that make up the African diaspora, including Africa, the Caribbean, Spain, and the United States.

Social Support: A combination of social cognitive and behavior support domains that are protective factors which may reduce and manage stressors (Drageset, 2021).

Structural racism: Macrolevel systems, social forces, laws, policies, institutions, ideologies, and processes that interact with one another to perpetuate inequities among racial and ethnic groups (Bonilla-Sila, 1997; Powell, 2007)

Weathering: Racial inequalities in health that exist across a range of biological systems among adults are not explained by racial differences in terms of poverty (Geronimus et al., 1996).

Limitations

Some potential challenges with this study may include candidate bias and building trust with interview candidates to ensure most complete response are provided (Glanz et al., 2008; Patton, 2015). Interpretation of responses and separating perceptions and beliefs will be important to ensure an appropriate analysis is conducted (Patton, 2015). Lastly, sampling bias may be considerations given the sample population will be

target participants of a particular organization (Glanz et al., 2008). Incorporating a third-party reviewer in the thematic process to limit bias in the interpretation of results will be critical to address these biases.

Recruitment of Study Participants

For my planned research design, I will need in-depth semi structured interviews with a sampling of the population (10-15) black women will be the primary data collection tool (Drageset, 2021; Glanz et al., 2008). I will need to recruit interview candidates for this study. An interview protocol will be developed to address the problem and purpose of the study.

Significance of the Study

This study is significant in that it will provide new insights at the community and institutional level by informing health decision-making interventional public health design for Black women. Understanding the role social support factors play in health-seeking behavior can inform health behavior modification approaches design. By addressing this gap, public health professionals will be better equipped to enable shaping decision-making proactively and may enable preventive care. Research in this area is limited and therefore the study may uncover social support strategies that improve overall health outcomes for these women.

Informed decision-making plays a significant role in health outcomes causing persistent disparities in health outcomes for black women when it is lacking. This challenge has attributed to improved health outcomes for this population. Overcoming health disparities across disease states continue to be a challenge in public health and

black women continue to present with worse health outcomes regardless of socio-economic status. One of the ways to counter these disparities is by enabling improved health decision-making and patient empowerment for constructive dialogue with healthcare providers. This study will explore social support factors that influence health decision-making through the lens of black women and ways social support influences their behavior. Learnings from this research could be leveraged to inform broader community level health behavior practices.

This study may uncover new information on the health-seeking behavior and influencers for Black women. The ideas derived from this research could be utilized to address continued gaps in health outcomes for this population and provide insights that inform different ways to approach intervention. The study will also help better understand the relationship between lived experience through these support systems. In communities with high social network activity improved health outcomes including benefits to physiological and psychological attributes have been realized. If Black women are deriving positive benefit from social support systems, understanding of the factors involved can serve as a model for improving health behavior overall.

Literature Review

Weathering and Health Disparities

The concept of “weathering” on specific populations was coined by Geronimus et al., (2006) as the “...stress inherent in living in a race-conscious society...”. Health indicators including biological variables such as pregnancy outcomes, increased mortality rates were linked to social measures that can be detrimental (Geronimus, 1992;

Geronimus et al., 1996). By correlating biomarkers such as cortisol level, blood pressure and hemoglobin level to social disparities, Geronimus argued health status was impacted, known as weathering (Geronimus et al., 2006). The concept of allostatic load score, established by McEwen & Seeman (1999) linked the biological markers to the stressors, creating a framework for analysis that was applied by Geronimus et al., (2006). The higher the allostatic load score the poorer outcomes were observed. Weathering integrates the allostatic load score as part of the evaluation of disparities and goes one step further to assess both clinical and subclinical factors (i.e., elevated blood pressure lower than clinical standards). Geronimus et al., (2006) and Forde (2019) research found that people of low income, blacks and black women disproportionately had worse biological outcomes at the clinical and subclinical level as compared to their white counter parts. Black women even in the cases where they are higher income earners, the outcomes were still disproportionately worse (i.e., higher allostatic load score). Rationale for these differences is attributed to black women carrying a heavier burden both socially and economically in the household and in their communities (Geronimus, Bound, Waidmann, Hillemeier, & Burns, 1996; Geronimus, 1992). These differences were most prominent in the middle-aged adult years (35 to 64 years), prime employment years for adults.

The importance of connecting biological, physiological and current state pressures could further uncover gaps in health disparities. Brown (2019), Chinn (2021), Cogburn (2019), and Tipre (2022) found that most interventions lacked multi-level and stakeholder involvement to create sustained behavior change. They recommended actions

to strengthen approaches moving forward and identified the importance of social, economic, environmental and policy drivers impacting health outcomes, but stopped short of further exploring how social support impacted decision making. The routing of weathering in high infant mortality rate for black women, may have skewed focus on social support influence in this area, and thereby leaving a gap in understanding other ways social support influences health decision making.

Social Support and Biological and Physiological Health

Social support has been studied as a manifestation of positive and negative health behaviors. Social support has been shown to influence diet, exercise, smoking and alcohol intake behaviors (Cohen, 1988). The research starting in the late 70's was predominately focused on men and cardiovascular disease retrospective studies (Cohen, 1988). The link between social support and health outcomes has continued to be refined today. Like weathering, social support and health impact are linked to both physiological and biological consequences. Both can manifest negatively from the lack of support being perceived and or actualized. Social support's impact on health outcomes is also linked to social environment, disease and mortality. In this context, social support acts as a stress buffer, there is sufficient evidence across the research to establish associations for several diseases. There are examples of studies showing links to increased myocardial infarction risk (Ruberman, Weinblatt, et al., 1984), increased coronary heart disease resulting in mortality in men (Cohen, 1988), increased coronary artery disease and mortality in men (House et al., 1982), as well as overall decreased mortality in elderly women (Schoenbach et al., 1986). Using social integration (SI) as a measure of social

support function and perception, researchers determined SI associations to predict mortality but were limited by retrospective analysis of research studies which were not designed originally to test for social support understanding. The understanding of social support's impact on health has since evolved based on empirical evidence using prospective research designs and effect models. Research by Cohen & McKay (1984), Gore (1981) and House et al. (1982), showing links to stress-buffering model, psychosocial process models and main effect models which further differentiate use of social integration as an indicator. This research validated the interplay between social support, social norms and social networks demonstrating positive shifts in health behavior when perceived or received support are deemed beneficial. Berkman & Glass (2000) demonstrated links between social support as a predictor of mental health status. The range of diseases impacted by social support broadened over time ranging from mental health to mortality (Almeida, Molnar et al., 2009). As a result of continued research on social support it is now established that perception can impact health behavior and reactions to stress as well. Research on this topic impacting Black women's health decision making can inform public health practitioner strategies and policy at the individual, community and institutional level.

Social Support Gap

A literature gap exists involving health outcomes for black women in the United States regardless of socio-economic level and social support. These researchers identify disparities that persist due to systemic racism and weathering which have impacted black women but present no opportunities to address this disparity relative to social support.

Research relating to social support and black women's health challenges is narrow and hyper focused on maternity health and infant mortality (Okafor, 2021; National Academies of Sciences, Engineering, and Medicine, 2021). Here the focus is on maternity health outcomes and community-based organizations that assist pregnant women. These organizations help with health decision-making at critical stages of earlier timepoints during pregnancy to pre-empt maternal death rates. Research has shown 78% decrease in infant mortality for black women with supportive partners involved in the pregnancy and delivery process (Okafor, 2021). This is significant when black women experience three times higher infant mortality, over other women in the United States (Okafor, 2021; National Academies of Sciences, Engineering, and Medicine, 2021). Even in this situation, cognitive and behavioral support is not fully explored on health decision making, instead there is a disproportioned focus on the relational network. Research by Chinn (2021) and Preston, Bronner, & Bronner, (2022) supports regardless of income and educational level the continued disparities that exist and the fact that a breakthrough to change this health disparity are yet to be uncovered. This opens possibility for further analysis of social support as a potential solution.

Search Strategies

Searched strategies included key word terms including Black women, African American women, women of color, health disparities or inequality, health promotion, social relationships, social support, health decision making, health behavior, weathering, and women of color. Databases search included: EBSCO, Google Scholar, Walden's' Library Search, ProQuest One Academic and Oxford Academic, ProQuest, and ProQuest

Dissertations. The key word search terms were used in a variety of combinations such as *Black women social support*, *Black women health decision making*, *African American women health disparities*. This search did not surface prominent publications on social support and health decision-making for Black women. Research on social support's impact on health outcomes is limited, instead more information can be found when social support is combined with social capital and social networks which are associated frameworks. The three frameworks have been used to examine health decision-making and health outcomes across various populations. In research by Ehsan et al., (2019), for example, a review of 4941 the three frameworks have been used to identify both physical and mental health outcomes. However specific work in black females and social support was not incorporated and remains unaddressed. Seminal studies on weathering and structural racism impact on health outcomes were identified (Chinn, 2021; Ehsan et al., 2019; Geronimus, 2006) for the black population as well as specific implications facing Black women. Additional research on infant mortality, mortality and implications on Black women in the workforce was also identified to support the research (Bailey et al., 2021; Elick, 2019; Geronimus, 1992; Preston et al., 2022).

Summary

Section 1 has delineated the persistent health disparities affecting Black women in the United States, emphasizing the enduring impact of systemic racism, weathering, and structural determinants on health outcomes. Despite advancements in policy and healthcare, these disparities remain entrenched, necessitating a deeper exploration of factors that may facilitate sustained health behavior change. The literature reviewed

underscores the significance of social support as a protective factor yet reveals a notable gap in understanding its specific influence on health-seeking behaviors among Black women. This gap provides the rationale for the present study, which seeks to examine how social support networks shape health decision-making and contribute to improved outcomes for this population. By establishing the theoretical framework, articulating the research problem, and identifying limitations in existing scholarship, Section 1 lays a robust foundation for the subsequent qualitative inquiry and analysis that follows.

Section 2: Research Design and Data Collection

Research Method

Qualitative basic research is used to understand individual life experiences via individual perspectives (Lewis, 2015; Patton, 2014). It involves gathering insights directly from individuals and probing further as emergent thoughts are shared by participants. The purpose of this qualitative study was to understand the influence of social support on health-seeking behaviors of Black women living in the United States to address health disparities. Barriers to black women achieving similar outcomes to their counterparts include socioeconomic, environmental, and factors related to structural racism (Chin et al., 2021; Volini, 2021). Social support has a positive impact on health outcomes but is not well researched in this population. Understanding the role of social support through this qualitative research will lead to new information that could affect innovation in public health.

The data collection plan for this study involved conducting semi-structured interviews of adult Black women living in the United States. Participants were randomly recruited across the country with varying socioeconomic, professional and educational circumstances. Insights were sourced solely from interviews.

I used a qualitative approach in this study to generate insights regarding protective factors including received and perceived factors involving health-seeking behaviors for this population. The research design was appropriate for in-depth discussions with participants using semi-guided interview questions to identify common trends and themes. Qualitative research is used for follow-up questioning that goes

beyond interview guides to enable further probing and identify root causes. This also facilitates generating rich data for thematic analysis. The process involves guided discussion, followed by deeper introspection, followed by coding, categorizing, and further delineating themes that are relevant to health-seeking behaviors (Patton, 2014). Additionally, the basic research approach aided identification of appropriate participants with interest in sharing their experiences.

In this chapter, I discussed research design, rationale, and role as the researcher in the study. The selection criteria, selection approach, and interview process are also described in this chapter. In the final section of this chapter, I explain methods and instruments for data collection, analysis process, and ethical considerations.

Research Design and Rationale

Research questions for this study were:

RQ1: How does social support influence health-seeking behaviors for Black women?

RQ2: What were perceived and received support types for Black women that influenced their health decision processes?

Participants were adult Black women who were 18 and older residing in the United States. According to Patton (2014), qualitative research involves introspective understanding of individual, community, and institutional-level barriers to public health progress. These insights can be used to identify trends and theoretical positions to inform constructive health interventions (Vanover, Mihás, & Saldaña, 2021). Understanding the role of social support in terms of protective barriers to these gaps for some populations

can lead to insights to improving health outcomes disparities that are specific to Black women. In this study, I analyzed health behaviors as well as perceived and received support types and their influences on health behaviors, health decisions, rewards, and acknowledgement of support systems. I also collected high-level demographic information for participants including geographic location, age, profession, educational level, and professional roles.

Social support has both positive and negative health impacts that are both physiological and psychological. Research by House et al., (1982) and Schoenbach et al., (1986) demonstrate these clinical links, however most of the research has focused on male cardiovascular health and elderly women. Disparities in health outcomes for Black women has been well documented in the United States regardless of socioeconomic level. These disparities that persist due to systemic racism and weathering have been understudied relative to the role and influence of social support except for maternal health and infant mortality. This qualitative research study involved examining the role of social support among individuals whose lived experience can help to shape future public health interventions for this population. I conducted this qualitative analysis to determine perceived and received social support as well as how it influences health behaviors overall.

Role of Researcher

My role in qualitative research is to objectively collect content-rich data from individuals that can be further probed in the moment to address root causes and trends involving a phenomenon (Drageset, 2020; Patton, 2014). Researchers can observe,

interpret, and confirm insights that otherwise could not be further investigated (Patton, 2014; Vanover et al, 2021). In qualitative research, it is important to maintain nonbiased discussion environment with participants and avoid personal experiences influencing discussions. A semi-structured interview guide approved by the Walden University Institutional Review Board (IRB) was used in this study to ensure consistency and ethical standards were respected in alignment with research questions. Inclusion and exclusion criteria approved by the Walden IRB were used. Criteria included age, gender, and geographic location requirements. Additionally, participants were able to complete informed consent forms as well as participate in interviews. These criteria ensured uniformity in alignment with the target population for the study. Participants were recruited by posting Walden University IRB-approved advertisements on the professional online platform LinkedIn. The approved study email communication was shared with my network and nonprofit organizations who focus on Black female constituents to refer on my behalf to potential participants. The study was approved for posting on the Walden research portal; however, this did not move forward because recruitment goals were not obtained after 5 days on the social media platform and email communication being sent. Sixteen of 20 interested participants were selected to participate. A digital version of the informed consent form was incorporated in advertisement and email communications regarding the study.

Once participants reached out to express interest, Zoom interviews were scheduled. The informed consent form was reviewed at the beginning of each Zoom interview for all participants to ensure understanding of the study and willingness to

participate. The consent process and interview were audio recorded. Transcripts from Zoom interviews were used for analysis and journal notes were taken concurrently. The Zoom platform ensured privacy, and each call was passcode-protected requiring admittance approval by me prior to entry. Participants were not required to have video cameras turned on; this was based on individual preference, and most participants did not turn on their cameras. My camera was left on for all interviews. My role during this part of the process was to collect data and allow free flowing discussions based on interview guide questions. Additionally, process guidelines that were submitted to the Walden IRB were meticulously followed to ensure consistency for participant discussions. Reflective journaling was used during and after the interview process, and privacy and confidentiality guidelines that were outlined in the informed consent form were followed.

The Walden IRB approved a research study plan and study materials prior to the study being conducted. Participants were offered a \$20 amazon gift card that was approved by the IRB. The gift cards were provided electronically to each participant to limit access to contact details beyond email. The researcher provided the gift cards upon completion of the initial interview. As part of the recruitment process contact information such as first name and email address were visible to the researcher for participants. This was necessary for initial contact and for scheduling the interviews. Additionally, LinkedIn profiles were visible to the researcher for some participants if LinkedIn was utilized to express interest. However, at all stages of the process the contact information was kept private and confidential.

To maintain the participants' privacy, each participant who expressed interest was de-identified. A unique code number in sequential order of interest, followed by the first and last name initials was assigned to each participant. The unique code was utilized to refer to the participant for scheduling purposes through Zoom as well as the calendar invitation for the meeting. If a participant did not proceed with the interview, the unique identifier was considered a dropout and the identifier was not re-used. After interviews were completed, to further maintain confidentiality and privacy unique identifiers were referenced in study records by the unique sequential numbers only and the initials were dropped. All records were stored in a locked storage cabinet in my home office. Physical data were scanned and stored digitally in pdf format on an external device that is protected by password. The device will be stored in a lock cabinet only accessed by the researcher and will remain there for the minimum requirement of five years. After such time, the content will be permanently deleted along with all data pertaining to the research from all platforms including computers, emails and telephone.

Methodology

Population

Adult black women over the age of 18 who resided in the United States participated in this qualitative research study. The population was selected to align with the study research questions which explore how social support factors influences health outcomes for black women who experience health disparities in this country (Brown et al., 2019; Chin et al. 2021).

Sampling Strategy

I utilized purposeful random sampling to identify 10-15 initial participants for the study. This process adds credibility to a research study, is perceived by the research community to reduce biases and is recommended to use when the potential number of cases could potentially be larger than what could possibly be studied (Lewis, 2015; Patton, 2014). Additionally, I followed saturation redundancy sampling which allows for collection of rich data and knowledge from an individual until a saturation point is reached and nothing new is being learned (Patton, 2014). The saturation point for this study was reached after 14 participants were interviewed. I continued with a total of 16 participants to assure the saturation point was reached.

Selection Criteria

The study entailed three criteria. Participants had to be adult black women living in the United States and who were willing and able to complete an audio recorded informed consent process. Additionally, the participant's availability to complete a 60-90-minute interview with the potential for a follow up interview for 30 minutes was required. Study participants were contacted via email, telephone and text to secure appoint dates and to address rescheduling as was needed due to timing conflicts. Only after participants completed the consent process and confirmed verbally meeting criteria where they entered the study.

Relationship Between Saturation and Sample Size

According to Patton (2014), data saturation is reached after new information is learned and participant input becomes repetitive in nature. In qualitative research this

indicates that sample size maturation has been achieved, and no additional meaningful data would arise from new additional participants. This is a well-established methodology for managing sample size in qualitative studies. I initially targeted 10 to 15 participants in this study. A total of twenty participants expressed interest. Due to scheduling challenges and reaching the saturation point, 3 participants (004, 018 and 019) did not proceed with interviews. One participant (020) requested the interview to be done in Spanish for which it was not approved by the Walden IRB and therefore could not be conducted. As noted in the sampling strategy section, saturation was anticipated at 14 participants. Two additional participant interviews were completed to confirm the saturation point had been reached. Participant eligibility was assessed via email and during the initial phase of the audio recorded informed consent process.

Instrumentation

Qualitative research involves deep inquisitive discussion with communities, groups and individuals that share their lived experiences as expertise (Lewis, 2015; Patton, 2014). Proper instrumentation is needed to appropriately capture and drive insight gathering for these studies. To drive the participant interviews for this study an interview guide based on social support theoretical frameworks, social provision scale (SPS) questionnaires and qualitative analysis expert researchers were developed. The social provision scale long and short form questionnaires have been utilized in large population social support and social network research studies (Drageset, 2021; Glanz, Rimer, & Viswanath, 2008). However, a questionnaire specifically on this research topic could not be identified therefore a new interview guide was created. The interview guide

incorporated a study question based on the theoretical framework and SPS questions. The questions were further modified to specifically focus on health seeking behavior in general, perceived support and received support experiences (Drageset, 2021). The questions were reviewed by the Walden Committee Chair and an additional qualitative research expert at Walden University approved by the chair. This approach supports the credibility and reliability of this study. The interview guide was included in the research plan submitted to the Walden IRB for approval (see Appendix A). Demographic questions were also integrated into the interview guide to support understanding of the sample population make up, individual participant profiles, and demographic trends across the study population.

According to Patton (2014) and Lewis (2015) best practices in qualitative interviewing include using open-ended question structures that allow for free-flowing descriptive responses, and that allow the researcher to further probe in the moment without introducing bias. Structured, informal, and semi-structured interviews are characteristic to this form of interviewing to allow room for exploration, rich data collection and further probing of participants. In this research study, a semi-structured interview approach was utilized based on the interview guide. The interview process consisted of an introduction of the study, the audio recorded informed consent review and six qualitative interview sections including twenty-two overall open-ended questions as outlined in Appendix A and Appendix B. To ensure content validity and credibility, all participants were provided with a link to the informed consent prior to the interview. The informed consent in Appendix D explained the nature of the interview as well as risks

and benefits of the study and provided sample questions. The informed consent was reviewed by showing the form on the zoom screen and walking through each section for all participants.

The qualitative interview guide consisted of five question subsections and a health behavior network mapping exercise as outlined in Table 1 below. The sections included a review of demographics which served as an ice breaker. This was followed by review of the informed consent and confirming participation. Two additional demographic questions were asked in follow-up regarding how the participants learned about the study and in which state they resided. The participant was given two to three minutes to conduct the health behavior network mapping exercise outlined in Table 1. Questions regarding the mapping ensued followed by questions to understand received and perceived supportiveness of their social support network. The interview concluded with a summary question and reiteration of next steps regarding the study.

Table 1*Outline of Semi-Structured Interview Questions*

Section	Description
1. Demographic Information	Age, professional level of education, role in society (e.g., mother, daughter, sister, caregiver, etc.), and state.
2. Health Behavior Network Mapping Exercise	<p>Step 1: Write down the ten most important relationships in your life relative to your health.</p> <p>Step 2: Questions regarding the list generated:</p> <ol style="list-style-type: none"> (1) What does it include? (2) How were individuals chosen? (3) Describe your interactions with those listed. (4) What are the characteristics of the group? (5) What is the level of support given and received?
3. Received Supportiveness	<p>Questions regarding:</p> <ol style="list-style-type: none"> (1) network informing health behavior, (2) influence on health decision-making, (3) help in researching health information, (4) assist in finding a provider, and (5) aid in dealing with illness and managing follow-up.
4. Perceived Supportiveness	<p>Questions regarding:</p> <ol style="list-style-type: none"> (1) emotional support, (2) showing appreciation, (3) reliability, and (4) availability of the network.
5. Summary Question	What are the rewarding aspects of the social support health network?

Throughout the interview process, follow up questions were asked to ensure understanding of descriptors and to investigate responses. Two spontaneous questions were added after the first participant interview, then extended to all interviews to ensure consistency in the data collection. The participants were asked about their location in the country in which they lived and how they learned about the study.

Procedures for Recruitment and Data Collection

After receiving approval from the Walden University IRB, I collected data through 60–90-minute semi-structured zoom call interviews. The instruments for the interview included a pen, legal pad, and laptop computer through which zoom call was conducted. Zoom audio recording and transcription software was utilized to capture the discussion and the legal pad was utilized to capture journal notes, which was disclosed to the participants. Journal notes included capturing voice inflections, category and theme considerations as well as personal reminders for follow up questions. Ethical procedures to protect the participants were taken by securing all data collected during the study with password protected software and maintaining the records in a secure and private location. The participants' individual name and any personally identified information were removed from information presented and or included in this report.

Data Analysis Plan

Data analysis involved utilizing zoom interview transcripts to identify specific words for coding, categorizing and subsequently combing into themes. Both social support theory driven codes and data driven codes were utilized to establish reliability in the analysis and to develop a codebook for the analysis (DeCuir-Gunby, Marshall, &

McCulloch, 2011). The transcripts were downloaded and placed in a central folder as rich text files then imported to excel for coding. Additionally, a hard copy of the transcript was printed and placed in binders to facilitate coding and review. This process was repeated twice until a final codebook was established and utilized for the analysis. The codebook was developed and maintained in the excel workbook along with the transcripts which were manually coded.

Demographic Questions

Participants demographic responses were captured as part of the interview process as outlined in the instrumentation section. This data was utilized to create participant descriptive statistic summaries and to identify trends that could inform the research findings. Microsoft Excel software and Adobe Acrobat PDF were utilized to analyze this data for inclusion in the research.

Issues of Trustworthiness

Trustworthiness is the main driver for evaluating qualitative research design and this is supported through four primary criteria including credibility, transferability, dependability, and confirmability (Laureate, 2015; Golafshani, 2003). Focusing on one criterion, credibility arises from a multitude of variables being involved in qualitative research process to ensure there is rigor, high quality and ensuring researcher bias doesn't influence the outcomes (Golafshani, 2003). In qualitative studies, researchers seek to explain and understand a phenomenon that cannot be explained using quantitative measures. These criteria act as a guide to ensure standards in expectations for collection of data, degree of research involvement and analysis approach to produce trusted results

can be generalized to a broader population (Golafshani, 2003; Burkholder et al., 2020). A qualitative study design should have the integrity and quality level that is amenable to scientific scrutiny. Trustworthiness and its respective criteria are the benchmark to ensure scientific integrity (Laureate, 2015; Golafshani, 2003). The following sections will cover the steps taken by the research to incorporate these criteria into this research study.

Reliability

Reliability speaks to the dependability of the data when quantitative measures are not utilized to test a hypothesis (Golafshani, 2003). During the interviews, I assured participants were asked the same questions in the same order and in the same way, and that the interview guide was intently followed. According to Cypress (2017), reliability could be achieved by asking the participants the same questions at different times and obtaining the same answers which were achieved at the point of saturation for this study.

Credibility

Credibility refers to the internal validity of the research and using well established methods that are recognized in the respective field of study (Laureate, 2015). In this research study, methods and established theoretical framework tools were utilized in the design of the study, study planning and approach to the analysis. The instrumentation (e.g., interview guide) used in this study, for example, was developed based on this approach and principles. This ensured a consistent strategy and well-known framework was applied in the study to ensure its credibility.

Transferability

Transferability refers to the external validity of the research and the ability of the findings to be applied to another study (Laureate, 2015; Golafshani, 2003). To address transferability researchers can include persistent observation, thick description, saturation, reflexive journaling and create an audit trail. The researcher must ensure the study's findings are sufficiently explained so that the finding is replicable and learnings can be transferable to other points in time, people and situations. Validity, a component of transferability, refers to consistency between the research intention and what was studied as well as the accuracy of the research findings reported. Quality in the conduct of the study, appropriate documentation, and management of the data and its participants is important to establish validity and reliability. Both are critical underpinning to transferability. There are several ways transferability was incorporated into this study design. First, audio recordings to produce transcripts provided a repository of data for the analysis via zoom. Secondly, Audit trails are automatically built into the analysis platforms used including excel and adobe acrobat PDF. Each software includes time stamps, date trails, and file transfer records. Lastly, persistent observation, saturation point, and reflective journaling were implemented concurrently with the recordings.

Dependability

Dependability refers to the reliability of the research. To ensure data quality, transcripts of the interviews were reviewed in two different manners first manually as printed documented then manually as electronically files and categorized by typology, then analyzed. This process ensured a high degree of validity to the results (Burkholder et

al., 2016; Laureate, 2015). I established dependability by using the same interview guide for all participant interviews and maintained a journal throughout to document any adaptations needed to the guide and capture personal insights for coding and for the analysis.

Confirmability

Confirmability refers to the objective nature of the research data itself and the ability to verify its authenticity (Connelly, 2016). It can be addressed if the research process includes audit trails, sufficient documentation to verify the data collection from participants and mitigation of researcher biases. Additionally, maintaining a journal of the data collection process that can be assessed by reviewers builds trust in its confirmability. As mentioned in the previous section, reflective journal to document my learnings, the recruitment process, and to serve as a source for future references during the analysis and report writing process. This approach establishes transparency in the research processes and supports confirmability in the research conduct.

Ethical Procedures

The codes of conduct for research studies are grounded in legislative and policy doctrines such as the Nuremberg Code, National Research Act, and the Common Rule, which have outlined standards for engaging research participants and overall research conduct that minimize risk to participants (Burkholder et al., 2020). Given the intimate nature of the researcher's role in a qualitative study design, proper informed consent of participants and utilizing institutional review board to ensure appropriate risk benefit analysis is required. Data collection methods such as surveys and interviews should be

executed in a manner that ensure anonymity of the participant is protected. Secondly, no coercion and or deception of participants on the intent of the study should occur.

This qualitative research study followed ethical guidelines established by the Walden University IRB. Participants' rights were protected, maintained confidentiality and privacy was respected throughout the study process. IRB approval was obtained prior to any recruitment processes starting. As previously noted, the Walden IRB also approved a study plan, recruitment materials, informed consent and the interview guide. A digital version of the informed consent was provided to all participants as part of the study recruitment and subsequently reviewed during the interview process. The informed consent confirmation of understanding, willingness to participate as well as confirming meeting inclusion criteria for the study was audio recorded.

This study maintained the privacy and confidentiality of participants by maintaining all materials and communications that could potentially identify individuals' private information. Participants' names were kept private, and their information was de-identified using unique numeric identifiers. Additionally, the participants' information was kept in a private and secure location including binders containing transcripts. Interview and process documentation journals were also maintained in a secure location. Scheduling interviews were managed using the contact email from which the participant reached the researcher. All interviews were scheduled using the Walden University Outlook platform. Interview materials such as the audio files and transcripts were maintained in a password protected folder file until subsequently moved to a secure external drive. Journal logs and notes were scanned and stored digitally in pdf and

transferred to an external drive that is password protected. The drive is stored in a locked file cabinet until the five-year requirement for destroying materials relevant to the study is reached.

As part of the informed consent review process, participants were reminded that their participation was voluntary and could be redacted at any time. Participants were not pressured to participate and were informed of a hotline that could be reached in the event the individual was in distress because of the interview process. The interviews were held in a private location and phone messages including text messages were securely protected.

Summary

Trustworthiness of a qualitative research study is essential to research community. The approach to recruitment, sampling of the population, treatment of participants and management of the data collection process are equally important. This basic qualitative research study sought to satisfy these criteria by creating an audit trail of the research and data collection process. Journaling was utilized to capture emergent thoughts, reflective thoughts, and supplement documentation of a methodical and consistent process being implemented for all participants. Enhanced digital technology (Zoom and Microsoft excel software) were utilized to document and establish an audit trail. The following chapter will confirm the trustworthiness of the study and share the study results.

Section 3: Presentation of the Results and Findings

Results

The purpose of this qualitative study was to explore the influence of social support on health-seeking behaviors of Black adult women living in the United States to address health disparities. Although studies have been conducted to understand health-seeking behaviors, they lack a focus on Black women in terms of design of public health interventions to increase the likelihood sustained positive health outcomes will be realized for this population in the United States. Findings from this research are presented based on salient codes to frame results that informed the following research questions:

RQ1: How does social support influence health-seeking behaviors for Black women?

RQ2: What were perceived and received support types for Black women that influenced their health decision processes?

In Section 3, I provide an overview of the study setting, demographics, and results of data collection. The section also includes information about participant interviews followed by analysis of the most salient codes, categories, and themes. Additionally, trustworthiness and credibility are addressed. A threshold of salient anchor codes meeting 25 or greater occurrences was applied to data (see Table 4). I concluded the section with a summary of study findings and a brief preview of Section 4.

Participants were interviewed using a list of 21 questions and health mapping exercise. Notes were taken during the interview process which enabled me to focus and

probe further with follow-up questions during 60 to 90-minute interviews. Allowing participants to elaborate helped me better understand motivations for their responses, interpretations of responses, and create trust with participants by showing interest in their lived experiences. Upon completion of interviews, transcripts via Zoom were downloaded and converted to Adobe PDF files for thematic analysis. Downloaded transcripts were also printed and placed in binders along with my notes reference during the analysis process. Printed transcripts and notes were retained in my office in a locked file cabinet, and downloaded transcripts were kept on a secure computer.

Setting

All interviews were held virtually using the Zoom platform from my home office. This ensured participants had privacy and no information could be overheard from my perspective. Interviews were scheduled based on availability of participants between 9:00 A.M. eastern standard time and not later than 7:00 P.M. eastern standard time, Monday through Sunday. A diverse group of adult Black women responded to advertisements, resulting in 16 participants being recruited.

Demographics

This study was delimited to Black women over 18 who resided in the United States and responded to the advertisement for this study via an email directed to my network, advertisements on LinkedIn, and or referral by a friend (see Table 2). Sixteen participants ranged in age from 22 to 49. They came from California, Florida, Georgia, Illinois, Ohio, New Jersey, New York, Georgia, Texas, and Washington D.C., with five residing in New Jersey. Educational levels ranged from high school to doctoral level,

with six participants having completed master's level education and five having completed high school (see Table 2).

Table 2

Participant Demographic Characteristics

Participant	Gender	Age	Ethnicity	State	Highest Educational Level	Professional Role
1	Female	41	Black	NJ	Doctorate	Regulatory affairs manager
2	Female	46	Black	NJ	Bachelor	Entrepreneur business owner
3	Female	49	Black	NJ	Master	Clinical research operations manager
5	Female	26	Black	IL	High School	Nanny
6	Female	27	Black	TX	Master	Data analyst
7	Female	25	Black	NY	Bachelor	Case manager
8	Female	27	Black	FL	Master	Financial analyst
9	Female	28	Black	CA	Master	Social worker
10	Female	23	Black	NJ	Bachelor	Unemployed
11	Female	35	Black	NJ	Master	Public health professional
12	Female	30	Black	NY	Associate	Restaurant cashier
13	Female	22	Black	TX	High School	College student
14	Female	26	Black	GA	High School	Administrator for property management company
15	Female	29	Black	DC	Master	Public health professional
16	Female	29	Black	OH	High School	Vocational undergraduate student
17	Female	25	Black	TX	High School	Nanny and undergraduate student

As part of the demographic interview section, participants were asked to describe other roles they had in their lives such as mother, wife, and caregiver. Table 3

summarizes self-reported roles they described which led to an understanding of the extent to which participants managed multiple support roles as part of their social support networks. Throughout interviews, participants revealed additional roles once they were further probed.

Table 3

Participants' Self-Reported Other Support Roles

Participant	Social Support Role 1	Social Support Role 2	Social Support Role 3	Social Support Role 4	Social Support Role 5	Social Support Role 6	Social Support Role 7	Social Support Role 8
1	Wife	Mother	Aunt	Daughter	Sister	Friend	Christian	Job
2		Mother			Sister	Friend	Mentor	Community member-professional
3	Has Boyfriend			Daughter	Sister		Volunteer	Community Member
5	Student		Aunt	Daughter	Sister	Friend	Take care of children	
6		Mother			Sister			
7					Sister		Caregiver	
8	Wife	Mother				Colleagues	Caregiver	Community member - church Job,
9	Wife	Mother		Daughter	Sister	Friend	Caregiver	Community member
10				Daughter	Sister		Caregiver	
11	Wife	Mother		Daughter				
12	Wife	Mother			Sister	Friend		
13				Grand-daughter	Sister		Caregiver	Community member
14	Social media influencer				Sister	Friend		Community member - Church
15	Has Boyfriend			Daughter	Sister	Friend		Community member
16				Daughter	Sister	Friend		
17		Mother			Sister			

Data Collection

Data collection began after I received IRB approval on May 18, 2025. The IRB approval number for this study is 05-19-25-1046291. Participant recruitment began on May 29, 2025, and concluded on June 2, 2025. Participants who responded to study advertisement were scheduled for interviews based on their email outreach sharing interest to participate in the study. All outreach and scheduling were managed through the Walden University outlook platform. After prescreening to ensure eligibility and ability to meet criteria, ability to participate virtually via zoom, an Outlook calendar invitation was shared. Prior to beginning each interview, participants were asked if they had reviewed informed consent forms to confirm understanding of the study purpose prior to obtaining verbal consent.

The informed consent process and confirmation of consent was audio recorded for all sixteen participants. Participants were treated with respect and ample time was allocated to address any questions or concerns raised. I followed the IRB approved interview guide and interview questions previously outlined in Chapter 2. Participants were informed that I would be capturing notes concurrent with the taking audio recording of the interview. During the interviews my video camera remained on. Three of sixteen participants had video cameras on, all other participants had cameras off. It is important to note that video participation was not required, nor were any participants pressured to turn on their cameras. The interviews ranged from 60-110 minutes in duration. As outlined in Chapter 2, and Table 2, the interview process included five distinct sections of questions: (1) demographic data, (2) health mapping exercise, (3) received support

questions; (4) perceived supportiveness of network questions and (5) a summary question. After prescreening was completed by email, participants were assigned an enrollment number in sequential order until recruitment was closed. The interview materials were maintained in my home office and on secure computer which is password protected. After the interviews were concluded, participants were referred to solely by their enrollment number in all study materials. Participants 004, 018, 019 and 020 were not included in the study due to scheduling conflicts, lack of response to scheduling, language barriers identified as part of the pre-screening and saturation point being reached.

Data Analysis

To conduct the analysis, sixteen participant transcripts were downloaded as rich text files from the zoom platform. The rich text files were uploaded to adobe and integrated into one adobe PDF file. The combined file enabled thematic review and tabulation for the 938 pages of transcript data collected. The search and find tool were used to de-identify the data prior to the analysis. All participant identifiers were replaced with the participant assigned number. Additionally, participant references to friends or family members by name were de-identified and deleted prior to the beginning analysis and to maintain confidentiality and protect the identities of the participants.

As outlined in Chapter 2, a discussion guide was developed based on the social support framework and other health behavior related literature. The questions were also reviewed by Walden University qualitative research experts and the capstone Chair to ensure rich qualitative discussion and ethical approach was being taken. The semi-

structured interview results were coded using theoretical driven codes first, followed by 3 rounds of review based on data driven codes.

The codebook, coding text examples, and the analysis results were captured in an excel workbook and version controlled. Codes were applied to the Adobe PDF integrated file of survey transcripts. Adobe software was used to apply the codes and used for tabulation of the codes. Social support theoretical drive codes were initially applied followed by three rounds of data driven codes being applied. The data driven code initial output generated 91 codes which were refined and reduced to 46 codes. The most salient codes were based on a threshold of 25 or greater occurrence across all the transcripts. Table 4 provides a summary of the salient code based on this threshold. Overall, 12 codes, 5 categories and 4 themes resulted from the tabulation.

Table 4*Key Categories and Themes*

Anchor Codes	Frequency of coded segments	Categories	Themes
Characteristics "Because these relationships are built on trust"	42	Motivating health activity	Network powers being in charge of my health persona
Characteristic "... They've been on this health journey with me..."	81	Motivating health behavior	
" It encourages me to prioritize my health ..."	43	Motivating health activity	
"...It gives me self-confidence..."	26	Motivating health activity	
"...The healthcare scare that I had I might not have done that..."	40	Motivating next steps to address health concern	
Characteristics "...I can count on them 100%..."	40	Dependable network showing	Network acting as safety net
Characteristic "I feel I can talk to them..."	25	Authentic and effective communication	
Relationships that shape support network - family	28	Dependable network showing	
Characteristic "it helps me make informed decisions"	40	Intentional Health Planning	Health information triangulation
Characteristic "my friends, we share information..."	36	Intentional Health Planning	
I generally follow a process (find term to for this) or"...The situation determines who I go to first..."	27	Intentional Health Planning	
Special relationship with my specialist or primary care physician	35	Suboptimal provider treatment or care	Umbrella medical advisory status

I coded each interview transcript according to the phenomenological approach for thematic analysis. The codes were all applied manually to segments of text that provided context. The anchor codes were then organized, mapped to categories then further mapped to emergent themes. One round of theoretical-driven codes was applied to the data followed by three rounds of data driven codes being applied. Each round of data driven code served as an opportunity to streamline the coding, identifying subsample themes (categories), comparing themes across subsamples and creating or editing or combining codes, categories and themes. Additionally, an attribute description was developed for each anchor code to distinguish code meanings. This iterative process

continued until all transcripts were coded. The frequency of coded segments was then tabulated using the adobe search and find function. The result of this analysis is presented in Table 4.

Throughout this process the codebook was shared with my capstone chair for input. The codebook and my analysis process were also reviewed periodically with the Walden University Department of Research qualitative research experts. There was also the opportunity through Walden Department of Research to share best practices with other doctoral students to support the capstone development. Several of these events were attended to gain input on approaches to conduct the research. This progression safeguarded reliability of the coded segments and an appropriate systematic approach was taken to ensure transferability and reproducibility of the study. Obtaining this objective input also helped to reduce bias in the code development process. The patterns that emerged from the individual interviews for this qualitative study facilitated further understanding the influence of social support on health seeking behavior for Black women in the United States.

Evidence of Trustworthiness

To maintain the credibility of this study, I followed the guidelines outlined in Chapter 2. I also received approval from Walden University IRB in April of 2025. Trustworthiness was assured through following the interview guide approved by the IRB, following ethical principles of study conduct and saturation of data. Throughout the interview process participants, I ensured participants were allowed sufficient time to respond to questions and addressed their questions throughout the interview. I asked

clarifying questions and were also asked throughout the process to ensure participant statements were interpreted accurately. All participants were properly consented prior to starting the interview and at the conclusion of the interview the next steps for usage of their insights were reiterated. I achieved saturation after interviewing twelve participants.

The transferability of the study was achieved with detailed description of setting, context, data collection and coding processes being provided. Additionally, detailed demographic information on the participants, their sentiments and depictions of ways they contributed to the dialogue during the interviews demonstrated the applicability of the content collected. Examples of this dialogue are provided with statements extracted from the participant transcripts.

The dependability of the study was achieved by ensuring the findings were aligned to the intended study population and research questions under study. Mapping direct responses of participants to codes, categories and themes that are documented in a code book ensures a consistent methodology was followed that supports accuracy of the results. As previously stated in chapter 3, all participant transcripts were coded through an iterative process that received Walden faculty throughout the process.

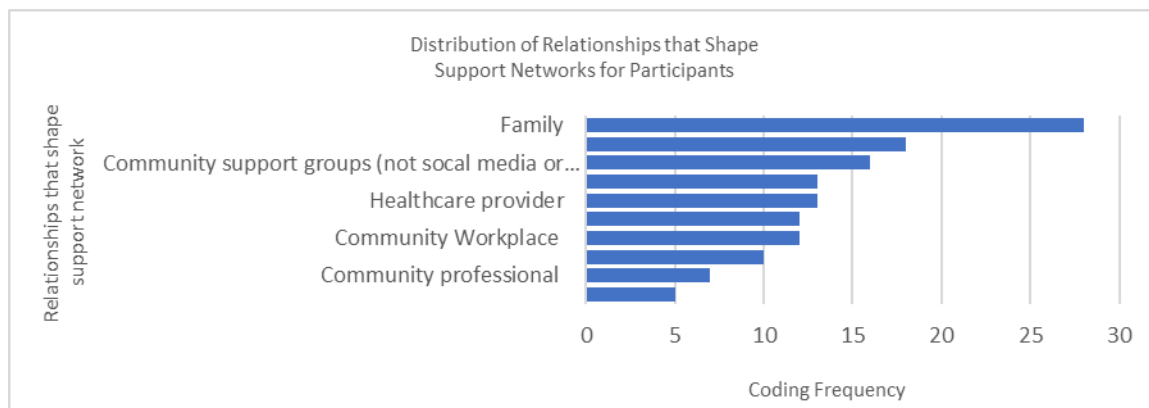
An objective semi-structured interview research process was implemented to ensure confirmability of the study. By monitoring my personal views and creating an environment for open dialogue with participants that was non-judgmental, biases were mitigated. This allowed me to approach the research with an open mind, identify new insights and findings.

Results

The results section of this study is organized first with a summary of the network make up itself. It is important to understand the make-up characterized by participants, the most influential roles in the network and how these relationships create the foundation for influencing health seeking behavior. It is then followed by a summary of the salient themes described in the introduction to this chapter and categories derived from thematic analysis. The semi-structured interview questions provided the basis for rich data collection and open dialogue regarding their experiences. The network make-up and themes revealed opportunities to address disparities in health outcomes for this population based on the lived experiences of the participants.

Social Support Network Make-Up

Figure 2 below shows a distribution of ten relationships that shaped the social support networks for participants. The relationships reported included (1) family, (2) friends, (3) community support groups not related to online or social media, (4) community support groups related to social media and online, (5) healthcare provider relationships, (6) mentors or coaches, (7) community support groups in the workplace, (8) community or individuals that are spiritually based, (9) community support related to their professional network, and (10) therapist. It is important to note that the family relationship encompasses parents, siblings and partners. Similarly, mentors and coaches included multiple roles such as traditional mentor, fitness coach, and life coaches.

Figure 2*Distribution of Relationships that Shape Support Networks for Participants*

The social support family relationships ranked the highest in frequency of being mentioned across all transcripts followed by friends and community support groups that were not online, or social media based. The community support groups included group chats with friends, family chat groups, neighborhood support groups, and women’s support groups.

P7 noted “My group chat. Oh, my girlfriend! Honestly, they became part of my health support system. Naturally. At first it was just jokes, memes, and catching up, but over time we started sharing our experiences and whether it was someone talking about Birth control side effects, or another person recommending a therapist. It became a space where. I could be honest and get real advice...”

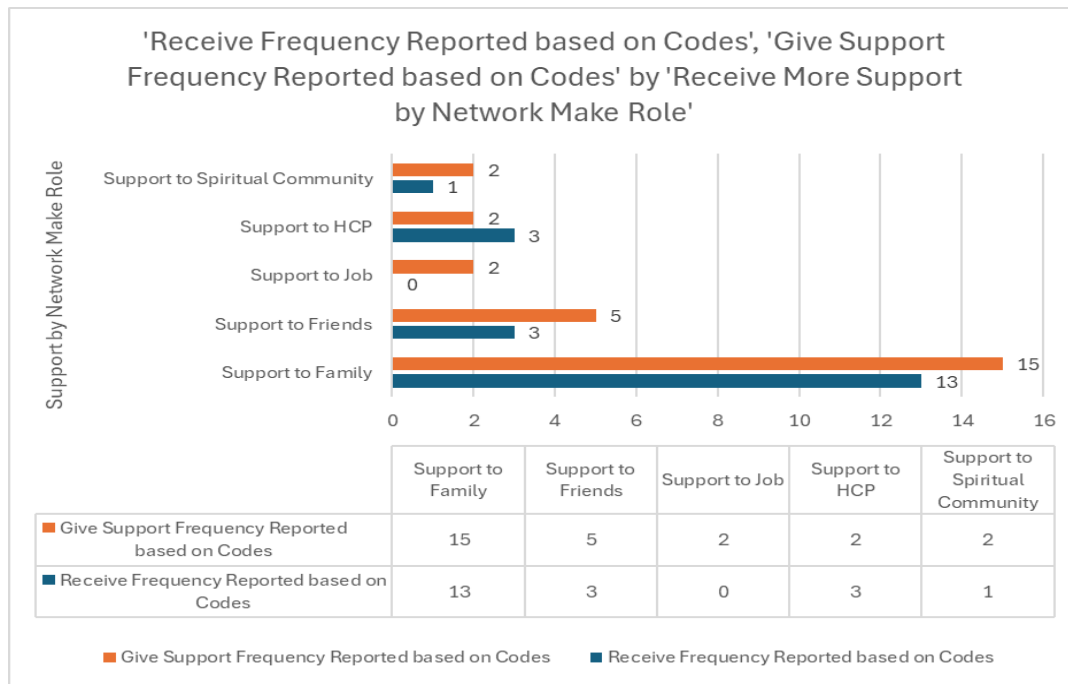
P9 said, “The support groups I am in. You know, whenever we get together. And I do, you know. I would say things I would say. Um my experience where I am now. They

would be happy. Um actually coming up. I'm leaving my old self. So literally, people like talk to people.”

When asked which relationships participants received more support from and to which relationship they gave more support, there was a close correlation in which roles were prioritized. The data represents a combined coded frequency reported across transcripts for the role as well as when directly asked this question. The relationship with family was reported the most often for both receiving and giving support. Friends' relationship was consistently in second place for giving and receiving support. Network make-up roles including support to spiritual community, HCPs and one's job were reported in lower frequency than Family and Friends. The summary reflects a strong correlation between how participants perceive receiving and giving support the most and by which roles. This may indicate that a degree of balance in expectations of support being bi-directional in nature for the social support network construct as an important aspect of interventions developed based on this premise.

Figure 3

Reciprocal Support Assessment Summary as Reported by Participants for Relationships Related to Their Health Journey



The relationships which shape the social support network framework reflect important roles which participants depend on for guidance, information sharing, physical and psychological support in navigating their respective health journeys. As stated previously, the family relationship consistently rose to the top as the most frequently reported relationship among the sixteen participants. Friends and community support groups (both online and offline) were also higher ranking in importance in the network structure across both perceived and received benefits related to one’s health in leveraging their social support network. Lastly, roles such as health care provider, mentors, coaches, and spiritual based influences contribute to the network structure, forming a

comprehensive distribution of relationships with varying degrees of importance and influence on a participants' health seeking behavior. In the next section I will share the results for the most salient themes arising from this research.

Theme 1

Theme 1 has six salient anchor codes and three categories (see Table 4) for which the participants provided their experiences. The categories associated with the salient codes included (1) motivates healthy activity, (2) motivates healthy behavior and (3) motivates next steps to address health concerns (see Table 5).

All participants discussed a perspective of their lived experience which connected to this theme, powers the I'm in charge of my health persona. This theme encompasses relationships built on trust, the social support key roles being on the their health journey, confidence the support system creates, and health scares that trigger a personality of ownership in their health seeking behavior and health journey. The concept of persona and the true self, according to Schlegel, Hicks, Arndt, & King (2009), can contribute to one's well-being and have an impact on an individual's perception of the meaning of life. In research by Giles (2020), a persona specifically is described as a "course to construct a version of themselves to interact in a specific medium" According to this research, traits exhibited by an individual can vary based on who you are verses who you are during certain activities. A persona helps an individual to compromise between their individual needs and that of society. When a lived experience triggers this aspect of personality, it's influenced by their environment (Schlegel et al., 2009; Giles, 2020). In the case of this

research study, I believe this shift enables the participants to take action to improve their health situation.

Table 5

Theme 1: Network Powers Being in Charge of One's Health as a Persona

Category	Anchor Code	Participant Responses
Motivating healthy activity	Characteristics "Because these relationships are built on trust"	Participant 005 "... I feel like my partner is kind of like a support system to me as well, um, I stay correct on what I'm supposed to like, eat and stay healthy, and also.... My siblings go as far as also, um sharing recommendations of what they think would help,"
		Participant 002 "...And that moment sometimes I may feel like I'm crazy or not necessarily crazy, but maybe I feel like um, I'm lost, or I'm scared...My support system has made me feel that what I feel is valid, that I'm not alone...."
Motivating health activity	"...It gives me self-confidence..."	Participant 003 "... Yeah, absolutely...Trust, and just as an intimacy. There's, you know, just the closeness. That allows. Um me to be vulnerable..."
		Participant 003 "... What are my options, you know, to be able to feel confident in asking those questions and getting the response that I deserve..."
Motivating health behaviors	Characteristic "... They've been on this health journey with me..."	Participant 006 "... for example, my mom. Sometimes, you know, having someone to tell you that. You need to go see a doctor, or probably I will go with you, so that you know that fosters confidence..."
		Participant 008 "...has actually um created um made me to be more um more comfortable, when, when, whenever. I'm around them. They've created this um, this um platform for me to do me. like um a bond that is unbreakable...."
Motivating health activity	" It encourages me to prioritize my health ..."	Participant 002 "...The reason why I am connected to so many friends who um are MDs...is because they're active. Right. ... I started to surround myself with people like that, like... I won't say I hate the gym. I hate Cardio..."
		Participant 005 "...keep me focused on rewards. I. I expected myself to do all where I expect myself to be at. It kind of helped me set goals and. Quantify my goals and. It really helps me a lot to stay focused. So, um. They are really important as well.
Motivating next steps to address health concerns	"...The health scare that I had I might not have done that..."	Participant 006 "...The um situation is, or regardless of how busy. ...Individual is, he has your best interest at heart. And that will actually give one this big motivation or confidence, to want to take any more step"
		Participant 011 "... Um, I would say, like being able to just physically do things. With each other, so whether that be, take a walk... run, play. Play basketball. Dance, you know, like just being able to be like physically present, because I feel like that's. Probably that's the that's the main reason why people, you know, want to take care of themselves"
Motivating next steps to address health concerns	"...The health scare that I had I might not have done that..."	Participant 001 "... I found out about the my numbers. And because my symptoms were so. Just, egregiously aggressive.... I needed to do something different..."
		Participant 003 "...I had major surgery about 4 weeks post-op. I had a hysterectomy...Thankfully, they did it robotically. So, there was no major incision.... Massive uterus filled with fibroids that I've been battling for years and years and years. I'd actually had them removed twice before..."
		Participant 015 "...We have to take care of ourselves. More than ever in this moment, and I think mental health wise. That's also really important. I think, for context. I had one of my best friends passed away by suicide a little over 2 years ago. And after that happened. The way that, like me, I would say, like my support system has always shown up. But after that I think they started showing up tenfold...."

Motivating Healthy Activity

All participants provided examples ways they were motivated to healthy activity by because of the influence of trusted relationships in their social support network. Trusted acted as an anchor for setting goals, staying on track and pursuing healthy activities such as exercises, seeing a doctor and or focusing on their mental health. Participants were motivated by trusted relationships, relationships which built up their confidence and those that encouraged them to prioritize their health. Thirteen of the participants noted this anchor code shifted their perspective on how to prioritize their health. Participant 017, for example, who had a teenage pregnancy, noted the importance of her support helping her to prioritize her health, was an indirect way to ensure her child would be healthy. At the time of her pregnancy, she was not able to see this herself because of her mental state. She stated "...Yes, I have one specific person. I met him before I got admission. And I was going through a lot when I got pregnant, and I was having a lot of um crisis... Yeah. So, this one person has really helped me put my life in check and pushed me to where I am right now..." The support network encouraged conversation with their provider regarding their health and wellbeing and motivating participants to pursue initial care, follow up care, and to interrogate their healthcare options.

Motivating Healthy Behaviors

This category encompasses participants who expressed how role modeling behavior and their social support network being there for the entirety of one's health journey influenced their health seeking behavior. The participants expressed varied levels

of support from friends, families, spiritual leaders, mentors, coaches and support communities both online and not. Responses associated with this anchor code demonstrated a consistent result in participants embodying the support guidance and making efforts modifying their behavior, mimicking and or taking on individually positive health attributes related to eating, exercise and mental health. For example, participant 011 shared “Um, I would say, like being able to just physically do things. With each other, so whether that be, take a walk.... run, play basketball, dance, you know, like just being able to be like physically present, because I feel like that's. Probably that's the that's the main reason why people, you know, want to take care of themselves....” The attributes associated with this anchor code encourage a persona of confidence to take charge of one’s health.

Motivating Next Steps to Address Health Concerns

Fourteen participants, the majority, reported experiencing a health scare or significant health-related event that involved their social support system being important to navigating and or managing through health concerns. Examples of these health-related concerns were broad, including depression requiring medical intervention, hysterectomy due to fibroids, uncontrolled diabetes management crises, misdiagnosed urinary tract infections and unexpected pregnancy. These health-related situations often prompted the participant to act aggressively on health concerns and leverage their social support network to help them effectively manage through the situation. For example, participant 001 shared” ... I found out about the my numbers. And because my symptoms were so. Just, egregiously aggressive.... I needed to do something different. I couldn't just....” In

another example, participant 003 shared,” ... I had major surgery for about 4 weeks post-op. I had a hysterectomy...Thankfully, they did it robotically. So, there was no major incision.... Massive uterus filled with fibroids that I've been battling for years and years and years. I'd actually had them removed twice before....” Both her mother and partner supported her actively through this process. In another example participant 013 who reported “...Uh, yes, of course I did battle with depression at a specific time...” She subsequently brought her family together in a conference call to bring attention to her mental state, triggering them to support engaging a family doctor to help navigate her depression.

Theme 2

Theme 2 has two salient anchor codes and two categories as outlined in Table 6, for which the participants provided their experiences. The categories associated with the salient codes included (1) I count on them 100%, and I feel I can talk to them. This theme was pervasively presented across all participants. The theme includes characteristics and traits that are meaningful to and prioritized by the individual when deciding who should be in the support network because they exhibit consistent availability to support them. Additionally, it includes reference to when the social support network relationship role is a good listener, creating a judgement free zone, where the individual feels they can share their health situation freely. Participants noted that this type of support was distinct from other areas of their lives, such as career advice or financial guidance.

Table 6*Theme 2: Network Acting as Safety Net*

Category	Anchor Code	Participant Responses
Dependable Network showing	Characteristics "...I can count on them 100%..."	Participant 002 "... Where I am right now, with my health. I tend to surround myself or go places where I know I'll have that support... For example, I went to that ...concert right. Recently I went with my daughter. ...Would I go? Would I go to a concert with people who I'm not comfortable with? Because I don't know if I'm going to have a low, or if I'm going to have a high, or if I'm going to have any kind of episode? Probably not. I make decisions around like, I make decisions around what I do. Based on who's around me, and who can help me and support me if I get in trouble..."
		Participant 007 "...My best friend, my mom, my roommate. They are super, reachable. And no matter what time of the day, I know I can text or call them. If I'm feeling off or need advice..."
		Participant 009 "...Oh, they are very much available, you know. Some. What I've said so far. Um! They are always available for me..."
		Participant 012 "... Yeah, that's 100%. Because I know they always come through..."
Authentic and effective communication	Characteristic "I feel I can talk to them..."	Participant 003 "...Um keen to follow doctor's orders. Whatever I need to do to manage this and to get through. This is what I want to do so. I need the medical team to really talk to me through that..."
		Participant 007 "... I searched specifically for someone who would listen to me, not just. Brush through the appointment..."
		Participant 015 "...I'd say it's been a positive experience. Um, I feel like I have. You know, like I said before, really like trusting relationships with um.... My support network and system. And so. They're conversations. I feel like I can have candidly. And openly..."

Dependable Network Showing

Thirteen of the sixteen participants shared examples of how they could count on their social support network regarding their health. The participants reported having these individuals available at all times and without question is a role they can turn to if there was a health concern, in need of health information or resources and as noted previously to keep them motivated. One participant mentioned that for this aspect of their social support network, these were people who cared about her deeply and would advocate for her in times of need. Several participants referred to the dependability as being expected for relationships in the network such as with their family members. Conversely it would

naturally not be expected for others such as with co-workers. One participant noted not ever receiving support from anyone but her mother. While all other participants noted the dependability being falling to family, friends, and their healthcare provider. All participants note reciprocation of the support to some degree. Indicating a level of shared dependability across the social support network. Additional characteristics of valued elements for this category were trust, accessibility, and familiarity with their health.

Authentic and Effective Communication

Twelve of sixteen participants noted authentic and effective communication influenced their health seeking behavior. Decisions impacted a broad range of health decision areas from treatment options, surgical interventions, to choosing a healthy care provider, to self-advocating at hospital treatment centers, diet and exercise. The participants shared their most intimate health challenges with roles who exhibited this behavior well in their social support network. One participant noted developing a relationship around her health with her fitness instructor because of his availability and ability to listen even though she did not know him well. Another attributed her comfort speaking with her mother as an adult, was due to having an early relationship with her mother that encouraged open dialogue about her health at the time she got her menstrual cycle. Three participants reported doctors or nurses' treatment during visits could be a deterrent to proper treatment. All participants expressed seeking out health care providers follow up with providers and sticking to a health care provider was based on their ability to listen and not brush off their symptoms.

Theme 3

The results of Table 7 outline the health information triangulation theme which encompassed one category intentional health planning, and three salient anchor codes. The anchor codes included (1) making informed decisions, (2) sharing information across social support networks roles, and (3) having a process to follow with their health seeking behavior as the need is presented. Health information triangulation refers to participants efforts to integrate multiple aspects of health information inputs across the social support network to make health seeking behavior decisions. The participants cross-check information from various trusted sources prior to making final decisions regarding their health. The social support network relationships act as a resource providing encouragement, judgement calls and sharing health information, that ultimately help the participant reach consensus on next steps.

Table 7*Theme 3: Health Information Triangulation*

Category	Anchor Code	Participant Responses
Intentional Health Planning	Characteristic "it helps me make informed decisions"	Participant 001 "...Go directly to hematologists. And didn't even bother with her PCP. She just went straight to the hematologist, and I was like, oh, I never thought about that. and so, she gave me her hematologist phone number. I called them, and they, you know, came in...."
		Participant 002 "...And their connections to healthcare are not just rooted in their own personal challenges and experiences, but they're rooted in true background in terms of their education, in terms of. Um even their own individual networks. So, I consider them trusted sources..."
		Participant 016 "... I have leaders in my congregation that um kind of like. ...Someone that I could like go to for advice..."
	Characteristic "my friends, we share information..."	Participant 001 "...Um, my husband will help me look for providers online, and you know. Um, or he'll come with me if I have a console. Um or friends will give recommendations based on their personal experience with the provider, because they, too, are a patient...."
		Participant 002 "... I'm happy to say that you know my network has always offered. Uh alternative options, whether it be another doctor or um. An article to read help, you know. Better inform me. Um...."
	"...The situation determines who I go to first..."	Participant 002 "...Primary example. Um. Last year I had to have an Angiogram. I had some chest pain, didn't know where it was coming from. I have a history of um high blood pressure. Um had to go to the hospital, of course, and then I was admitted, and then they did they did the angiogram, or whatever. Um. I wasn't sure of next steps after the angiogram..."
		Participant 006 "...I mean, I will get information from my family members. ...Okay, you know. As a family we created um. A group on WhatsApp. Whereby we get to converse my autumn. So that's where we get to go..."
		Participant 009 "... For me. I do talk to my mom first, you know, if I wake up, and I'm kind of feeling. Somehow, you know she is my mom..."

Intentional Health Planning

Based on participant feedback, intentional health planning entails traits that are meaningful to the participant when deciding who should be involved in making better health decisions from their social supporting network. Four participants expressed aspect of these traits across all three codes. Participant 002 for example noted "...having access to people with not just personal experience but also formal education in healthcare". She continued to explain later that she intentionally reshaped her social support network for

over 10 years. Later the participant outlined the step wise approach taken to rally the social support network roles to help with health decisions. For example, participant 002 stated "... how I navigated most of my friendships. So, she's step one...step 2 is the friend who has high blood pressure. Who's been navigating the challenges with blood pressure... Step 3 ...overall worship community."

This theme assumes a level of intent to proactively identify network roles that are trusted, are knowledgeable of the health field, and creates an environment for comfortable open dialogue that is nonjudgemental. Fourteen of the sixteen participants expressed intentional planning where the social support network was leveraged to help make informed health decisions. The decisions ranged from selection of a provider to treatment and surgical intervention options to pursue. Provider selection informed by this attribute ranged from selecting a primary care physician to a specialist for a significant health event. It also involved seeking out referrals and support for advocacy to mitigate fears of anticipated mistreatment by health care practitioners. Ten of the sixteen participants noted having an intentional process in place to support their health decisions. Eight of the sixteen participants overlapped in their characterizing informed decision coupled with sharing information being informed by the social support network. Twelve of sixteen overall noted sharing information as a resource on health from their social support network. Lastly, ten of the sixteen participants noted having a process in place to mobilize their social support network around their health decisions.

Theme 4

The results of Table 8 outline the umbrella medical advisory status theme which encompassed one category, suboptimal provider treatment or care, and one anchor code, characteristics, “...I have a special relationship with my doctor...” This code was attributed to traits participants reported as doctors expanding their guidance beyond their professional expertise. Due to the level of trust and comfort noted by participants to have an open dialogue, a special patient provider relationship is established. In these instances, the provider has an ability to influence health decision making beyond their specialty. Table 8 provides examples of participant responses that substantiate this theme. For primary care providers who fall into this category, their referrals to specialists are highly valued as a result as well as direction to address health areas of concern across the individual health journey. This influence transcends mental health concerns, fitness and disease management.

Table 8*Theme: Umbrella Medical Advisory Status*

Category	Anchor Code	Participant Responses
Suboptimal provider treatment or care	Characteristics, "I have a special relationship with my doctor"	Participant 002 "...she became more than just my doctor. She became someone who ...challenged me. Someone who listened to me...I had to make a decision about a gynecologist ...Obviously, she's not a gynecologist... But I had to go ...she did have to weigh in ..."
		Participant 006 "...Okay. Um, you know. I st um, my mom, you know. For information. She calls the. Family doctor and the Family doctor in turn keeps us, keeps us updated... Actually, um. try to educate us more often on our health conditions and health issues."
		Participant 015 "...There's literally sometimes a requirement to have a referral because of insurance. But I also think I have a like a trusting relationship with my primary care. It's like there was one time I went to a gastroenterologist actually didn't love it. And I did. I went without a referral and then told my primary care. She gave me someone else, and I was like, all right like I trust to keep gonna call her..."
		Participant 016"... There was a point where I needed to like talk to someone, to the doctor, to know what's going on, and. Since then, um! When I met my doctor. I love the way we've been. Um interacting. He is one doctor that. Paid attention to most of. The things I have to do..."

Suboptimal Provider Treatment or Care

Ten participants expressed aspect of these traits. Participant 003 for example noted being able to connect with her physician's medical team through an online portal as providing an invaluable aspect of treatment and care. Participant 003 stated:

"Whether I'm having the conversation with my doctor during an appointment.

Sometimes I'll just throw something in. The online portal, you know. Just to kind of send a quick email. Ask a quick question. You know, someone from the medical team will respond. And um. Sometimes it's affirming, sometimes it's not exactly what I expected

The relationship is trusted and further support the social support network by creating a nondiscriminatory and safe space for the participant to develop a relationship

with the provider. Suboptimal provider treatment and care are no longer a worry for the participants once the relationship with the provider reaches this level. Participant 009 stated:

You know. Um them being able to provide um. The best care. You know, being able to be there for me, and giving me the most um. Professional advice and. Medications.... You know, and most importantly, not discriminating.

Providers who fall into this category offer additional education and forums for patients to exchange best practices about their health. For example, P8 stated:

And that has been very helpful. And also, I would. Talk about my family doctor. ...But I'm always being there for us whenever we replace the classroom.... And always educating us and making sure that we'll follow up with. Proper treatment and trying to um engage in online classes. For us to obtain good more like a forum.

Additionally, five participants noted the providers being available using alternative forms of communication including texting, online portals, by phone and making home care visits in times of crisis. Four participants noted these doctors were typically referred to by a social network relationship whom they trusted and two of the three noted having long standing relationships with these providers. P15 had been seeing the same dentist since she was six years old. This was also the same dentist her mother and sister went to for care.

Summary

This qualitative study was conducted to explore the influence of social support on health-seeking behavior among Black adult women in the United States to address health disparities. The findings reveal trusted relationships within social support networks, including family, friends and community groups play a crucial role in motivating health activities, behaviors, and addressing health concerns. Participants emphasized the importance of dependable networks and authentic communication in making informed health decisions. Participants insights shed light on how the social support network acts as a safety net for health decision making at varying levels of decision making from critical life threatening to general health and wellness maintenance. The study also highlighted the concept of health information triangulation, where individuals cross-check information from various trusted sources before making health decisions. These insights underscore the need for public health interventions that leverage social support systems to improve health outcomes for Black women. Section 4 will consist of interpretation of the research findings, its application to professional practice of public health and implications for social change.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this qualitative study was to understand the influence of social support on health-seeking behaviors for adult Black women in the United States. Disparities that have endured with this population despite progress involving educational and socioeconomic levels which merit new ways to engage and support this population towards sustained positive health outcomes. Social support plays a critical role in influencing health-seeking behaviors by promoting positive physiological factors and mindsets to process and adopt health information. As a result, social support networks, including family, friends, and community groups provide emotional, informational, and instrumental support that can positively impact health decisions. A breakthrough is needed in public health to better translate this impact for Black women in the United States who continue to have poorer health outcomes than their counterparts. Social support and its influence on health-seeking behaviors is one area of opportunity to address this gap.

Interpretations of Findings

This study revealed social support network roles of most importance in terms of supporting participants' health decision-making and how perceived and received support is being leveraged by this network by participants. They were motivated to act on their health behavior opportunities to improve their health in various ways including follow up regarding their care, self-advocating, leveraging educational resources to drive informed decision making with providers. Four themes emerged from the research: network power

being in charge of my health persona, network acting as a safety net, health information triangulation, and umbrella medical advisories.

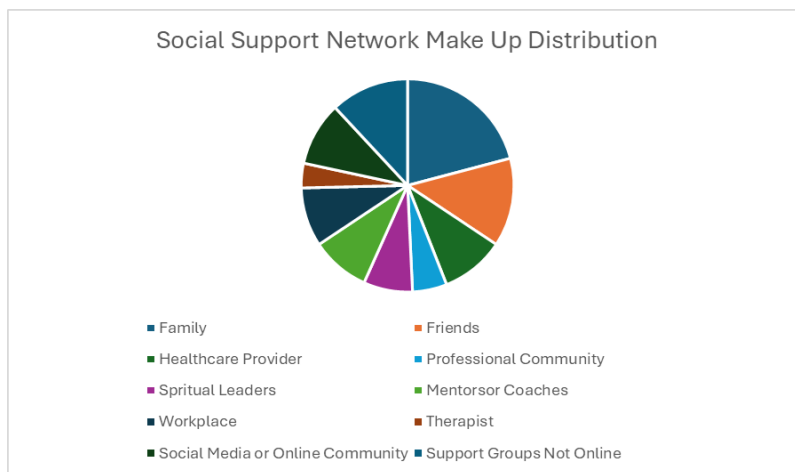
These themes, coupled with social support network structures, promote positive health behavior, adoption, application, and sustainability.

Social Support Network Make-Up

Findings included outlining roles of social support across various roles defined by partners including parents, siblings and significant partners, friends, community support, and social media and online platforms. The health mapping exercise revealed roles which complemented each other in terms of prioritizing health-seeking decision making processes (see Figure 4).

Figure 4

Social Support Network Make Up Distribution



Family, followed by friends, community groups on social media, and community groups that were not online ranked in the top four prioritized roles that provided critical

support to participants involving their health journeys. The roles identified within participants' social support networks may be understood as carrying particular value and responsibility in the context of health-related decision making. These roles were referenced as reliable and trusted sources of information and guidance, contributing to the overall process by which participants considered and evaluated their decisions. P2 noted "I can rely on them 100%." P1 went directly to a hematologist instead of her primary care physician based on a referral and recommendation from a trusted network friend. Triangulation of health information from complex sources is a tool that participants used to improve their health discussions with providers as well as decisions to seek traditional versus nontraditional intervention. Additionally, perceived and received support can influence health behaviors. Perceived support of networks was highly valued by participants. P10 stated "I guess the person apart from my mom. That's most supportive cause he's constantly checking in." The study identified social support network composition that constituted involvement of key roles such as family, friends, community groups and healthcare providers in various aspects of health-related decision-making and support. Participants attributed positive value to these roles, describing them as influential in their health decision-making processes.

Network Powers Being in Charge of One's Health as a Persona

Making healthy choices and putting steps in place to encourage positive health behavior are an essential aspect of health behavior change (Drageset, 2021; Ellick, 2019; Gangster & Victor, 1988). Research revealed an increased accountability for health behavior change, addressing health concerns, making informed health decisions and

health related follow-through occurred when the social support network was activated. Participants moved from lack of confidence to confidence and had a higher propensity to self-advocate when the social support network is activated. The majority of participants had health scares such as participant 001 who was hospitalized for anemia and Participant 002 who was hospitalized in the evening prior to the interview for a perceived anxiety attack. Participants relied on the support network to help them manage through the health scares. For example, participant 007 stated "...The biggest thing is that my network, with a sense of emotion and safety... makes me more willing to actually think what's going on health wise, instead of avoiding it..." Participants perceived ability to rely on this network for support through a crisis and when activated and the received support was equivalent. These characteristics of the social support network for black women trigger a persona shift that moves them from fearful and frozen, to confident and action oriented about their health. The received support over time gives the individual a sense that the network roles are "... on the health journey..." as stated by Participant 002. This provides a sustained sense of support which has a longer-term influence on health behavior. For example, participant 003 when describing the characteristics and traits of the social support network stated, "I'm here for you. I'm gonna be by your side. I'm gonna be there to support you. Certainly, from beginning to end...." Participant 002 when referring to how her interactions with health care professionals as result of the social support network has evolved stated "So I'm not going to do anything you tell me to do. I'm gonna do something based on what I've learned, what your knowledge is, and

we've made a decision together. So yes, now I have more confidence. Because of my support system...I feel that I don't have to do everything a doctor tells me to do....”

Network Acting as a Safety Net

Social networks can motivate healthy behaviors and activities. For this study group the social support network created a safety net for which trusted relationships, establishing a non-judgmental environment and role modeling positive health behavior within social networks encouraged individuals to prioritize their health and make informed decisions. This occurred in an environment where fears of mistreatment by the U.S. healthcare system remain a concern. Though not a salient text segment or theme, it was often connected to comments shared by participants regarding experiences of health scares. Ten of the sixteen participants reported either experiencing directly or indirectly through family members or family history mis treatment by the healthcare system. The network acting as a safety net becomes important to serve as a trusted support framework that counters fear of mistreatment by healthcare practitioners and strengthens capacity for the participant to manage through current health crises. Participant 017 for example share, “...and I was going through a lot when I got pregnant, and I was having a lot of um crisis...this one person has really helped me put my life in check and pushed me to where I am right now...” The behavioral influence of the safety net created by the social support network plays a crucial role in effectively managing the U.S. health care system and may have a significant impact on health outcomes for a population with a history of health misconduct and mistreatment Forde et al., (2019).

Health Information Triangulation

The concept of health information triangulation, where individuals cross-check information from various trusted sources within their social network before making health decisions was revealed as part of this research. This approach enables intentional health planning based on information being shared across the network roles, participants feeling they are making informed decisions and a general process being in place by participants to conduct the triangulation. Participant 005 for example stated "...and every bit of information that I get. You know, from groups, from people. People just make research and like, tell you what's up. I feel these are places that I get my support from..." Participant 007, noted "...My mentor helped me find affordable clinics and insurance resources. So that kind of knowledge makes me feel empowered. So, I'm not just reacting to health issues.... I'm making informed decisions..." Participants throughout the interview process acknowledge the importance of knowledgeable and supportive network members who share their experiences and references to improve the experience of younger generations and peers. Participant 002 for example shared "...and their connections to healthcare are not just rooted in their own personal challenges and experiences, but they're rooted in true background in terms of their education, in terms of um even their own individual networks. So, I consider them trusted sources...". The ability to utilize these multiple inputs creates an effective layered approach to having informed discussions with providers who are general practitioners and with specialists. This approach increased the individual's ability to self-advocate and seek the best appropriate care for their health situation because they are not alone in the process. P17

stated “So, yes, when I make decisions, I'm like, okay, this is what I'm going to do. But before I tell myself, okay, this is my final decision, depending on the information I'm looking for. I know the people to reach out to.”

Umbrella Medical Advisory Status

Umbrella medical advisory is a phenomenon revealed during the interviews. This theme refers to the participants instilling significant trust in a healthcare provider (HCP) that the provider can overreach their area of specialty to provide advice. Participants elevate these HCPs to “umbrella medical advisory status.” This is actually the opposite level of trust attributed by participants to HCPs for which participants we felt mistreated or discriminated against. Participant 003 stated when referring to their new gynecological surgeon, “That previous surgeon of mine actually passed away. But he was renowned for training others in that robotic procedure, and she was trained by him. So that was pretty amazing.” Through this process, a special relationship with the provider is developed that preempts this status. The same attributes given to family and friends, such as reliability, perceived benefit, and received benefits, are attributed to this relationship. Participant 016 for example stated “...This list aside the ones that I have online.... The ones I have in person, like my therapist, my family, my friends, I really trust them a lot.... I trust them with the information that I give them... And I'm confident that whatever decisions they make, or whatever they choose to share with me, as well is what they believe to be best...”. Similarly, participant 002 stated, “Speaking of my endocrinologist, after so many years, the relationship that I have with her is very special because I trust her.” Participant 012 stated “...Yeah, then for the doctor.... She also tries to assist me in

mental health.... Well-being.... So sometimes she gives me resources, or maybe just links...” All but two participants reported having a special relationship that rose to this level.

Theoretical Framework Context

Use of this qualitative research method was consistent with seeking to understand the lived experiences of black women relative to their health seeking behavior and how disparities are addressed through the lens of their social support networks influence on health decision process. Schwarzer & Leppin (1989) established a social support theoretical framework demonstrating how protective factors are exhibited in these situations. Cohen (1988) further demonstrated factors of social support, and its constructs help people build resistance factors to stressful events, health consequences and pathogenic factors that can lead to disease. Applying this theoretical framework to this study allowed for an open dialogue between the researcher and participants lived experience in leveraging social support.

Limitations of the Study

The primary limitation of this study was related to the recruitment process moving quickly. As a result of interest in the study enrollment was closed within three days of opening. Three individuals were not included in the study due to challenges with scheduling and having reached saturation quickly. A significant volume of information was also collected from the sixteen participants and therefore not all coded segments of text and themes could be included in this paper for the purpose of being able to complete in a reasonable timeframe. Other limitations included the age of the participants, which

ranged from 22 years of age to 49 years. Experiences of women under 22 years of age and over 50 were not captured. Lastly, the population though covering 9 states represent a small sampling of regions across the United States. There was a lack of representation, for example from the Midwest and West Coast of the country. Additionally, given that I am a black women haven personally experienced some of the challenges participants voiced during the interviews it was challenging to remain emotionally neutral to the lived experience shared. Having shared the recruitment with my network, I was familiar with four of the participants. Though I was not familiar with their health journeys, which allowed me to remain unbiased in the interview process for these individuals.

Implications for Social Change

The findings from this research study highlight the critical role of social support networks in influencing health-seeking behavior among Black women in the United States. There are several implications for social change through modified public health programs.

The study reveals that social support networks, including family, friends, and community groups, play a crucial role in motivating Black women to prioritize their health and make informed decisions. By leveraging these networks, public health interventions can be designed to empower Black women, providing them with the tools and confidence to advocate for their health needs. This was exemplified through the participants' insights.

The persistent health disparities faced by Black women, driven by systemic racism and weathering, can be mitigated by strengthening social support systems. Public

health policies and programs that incorporate social support mechanisms can help reduce these disparities and promote equitable health outcomes by incorporating some of the new phenomena identified in this study including health triangulation which helps to ensure informed decisions are made by the individual and umbrella medical advisory status which occurs when trust has been achieved with a provider.

The study underscores the importance of trust and authentic communication within social support networks across primary (i.e., family) and secondary roles (i.e., friends). Public health initiatives that engage community leaders and trusted individuals can enhance the reach and impact of health interventions, fostering a supportive environment for behavior change. The concept of establishing a safety net through these roles for individuals could positively impact the longer-term implication of public health programs.

Understanding the specific types of social support that are most effective (emotional, informational, instrumental) allows for the creation of tailored interventions that address the unique needs of Black women seeking to improve their health. This approach can lead to more effective health behavior modifications and improved health outcomes. This was illustrated through being in charge of my health persona finding.

Conducting longitudinal mixed-method studies to assess the long-term impact of social support on health disparities can provide valuable insights for future interventions. Combining quantitative data from social support surveys with qualitative insights can offer a comprehensive understanding of the sustained effects of social support on health outcomes.

The insights from this research can inform public health policies and programs, advocating for the inclusion of social support mechanisms in health interventions. Policymakers can use this evidence to allocate resources and design programs that address the specific needs of Black women, ultimately leading to systemic change.

The findings of this study suggest that strengthening social support networks- including family, friends, community groups, and health care providers- may play a pivotal role in addressing persistent health disparities experienced by Black women in the United States. By fostering trust, authentic communication, tailored support within these networks, public health interventions can be designed to empower individuals and promote informed health decision-making. Incorporating social support mechanisms into public health policies and programs has the potential to reduce barriers, enhance engagement, and contribute to more equitable health outcomes. These insights provide a foundation for systemic change and the development of targeted strategies to improve the well-being of Black women.

Recommendations

To address the health disparities and systemic racism affecting Black women, I recommend focusing on designing public health interventions, empowering Black women, exploring additional factors, longitudinal studies, and addressing study limitations. The study recommends the development of public health interventions that facilitate formation of social support networks, incorporating educational components to share best practices and resources for engaging trusted individuals. It suggests investigating strategies to empower Black women in patient-provider interactions

including approaches to reduce engagement fears and foster self-advocacy, particularly for those with limited access to role models or social support. Further, the study proposes examining additional factors such as provider race and gender, the influence of technology, and expanding the age range of participants to capture generational differences. Longitudinal mixed-method research is advised to assess the sustained impact of social support on health disparities, while future studies should address limitations by increasing sample size, diversifying geographic representation, and broadening the assessment of social support measures.

Closing

Addressing the persistent health disparities faced by Black women in the United States due to systemic racism and weathering remains a significant concern in our society. These disparities are exacerbated by barriers such as a lack of trust in the healthcare system and ineffective social support networks that hinder individuals from navigating their care and health-seeking behavior. This research provides valuable insights into the perceived and received support through networks that have effectively helped the participants overcome hurdles to their care, despite the ongoing disparities. By sharing their lived experiences, the participants have highlighted the critical role of social support in mitigating these challenges.

Public health interventions to date have had limited success in achieving sustained health outcomes to address these disparities (Chin et al., 2021). However, the findings of this study have the potential to inform public health practices and policies that can lead to positive health outcomes and social change. By empowering Black women to

engage in proactive health-seeking behavior and utilize preventative health services, as well as their social support networks, we can work towards achieving more equitable health outcomes.

This study underscores the importance of developing targeted interventions that leverage the strengths of social support systems and address the systemic barriers faced by Black women. Future research should continue to explore these dynamics and identify effective strategies to promote health equity and improve the overall well-being of this population.

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Appendix A: IRB-Approved Interview Guide

The Influence of Social Support on Health-Seeking Behavior Qualitative Research Study Participant Interview Guide

Audio record obtaining verbal informed consent via zoom.

Thank you for participating in this study. My name is Patricia Saint Cyr-Hager, I am the Walden University doctoral student researcher conducting this study. Before getting started, let us review the informed consent. *Researchers review all the informed consent. Concludes consent review by asking the following two questions:*

Do you feel you understand the study? Do you agree to participate in this research study?

Background questions

I'm going to move to a few background questions.

Can you confirm your age?

What do you do for a living?

Describe other roles you have in your life (i.e. mother, wife, caregiver)?

Can you share your highest educational level such as (i.e. graduated high school, undergraduate school, graduate school, vocational school)?

Health mapping exercise

For this next part I'd like to obtain more information on relationships that inform your health decisions. Can you write on a sheet of paper or capture in a way comfortable to you the 10 most important relationships in your life that inform your health decisions? Please take 1-2 minutes to capture this information.

1. Now can you describe the 10 relationships in your life relative to your health decisions that you wrote down?
2. In your relationship with these individuals/groups can you describe which of you gives or receives more support and help?
3. Please describe how this dynamic works in your relationship with these individuals?
4. Can you explain why you identified these individuals or groups as part of your health decision making network/support system (i.e. are there consistent traits like knowledge, experience caregiving relationship)?
5. Can you please tell me about how this support system/network might differ from your support system unrelated to decisions about your health?

Received Support Questions

1. Can you describe how your network informs your health behavior?
2. Can you describe how this support system influences your health decision process?
3. What has been your experience getting advice regarding your health from your support system?
4. Can you describe how your support system helps you with searching for information regarding your health?
5. What has been your experience working with your support system to find a provider/healthcare professional?
6. What has been your experience dealing with illness and using your network to support your health decision process?
7. What has been your experience using your network to ensure you follow up on health concerns or with your doctor?
8. **Perceived supportiveness of network questions**
9. Who can you count on to console you when you are very sick (i.e. partner, relative, friend, close coworker, some other close person, no one)?
10. To what extent can you turn to this person for advice about health problems?
11. Can you describe how people in your life show appreciation for what you do to stay healthy?
12. Can you describe how available your network is to help you with your health?

Summary Question

Overall, can you share what aspects of your social support system are most rewarding when it relates to your health?

This concludes our interview questions. Thank you for your participation.

Appendix B: IRB-Approved Interview Questions

The Influence of Social Support on Health-Seeking Behavior Qualitative Research Study Participant Interview questions

Demographic information:

Confirm your Name?

Confirm your Age?

What do you do for a living?

Can you share your highest educational level? (i.e. graduated high school, undergraduate school, graduate school, vocational school)

Describe other roles you have in your life? (i.e. mother, wife, caregiver)

Reciprocal support mapping

Health behavior network mapping: after health- seeking is described to the participant.

1. Can you describe the 10 most important relationships in your life relative to your health?
2. In your relationship with these individuals/groups can you describe which of you gives or receives more support and help? Please describe how this dynamic works in your relationship with these individuals?
3. Respondents to write the initials of network members on three concentric circles, with themselves in the middle.
4. Can you explain why you identified these individuals or groups as part of your health decision making network? (is there a consistent traits like knowledge, experience caregiving relationship etc.). Can you please tell me about how this support system might differ from your support system unrelated to health behavior decision making?

Reciprocal support assessment for each relationship related to your health (reference)

1. I receive support and help more than I give.
2. I give support and help more than I receive.
3. I receive support and help as much as I give.

Health seeking behavior specific questions(V3) post Dr. Schwaab and Isma's comments.

Received Support category

1. Can you describe how your network informs your health behavior?
2. Can you describe how your support system influences your health decision process? What has been your experience getting advice regarding your health from your support system?
3. Can you describe how your support system helps you with searching for information regarding your health? What has been your experience working with your support system to find a provider/healthcare professional?
4. What has been your experience dealing with illness and using your network to support your health decision process? What has been your experience using your network to ensure you follow up on health concerns or with your doctor?

Perceived supportiveness of network members

5. Who can you count on to console you when you are very sick?" from five different sources (partner, relative, friend, close coworker, some other close person, no one).
6. To what extent can you turn to this person for advice about health problems?
7. Can you describe how people in your life show appreciation for what you do to stay healthy?
8. Can you describe how available your network is to help you with your health?

Summary Question

1. Overall, can you share what aspects of your social support system are most rewarding when it relates to your health?

"Can you name ..." might become "Please tell me about ..." or "What was your experience of ..."
 Also, you will need to be prepared with prompts, e.g., "tell me more" or "how was that for you?" or "what happened next?" or "please explain."

Appendix C: IRB-Approved Advertisement

Health Behavior Study

Tag Line: Recruiting Volunteers for Health Behavior Study

(stock images below from Microsoft word to be used interchangeably)



Option #1

Caption:

A new study on the experiences of black women and social support in health-seeking behavior aims to help public health professionals improve health programs for their communities. For this study, you are invited to describe your experiences utilizing your social support system in the health seeking process.

Option #2

Caption:

There is a new study about how social support affects health-seeking behavior among black women in the United States. This research aims to help public health professionals in improving health intervention programs for their communities. For this study, participants are invited to describe their experiences with health-seeking behavior and their networks.

About the study:

- One 60-90 minute virtual interview that will be audio recorded (no videorecording)
- One potential 20-30 minute follow up virtual interview to provide feedback on the researcher's interpretations
- You would receive a \$20 amazon gift card as a thank you
- To protect your privacy, the published study will not share any names or details that identify you

Volunteers must meet these requirements:

- 18 years old or older
- Be an adult black woman
- Currently living in the United States

This interview is part of the doctoral study for Patricia Saint Cyr-Hager, a student at Walden University. Interviews will take place during May and June 2025.

Please message Patricia Saint Cyr-Hager privately to let me know of your interest or email me at patricia.saintcyr-hager@waldenu.edu.

The informed consent can be reviewed using this [link](#). Your consent to participate will be audio recorded as part of the interview if you participate in this study.

You are welcome to forward it to others who might be interested.

Appendix D: IRB-Approved Informed Consent Form

CONSENT FORM

You are invited to take part in a research study about the influence of social support on health-seeking behavior from the perspective of black women in the United States. This audio recording is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study seeks 10-15 volunteers who are:

- Adult black women
- At least 18 years of age
- Living in the United States

This study is being conducted by a researcher named Patricia Saint Cyr-Hager, who is a public health doctoral research student at Walden University.

Study Purpose:

The purpose of this study is to understand the influence of social support on health behavior from the perspective of black women.

Procedures:

This study would involve you completing the following steps:

- Complete an interview lasting 60-90 minutes, which will be confidential, and audio recorded.
- Potentially speak with the researcher one more time after the interview to hear the researcher's interpretations and share your feedback. This may take 20-30 minutes.

All information collected will be made confidential.

Here are some sample questions:

- Can you describe how your network informs your health behavior?

- Can you describe how your support system influences your health decision process?
- What has been your experience getting advice regarding your health from your support system?
- Can you describe how your support system helps you with searching for information regarding your health?
- What has been your experience working with your support system to find a provider/healthcare professional?

Voluntary Nature of the Study:

Research should only be done with those who freely volunteer. So, everyone involved will respect your decision to join or not.

If you decide to join the study now, you can still change your mind later. You may stop at any time. Please note that not all volunteers will be contacted to take part.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of-minor discomforts that can be encountered in daily life such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your wellbeing. If distress arises, support and referral can be obtained via dialing 988 for a national crisis hotline.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by providing new insights to support public health intervention development for black women that can potentially improve their health outcomes. The results of this study will be automatically published online in [Scholar works](#) (a publication of Walden University doctoral research) which can be viewed free of charge. Additionally, a 1–2-page summary will be shared with participants by email.

Payment:

The researcher will email a \$20 Amazon gift card to each participant who meets inclusion requirements and completes the interview process.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidential, within the limits of the law. The researcher is only allowed to share your identity or contact information as needed with Walden University supervisors (who are also required to protect your privacy) or with authorities if court-ordered (very rare). The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers. So, this would not involve another round of obtaining informed consent. Data will be kept secure using password protection and the use of codes in place of names. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You can ask questions of the researcher by emailing Patricia Saint Cyr-Hager at patriciasaintcyr-hager@waldenu.edu. If you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant Advocate at 612-312-1210. Walden University's approval number for this study is IRB which 05-19-25-1046291. It expires on IRB May 18, 2026.

You might wish to retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by stating "I Consent" on the audio recording.