2017

Identifying Communication Barriers and Trust Issues of Black Women Seeking Preventive Health Services in Houston, Texas

Melissa E. Shelton
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Melissa Shelton

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. Saran Wilkins, Committee Chairperson, Public Health Faculty
Dr. Naa-Solo Tettey, Committee Member, Public Health Faculty
Dr. Raymond Thron, University Reviewer, Public Health Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2017

Abstract

Identifying Communication Barriers and Trust Issues of Black Women Seeking Preventive Health Services in Houston, Texas

by

Melissa E. Shelton

MPA, Troy University, 1997

BAS, Troy University, 1991

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

February 2017

Abstract

Black women mortality rates are perceived to be impacted by communication barriers, trust issues, and the lack of quality preventive health services. The purpose of this phenomenological study was to explore communication barriers and trust issues perceived by Black women when seeking preventive health services. HMB was used to identify public attitudes around receiving preventive health services and to construct each question based on perceived susceptibility and perceived severity of communication barriers and trust issues. An ecological model of the communication process was used as a framework to identify fundamental relationships between the Black female patients and health care providers. Data were collected using open-ended interview questions from Black women in public health and health care professions in southeast Texas (N=10). Results were coded and evaluated by thematic analysis. NVivo 10 software was used to store and manage data. Study findings showed 4 participants voiced their beliefs that their healthcare provider was somewhat apathetic when it came to addressing their health care needs, and 3 of the participants who visited a doctor's office within the last 12 months reportedly expressed having poor communication and trust issues with their health care provider. Emerged themes included lack of attentiveness from health care providers and lack of a comfortable atmosphere or bedside manner when receiving preventive health care services from their healthcare provider. This research has implications for social change if the health inequalities of Black women are identified and addressed, then Black women may have a reduction in health disparities when receiving preventive health services and an increase healthier outcomes.

Identifying Communication Barriers and Trust Issues of Black Women Seeking Preventive Health Services in Houston, Texas

by

Melissa E. Shelton

MPA, Troy University, 1997

BAS, Troy University, 1991

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

February 2017

Dedication

My strength to complete my dissertation came from my spiritual father who has guided me throughout this process. The dedication of this dissertation work is to my family and many friends. A special feeling of gratitude and inspiration to my late grandfather Paul L. Shelton whose words of wisdom, encouragement and drive have always pushed me forward. To my mother, Jean V. (Shelton) Baldwin, thank you for your moving words and prayers; I appreciate and love you. To my sisters, Dameta Baldwin and Erica Sheffield, I appreciate your kind words and listening ears. I also dedicate this dissertation to Edward Hand and special friends who have supported me throughout the process.

Acknowledgments

I would like to thank my dissertation committee: Dr. Saran Tucker (Chair), for your commitment, encouragement, and wisdom during this process. Thank you so much. To Dr. Naa-Solo Tettey (Committee Member), thank you for your support, guidance, and time. To Dr. Raymond W. Thron (University Research Reviewer), thank you for your guidance and assistance during this dissertation process.

Special thanks to the one-on-one interviews participants who trusted me enough to share their experiences with me. I value you, your contributions and your shared experiences with this study.

You are all the best!

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

According to the Agency for Healthcare Research and Quality study (AHRQ), even though the population of the United States should have equal access to high-quality health care, racial and ethnic minorities' still experience barriers to health care and receive an inadequate quality of care from some health care providers (2013). Black women, for instance, continue to experience the higher rates of cancer compared with White women due to the lack of health care coverage, lack of early detection and unequal access to treatment (AHRQ, 2013). An American Cancer Society study indicated that the mortality rate of breast cancer among White women was 22 per 100,000 compared with 33.5 per 100,000 among Black women (2013). These statistics reflected health disparities among Black women, for example, the lack of access to health care in general and lack of mammography in specific (Akinyemiju, Soliman, Yassine, Banerjee, Schwartz, & Merajver, 2012). This study has implications for social change if the health inequalities of Black women are identified and address, then Black women may have a reduction in health disparities when receiving preventive health services and an increase healthier outcomes.

The Centers for Disease Control and Prevention (2014) noted that heart disease is the leading cause of death for 7.6% of Black women compared with 5.8% of White women in the United States. According to USDHHS, the HIV diagnosis rates among women were 1 in 4 new cases, and the newly infected women, an estimated 2 in 3 were Black women (2012). There are 1 in 4 Black women who live in poverty, have limited access to preventive services and health care, or lack of health insurance may receive

lower-quality health care in general (Asch et al., 2006). The Black women diagnosed with HIV who lack trust in the health care system, communication barriers, and generations of racism which can mean advancing from HIV infection to AIDS more quickly (USDHHS, 2012).

Social justice is imperative for Black women because it will enable them to receive the same quality of health care services as White women and other non-Blacks.

I designed this study to help explore communication barriers and trust issues perceived by Black women—10 Black female public health and health care professionals—who sought preventive health services in Houston, Texas. The health belief model (HBM) helped guide this phenomenological study in which participants' participated in a one-on-one, open-ended interview (Creswell, 2007).

In this chapter, the following topics were covered such as the research problem, the research design, the research questions, and a framework to help identify the communication barriers and trust issues perceived by Black women.

Background

According to the AHRQ study published in 2013, two factors impeded Black women from seeking preventive health services: perceived racial discrimination and lack of quality health care received from their doctor. According to the AHRQ study published in 2011, 12.1% of Black women stated that their health care provider sometimes listened carefully, may explained things thoroughly or may respect what they had to say. According to Asch et al, 2006, Black women who have limited means such as income or health insurance were less likely to seek or receive preventive health services.

Henceforth, the disparities mentioned above may contribute to the communication barriers and trust issues of Black women seeking preventive health services.

The mortality rates of Black women are an important aspect of exploring communication barriers and trust issues. The three highest mortality diseases for Black women in comparison to White women were heart disease, cancer, and stroke (The CDC, 2012). As reported in 2005, Black women between the age 45 and 64 were diagnosed with hypertension at twice the rate of White women in the same age range (Price, 2005).

There were indicators such as communication barriers and trust issues perceived by Black women that coincide with the historical events of mistreatment by the medical profession (Jacobs, Rolle, Ferrans, Whitaker, & Warnecke, 2006). AHRQ (2013) findings indicated that Black women patients perceived having problems with receiving health care as soon as it was needed. Jacobs et al (2006) noted that trust between a patient and a health care provider is an important factor when healthcare a decision is made.

Therefore, the significance of this research project was the ability to identify specific communication barriers and trust issues, as perceived by Black women, when seeking preventive health care services in Houston, Texas. This study may help empower Black women in addressing perceived communication barriers and trust issues with their health care providers.

Problem Statement

According to AHRQ, equal access to quality health care should be available to the population in the United States; racial and ethnic minorities still experience barriers to health care and receive an inferior quality of care (2013). AHRQ (2011) reported that

17.8% Black women who visited a doctor's office within the last 12 months reported perceived poor communication with their health care provider in comparison to 14% of White women visiting their doctor's office. Black women are less likely than are White women to have received many needed services, to include preventive health services (Musa, Schulz, Harris, Silverman, & Thomas, 2009).

Communication barriers and trust issues perceived by Black women were impacted by health disparities (AHRQ, 2011). The first indicator of a communication barrier was when Black women perceived that the health information presented by a health care provider was not easily understood (Banerjee & Sanyal, 2012). For example, a health care provider used innovative medicine to test and diagnosis a Black female patient; both of them sensed communication barriers (Banerjee & Sanyal, 2012). A second indicator is the distrust of health care providers perceived by Black women due to the mistreatment of African Americans in the Tuskegee syphilis experiment (Jacobs et al., 2006). The literature review revealed the lack of scholarly research on Black women's perception of communication barriers and trust issues when seeking preventive health services in specific regions.

Purpose of the Study

The purpose of the study was to identify communication barriers and trust issues perceived by Black women when seeking preventive health services in Houston, Texas. The qualitative guided research questions were designed to explore Black women's perceptions of communication barriers and trust issues when seeking preventive health care services in Houston, Texas.

Guided Research Questions

A researchable question entails doubt about a problem that can be explored, explained, and tested to deliver information (Thabane, Thomas, Ye, & Paul, 2009). The problem needs to have significance and interest and it must be researchable (Burns & Grove 2009; Thabane et al., 2009). The three research questions for this project met those criteria:

Research Question 1: What communication barriers do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 2: What trust issues do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 3: What approaches are identified by Black women to help enhance communication and trust relationships with health care providers?

Conceptual Framework

This phenomenology study drew on the HBM and an ecological model of the communication process as a conceptual framework. To explore communication barriers and trust issues perceived by Black women when seeking preventive health services, the HBM constructs were used: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy (Siegel & Lotenberg, 2007). The HBM was used as a guide to develop the guided research questions. The construct of each question was based on perceived susceptibility and perceived severity of communication barriers and trust issues (Siegel & Lotenberg, 2007).

Another theory for this concept was social cognitive theory (SCT) which emphasized social influence and its external and internal social reinforcement (Boston University, 2013). This theory demonstrated how an individuals' behavior while taking into consideration of the social environment in which the behavior was performed (Boston University, 2013). The theory takes into account a person's past experiences, which influences how a person engaged in a type of behavior (Boston University, 2013).

The ecological model of the communication process is based on how the patient and health care provider communicate and trust each other (Foulger, 2004). Foulger (2004) noted that the right side of his model served as the framework for the consumer/patient constructs as it pertained to one-on-one interviews with participants. The one-on-one interview questions focused on how Black women perceived communication barriers and trust issues when seeking preventive health services (Foulger, 2004).

A phenomenological investigation was used to answer the guided research questions. Bloomberg & Volpe (2010) noted that phenomenological research focused on what the participants have in common when one-on-one interviews are conducted with the participants. There were similar comments made by the participants, I used the transcripts to identify those common comments, categorized and coded them as emerging themes which helped guided the analysis of the qualitative data. The data analysis was based on the summarizations and consistency of the information transcribed from the one-on-one interviews (Creswell, 2007).

Nature of the Study

Communication barriers and trust issues perceived by Black women seeking preventive health services were identified during the qualitative study through one-on one interviews.ng the research questions. Participants' were allowed to openly express her thoughts that were captured and analyzed through dialogue facilitated by guided research questions (Creswell, 2007). The participants were identified and recruited through a professional organization or by social media. The participants consisted of individuals received preventative health services within the past 12 months and who currently or previously worked in public health or a health care environment.

Henceforth, the study consisted of one-on-one interviews with Black women, from Houston, Texas, for at least 1 ½ hours in a recorded dialogue about perceived communication barriers and trust issues with health care providers (Rudestam & Newton, 2015).

Definitions of Terms

Communications barriers: These are barriers that include language or sociocultural relationships which impedes meaningful interpretation and transmission of ideas between individuals or groups (Reference MD, 2014)

Health Belief Model: HBM consisted of the constructs perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy will be used as the theoretical base for the research study (Siegel & Lotenberg, 2007).

Health care: The services that are provided in a variety of settings to include public and private clinics, hospitals, and other health care facilities. These services are delivered by a range of health care professionals (Smedley, Stith, & Nelson, 2003).

Health care services: The services consist of preventive, diagnostic, or therapeutic medical or health services to individuals (Smedley, Stith, & Nelson, 2003).

Health care provider: This is an individual, institution, or agency that provides health services to health care consumers or patients (Medical Dictionary, 2015).

Mortality Rate: The portion of the frequent occurrence of deaths in a defined population during a specific time (CDC, 2012).

Phenomenology: This event describes what subjects have in common which allows for the identification of person's core experience or phenomena (Bloomberg, & Volpe (2010).

Patient Centeredness: This is consists of compassion, empathy, and responsiveness to the patient's needs and values (Agency for Health Care Research and Quality, 2011).

Social Cognitive Theory: This theory demonstrated show individuals attain and sustain behavior while taking into consideration the social environment where the behavior is performed (Boston University, 2013).

Assumptions

Communication barriers and trust issues perceived by Black women seeking preventive health services may be impacted by bias and prejudice of health care providers when they received less health services in comparison to White women receiving health

services (Musa, Schulz, Harris, Silverman & Thomas, 2009). In this study, I assumed that the participants expressed openly what they experienced when it came to the topics of communication barriers and trust issues with their health care provider sir health care provider.

Scope and Delimitations

This section discussed the design of an interview guide that was used to conduct one-on-one interviews with Black women who had preventative health services within the last 12 months. The aim was to create a commonality among the participants by identifying communication barriers and trust issues. These Black women currently work or previously worked in the public health or health care field.

Limitations

The limitations of this study were finding Black women who currently worked in public health or healthcare and had preventive healthcare services in Houston, Texas, that related to their lived experience of the phenomena. The study bias could have been influence by the participants sharing their experience among any potential participants. The potential biases were addressed by the participants signing a confidentiality statement prior to the one-on-one interviews (Polit & Beck, 2008). Although generalizability is imperative in quantitative studies, in this qualitative study I did not seek to make the findings transferability to all Black women in Houston, Texas. (Polit & Beck, 2008).

Significance

According to Morbidity and Mortality Weekly Report (2011), one of the indicators of health equity in the United States is infant mortality because it is associated with maternal health, quality care, and access to medical care. For example, in 2011, the infant mortality rate for Black women was 13.35 per 1,000 live births compared with 2.4 per 1,000 live births for White women. The increased mortality rates appeared to coincide with communication barriers and distrust of the medical community as perceived by these Black women. The significance of this research project was the ability to explore communication barriers and trust issues perceived by Black women seeking preventive health care services. It could add to the value of Black women's health through improvement.

This study results may facilitate social change and social justice by providing a pathway to help identify and address health inequality of Black women.

Summary and Transition

In Chapter 1, I presented the importance of the study, the background of the issue of health disparities, communication barriers and trust issues perceive by Black women seeking preventive health services in Houston, Texas.

In Chapter 2, I discussed the literature on communication barriers and trust issues perceived by Black women when seeking preventive health services.

In Chapter 3, I described the research design and the methodology.

In Chapter 4, I described and discussed the results of the research.

In Chapter 5, I discussed the conclusions and recommendations form the qualitative study.

Chapter 2: Literature Review

Purpose

The purpose of this study was to identify communication barriers and trust issues as perceived by Black women seeking preventive health services in Houston, Texas. The literature review supports for the need for this project. The HBM and an ecological model of the communication process guided the research. A geographic and demographic description of Houston, Texas, is included.

Review Procedure

. The research questions guided the literature review, which yielded both qualitative and quantitative studies over a period of 47 years, from 1967 to 2014. Due to limited literature review, the comprehensive research was not limited to quantitative or qualitative studies. The following databases were used: PubMed, Google Scholar, and Academic Search Complete/Premier. Additional research sources are University of Texas School of Public Health which has conducted population based research throughout Texas, in particular Houston. The following keywords were used: *patient communication barriers, patient trust issues, health inequity, Health Belief Model, discrimination and health care, Black/African American Women health care beliefs, preventive health services, patient and provider relationship, phenomenology, and cultural sensitivity.* I reviewed the citations at the end of each article for additional relevant literature. The inclusion criteria consist of research showing a scholarly approach in conferring the cultural aspects of what exactly is bias and how it relates to Black women seeking preventive health care services.

Editorials, newspaper and magazine articles, and informal reports were excluded.

The keyword searches resulted in 227 hits from PubMed, 238 hits from Academic Search Complete/Premier, and 153 hits from ProQuest. The literature review was screened based on the abstracts. The findings were organized into the following categories: (a) Black women and mortality rates, (b) Health disparities, (c) Black women beliefs and culture, (d) quality of health care, (e) communication barriers, (f) patient and provider trust issues, (g) HBM and (h) phenomenology.

Literature Review

The literature review was conducted to identify perceived communication barriers and trust issues of Black women seeking preventive health services.

Black Women and Mortality Rates

Black women are perceived to put their preventive health service needs aside to make sure their spouse, children or parents are taken care of first. Even when Black women do seek preventive health services, there continued to be alarming inequalities of health outcomes among them (AHRQ, 2013). Black women have higher rates of breast cancer mortality compared to white women, due to later diagnosis (Sadler et al., 2007). The American Cancer Society (2013) study indicated that the mortality rate of breast cancer was 22 per 100,000 among White women compared with 33.5 per 100,000 among Black women. The three highest mortality rates for Black women compared to White women were cancer, heart disease, and stroke (The CDC, 2012).

Health Disparities

University of Texas School of Public Health (2011) conducted The Health of Houston Survey (HHS)-2010 with 5000 participants. The survey indicated that 24% of Black residents in comparison to 15% of White residents were in fair or poor health. Black women, between ages 45 and 64, were diagnosed with hypertension, twice the rate for White women within the same age range (Price, 2005). The cause for health disparities in health care services was complex. Black women are less likely than are White women to have received many needed services, to include preventive health services (Musa, Schulz, Harris, Silverman, & Thomas, 2009). The perception of racism persisted in the United States. The beliefs and attitudes that were not deliberately racist resulted in racist behavior or outcomes that may not be racist (Shavers & Shavers, 2006). The socioeconomic differences and lack of access to health care are perceived to be evident to racial bias when it pertains to the receipt of preventive services for Black women (Musa et al., 2009). The significant disparities in health care had implications for health professionals, administrators and policymakers, and healthcare consumers of all backgrounds.

Black Women Beliefs and Culture

AHRQ (2013) findings indicated that Black women patients perceived having problems with receiving health care as soon as it was needed. Sadler et al. (2007) found that Black women were perceived to have a strong desire to make decisions for their health care needs.

Quality of Health Care

Even though the United States population should have equal access to high-quality care, racial and ethnic minorities still experience more barriers to health care and receive an inferior quality of care when they can get it (AHRQ, 2013). Black women, for instance, continue to experience the highest rates of cancer compared to White due to the lack of health care coverage, of early detection and unequal access to cancer treatment (AHRQ, 2013).

Communication Barriers

The communication barriers perceived between a patient and provider was common (AHRQ, 2011). The Agency for Health Care Research and Quality (2011) stated that 17.8% Black women visited a doctor's office within the last 12 months reported perceived poor communication with their health care provider in comparison to 14% of White women visiting their doctor's office. Banerjee and Sanyal (2012) indicated that a communication issue was seen to be persistent when a provider and patient have similar cultural backgrounds, but health information was perceived not to be related to a patient who can fully comprehend the information. Patients complained of the perceive communication breakdown between them and their health care provider (AHRQ, 2013).

Health care providers were seen to have different listening skills and viewpoints that may impact the treatment of a patient (AHRQ, 2011). There are other factors that are perceived to influence patient centeredness and communication with the health care provider (AHRQ, 2011). Some of the factors were perceived to be the cultural competency of providers, racial/ethnic situations between the patient and doctor, and

language barriers (AHRQ, 2011). In addition, Cuevas, O'Brien, & Saha (2016) findings indicated that Black women voiced they did not trust their health care provider because of the lack of support especially since patients were seen as consumers rather than a patient.

Patient and Provider Trust Issues

A patient expected a health care provider to act in their best interest (Wiltshire, Person, & Allison, 2011). The perception continued to be a long shadow between Black women and the medical community. Wiltshire et al. (2011) discussed how Black women were perceived to be less trusting of doctors than White women due to past experiences of inequity and abuse with the health care system. Black women had higher rates of premature health care services that were disproportionate with the health outcomes in comparison to White women (Wiltshire et al., 2011). Kreps (2006) study demonstrated how there were alarming health inequalities among Black women with elevated morbidity and mortality rates in comparison to White women.

The literature showed how communication and trust was important to how health care is provided to Black women (Krep, 2006). Cuevas, O'Brien, & Saha (2016) findings indicated mistrust is sometimes based on personal past experiences.

Phenomenology

Creswell (2007) described phenomenology as being a type of study that focused on the essence of an experience and then described the nature of the phenomenon (Creswell, 2007, p. 62). This study will allow participants to describe their perceived communication barriers and trust issues with their health care providers.

According to Rudestam and Newton (2015), the phenomenology researcher's role was to identify and investigate the meaning of a select few individuals who described their experiences in a language that was close to their lived experience (). Researchers typically use qualitative interviews as a source of their data. The information was analyzed based on specific themes or statements obtained from the open-ended questions used during the research project (Bloomberg & Volpe, 2010). A researcher must be able to listen, observe and form an empathic alliance with the participant (Rudestam & Newton, 2015).

Health Belief Model

The HBM was the theory for this qualitative research to explore Black women perceptions of communication barriers and trust issues when seeking preventive health services. The HBM identified public attitudes and actions around health issues (Changing Minds, 2015). The HBM model used by Duran (2011) will develop one-on-one interview questions. The model consisted of four main sections, such as perceived sensitivity, perceived seriousness, perceived benefits, and perceived barriers for qualitative research (Duran, 2011).

Social Cognitive Theory

Social cognitive theory (SCT) was formerly called the Social learning theory (SLT) founded by Albert Bandura (Pajares, 2002). The SCT focus emphasized social influence and its external and internal social reinforcement (Pajares, 2002). This theory demonstrated how individuals attained and sustained behavior while taking into consideration the social environment where the behavior was performed (Pajares,

2002).). The theory takes into account a person's past experiences, which influenced reinforcements, expectations, and expectancies when a person engaged in a type of behavior (Pajares, 2002).

Framework: An Ecological Model of Communication Process

The fundamentals and framework of an ecological model of the communication process consisted of a series of fundamental relationships between the patient and provider, messages, language, and media. The right side of the model was used as a framework for the consumer/patient constructs as it pertained to one-on-one messages (Foulger, 2004).

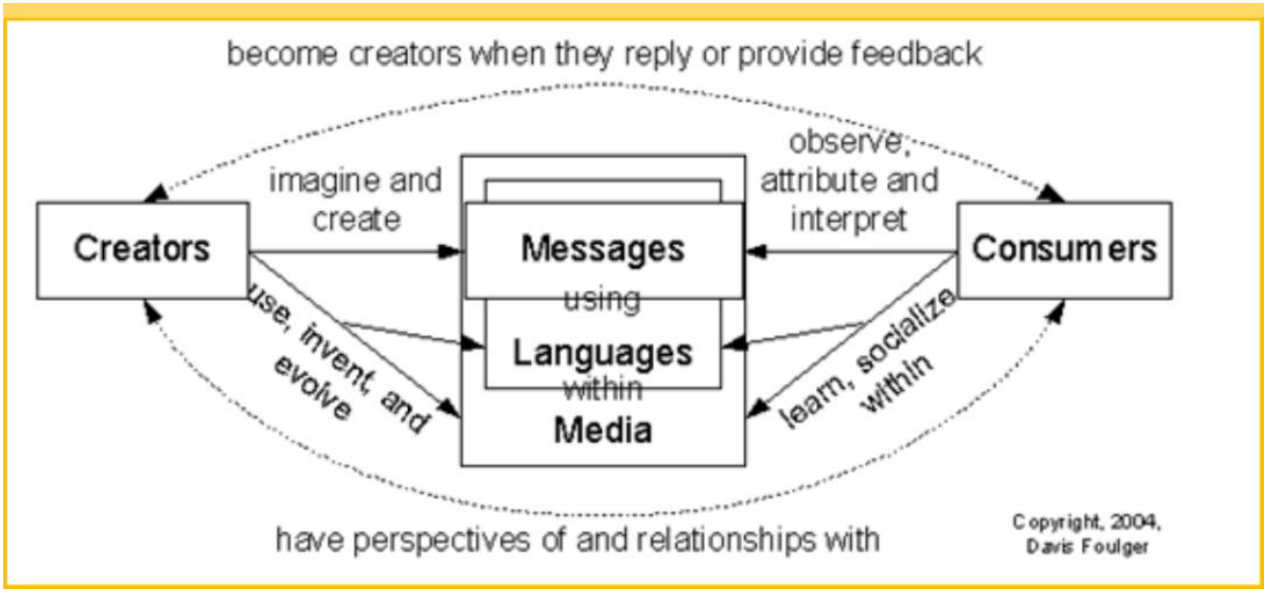

Figure 1. "An Ecological Model of the Communication Process in 2004," by D. Foulger, 2004. Retrieved from http://davis.foulger.info/research/unifiedModelOfCommunication.htm. Adapted with permission of the author.

Literature Strengths

After reviewing the literature, it provided a base for noteworthy differences when Black women were seeking preventive health services in comparison to White women seeking preventive health services. Several gaps were identified that need to be addressed when comprehending perceived communication barriers, trust issues and health disparities among Black women seeking preventive health services.

Summary and Transition

In Chapter 2, I discussed the literature on communication barriers and trust issues perceived by Black women when seeking preventive health services.

In Chapter 3, I presented the research design, research questions, theories and the framework that was crucial for this study. In addition, I described the participants, the recruitment process, and the data analysis process.

Chapter 3: Research Method

The purpose of this study was to explore the communication barriers and trust issues perceived by Black women when seeking preventive health services in Houston, Texas. The rationale and description for the data collection methods are provided. In this chapter, I described (a) research approach, (b) research design and methodology, (c) data collection, and (d) analysis. I concluded this chapter with procedures to protect the ethics and human subjects.

Research Design/Methods

My intent was to identify and a select few individuals and investigate the meaning of their life experiences—an interpretative process (Groenewald, 2004). Three qualitative research methods were considered for this study. Ethnography means a strategic inquiry of an intact cultural group in its natural environment for a lengthy time period to collect observational and interview data (Creswell, 2009). Ethnography was excluded as a methodology for this study because the guided questions focused on individual experiences rather than those of a cultural group.

A case study allows a researcher to deeply explore an event or process of one or more individuals restricted by time and activity (Creswell, 2009). The case study was excluded as a methodology for this study because it was not aligned with the guided research questions.

Phenomenological research, allows a researcher to collect data to understand a participant's perception (Creswell, 2009; Charmaz, 2006).This type of research integrates context and participants' voices, which served well for obtaining data (Creswell, 2009).

This study used the HBM and the framework of the ecological communication process to construct the semistructured questions for use in the one-on-one interviews.

This phenomenological study consisted of 10 one-on-one interviews composed of semi-structured, open-ended questions. The questions explored themes, new concepts, and the commonalities and differences between the segments for the period of 1 ½ hours (Creswell, 2007). Charmaz (2006) noted that a sample size of 10 was appropriate to the goals of the research project. The criterion sample consisted of participants who matched the criteria of the study. The individuals selected did not hesitate about sharing their ideas (Creswell, 2007).

I analyzed the data to identify themes from the one-on-one interviews (Bloomberg & Volpe, 2010). The guiding research questions were:

Research Question 1: What communication barriers do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 2: What trust issues do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 3: What approaches are identified by Black women to help enhance communication and trust relationships with health care providers?

The qualitative phenomenological design served as a preliminary research study to help explore the communication barriers and trust issues perceived by Black women when seeking preventive health services in Houston, Texas.

A narrative inquiry served best for a study of one or two participants' life stories through a series of chronological experiences (Creswell, 2007). Philosophic assumptions will not guide the research design. This design allowed a researcher to hear how Black women think and feel about their perception of communication barriers and trust issues. I maintained the flexibility and practicality to obtained responses to the exploratory questions that may be helpful with making recommendations.

Description of Houston and its Population Characteristics

The geographic area for this research project was Houston, Texas, which lies in three counties. The three counties are Harris, Fort Bend, and Montgomery. The location of Houston was the upper Gulf coastal plain, 50 miles from the Gulf of Mexico, and this region is 8,778.34 sq. mi. (Texas Best, 2011). The population was a pertinent demographic variable that's influenced by the area. According to the U.S. Census Bureau (2013), from 2010 to 2013, the population of Houston, Texas, grew from 2,099,451 to 2,195,914, a 9.5% increase. The percentage of Blacks in this region is 23.7%. (U.S. Census Bureau, 2013).

Education and Income

One of the perceived contributions to communication barriers and trust issues of Black women may be the level of education attained by adults over the age of 25. High school graduates are 74.8% in Houston compared to 80.8% in Texas (U.S. Census Bureau, 2013). Only 28.7% of the population living in Houston has a bachelor's degree compared to 26.3% in Texas (U.S. Census Bureau, 2013).

Houston known for its oil and energy industries and it still has a high poverty of 22.2% in comparison to Texas 17.4% (U.S. Census Bureau, 2013). The average income of $44,648 is an estimated 8% lower than Texas income average of $51,563 (U.S. Census Bureau, 2013).

Target Population and Sampling

The target population was Black women, between 25 years of age and 64 years, living in Houston, Texas, who work or have worked in public health or the healthcare field. The educational level was minimum high school. These Black women received preventive health services within the past 12 months. The definition of the adult population was between the ages of 20 and 64. The geriatric population defined as 65 years of age (Feldman, 2003). The Black women who currently work or have worked in the health field may perceive that communication barriers and trust issues exist when seeking prevention health services in Houston, Texas.

The samples size for the study was 10 one-on-one interviews. The sample size was appropriate to meet the goals of the research design (Charmaz, 2006). I used a sample size of 10 participants. I emailed a recruitment invitation flyer electronically to public health and health care organizations to distribute. The recruitment flyer listed the eligibility criteria requesting for Black females who worked or previously worked in the public health and health care field. The organizations were asked to either forward the email or post the flyer onto their bulletin. The flyer was also posted to Facebook.

Krueger and Casey (2000) discussed how it was important for a researcher to make sure that the participants were comfortable in sharing ideas. I analyzed the

information based on identified themes, statements or quotes obtained from the one-on-one interviews. I identified a full array of perceptions from the participants who provided input posed for the research. The qualitative study used identified participants who have experienced the phenomenon for further exploration (Rudestam, & Newton, 2015).

The literature gap existed in identifying the perception of communication barriers and trust issues of Black women, who work or previously work in public health or health care setting, seeking preventive health care services in Houston, Texas.

Theory and Framework

The construct of the qualitative phenomenological research study consisted of the HBM and the framework of an ecological model of the communication process. The HBM was used to explore Black women perceptions of communication barriers and trust issues when seeking preventive health services. The HBM identified public attitudes and actions around health issues (Changing Minds, 2015). The HBM assisted with developing qualitative interview questions. The developed questions consisted of HBM main constructs, such as perceived sensitivity, perceived seriousness, perceived benefits, and perceived barriers to qualitative research (Duran, 2011). The framework of an ecological model of the communication process included perceived fundamental relationships between the patient and provider, messages, language, and media (Foulger, 2004). This ecological model consisted of both the creators on the left and consumers (patients) on the right (Foulger, D., 2004). The right side of the model was used as a framework for the consumer (patient) constructs as it pertains to one-on-one messages (Foulger, 2004). The consumers (patients) of messages and the effects had different types of relationships with

the creators (health care providers) (Foulger, 2004). Some of the examples were the kind of communication style, self-concept, linguistic resources, verbal and nonverbal behavior that occur when seeking preventive health services (Thompson, Dorsey, Miller, & Parrott, 2003).

Population Approach

The recruitment of potential participants was a homogeneous sampling of Black women living in the Houston, Texas, area. The ages of the target population were 25 to 64 (Smith, Flowers & Larkin, 2009). These Black women currently work or have worked in the public health or health care field. There was limited literature research on the perceptions of communication barriers and trust issues of these women seeking preventive health services. The recruitment for participants to conduct the one-on-one interviews took place by emailing the recruitment flyer to local public health departments, local hospitals and clinics and professional associations such as the African American Health Coalition, Health Educators Network by requesting them to post and/or email the flyers out to the group. The announcement was available via Facebook or peer referrals.

Upon approval from Walden Internal Review Board (IRB) (04-20-16-0178165), I emailed the recruitment flyer with an invitation message to the organizations (Appendix B and Appendix C). The participants were not recruited by one particular organization and the one-on-one interviews were not conducted on the organization's premises or during an individual's work time. It was not deemed necessary to obtain IRB approval from any particular organizations (Creswell, 2007). The invitation will allow interested

potential participants an opportunity to contact the researcher via email or by phone of their interest to participate. Each participant was screened based on the eligibility criteria to participate such as having experienced the phenomenon and willingness to take part in an extended interview. The recruited individuals volunteered on their own personal time to complete the one-on-one interviews.

The eligible participants were informed that the one-on-one interviews are voluntary. An informed consent form was used for participants to complete, prior to the initiation of the study. I provided an overview of the study, how long it will take to complete the interview, and the next steps for using the results from the interview (Creswell, 2007). A follow-up with the participants took place by providing them with a copy of their transcript to review and validate. The information validated by the interviewee was accurate.

A participant may withdraw her participation from the study without any harm. There was an incentive of a $15.00 gift card provided upon completion of the one-on-one interview study. The demographics or identified information was not recorded electronically to maintain the anonymity of the participants. A demographic survey was completed and a logged book used to track the participants. The women in this study made up a determined sample that offered rich information about perceived communication barriers and trust issues when seeking preventive health services in Houston, Texas. By accumulating information from this sample, provided sufficient information to answer the research questions of this study.

Inclusion Criteria for consideration

- Black women in Houston, Texas
- Obtained preventive health services within 12 months
- 25 years of age to 64 years of age
- Minimum high school education
- English speaking
- Willingness to take part in a 90-minute interview
- Work or have worked in public health or healthcare field (There is limited literature on these Black women perception of communication barriers and trust issues when seeking preventive health services)

Exclusion Criteria

- Non-Black women in Houston, Texas
- Younger than 25 years of age or older than 64 years of age
- Non-English speaking
- Lack of willingness to participate in a 90-minute interview
- Do not work or have not worked in public health or healthcare field

Role of the Researcher in Data Collection

I explored the perceptions of the Black women about communication barriers and trust issues when seeking preventive health services by using an unbiased approach to the data collection process. Since 2000, I served in various roles serving as a health educator, health communications coordinator, and a military medical service corp officer in the fields of public health, health care, and military health field. I had the capability as a he

researcher to be able to access potential participants through their peers and prior professional relationships. For example, a potential participant may have heard about the study through a peer, an email or an announcement obtained through a social media platform. For example, the researcher previously served on the Texas Society for Public Health Education (TSOPHE) board or worked for a local health department whereas I still maintain a professional relationship with peers. The researcher will develop the interview guide to be in parallel with the research questions. The guide will have the research questions designed to provoke reflective discussions that will not allow the interviewees to answer in yes or no terms (Bryman, 2012). It was imperative that the researcher contacted the participant during the selection process to enhance the foundation of building a good interviewing relationship (Seidman, 2013).

Instrumentation and Materials

An interview guide will be developed to consist of the research's purpose, interview format, consent form, and 8 – 10 semi-structured questions. The interview guide will aid in exploring the communication barriers and trust issues perceived by Black women seeking preventive health services in Houston, Texas. The participants will be invited to participate in the study. The interview guide will explain to the participants that this is a voluntary research study. The participants are allowed to remove themselves from the study at any time. The signed consent forms and interview data collected is to be retained for 3 years.

All participants received the same open-ended questions that allowed for responses. A digital audio recorder was used to record the information from the

participants during the interviews. The software NVivo10 was used to assist in analyzing the coded data (Merriam, 2009; Strauss & Corbin, 1990). This software allowed for the qualitative data to be stored. The researcher will have the capability to compare her coding with NVIVO 10 coding in order to reach defensible conclusions and recommendations.

Qualitative Questions

An existing qualitative phenomenological research questions tool to conduct one-on-one interviews on the perception of communication barriers and trust issues among Black women was not available. The open-ended qualitative questions were developed based on the literature review, the HBM, and the framework of the ecological communication process. The development of the 8 – 10 semi-structured questions for the interview guide will relate to the participants' perceptions of communication barriers and trust issues when seeking preventive health services in Houston, Texas.

The interview guide was 3 pages long that allows for enough space between the questions for placement of the interviewee's responses (Creswell, 2007). I explored the interviewees' answers to provide a report based on themes that will demonstrate the researcher ability to collect and analyze data. The responses assist determining the best approach to enhance the perceive communication barriers and trust issues among Black women in Houston, Texas.

The interview guide consisted of separate topic areas such as general perception of health care providers; general perception of health care services; general perception of communication barriers and trust issues (Appendix E). For example, a question may be

asked, Have you ever participated in health care research? (Probes: family members, children, and personal experience) (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999). The interview guide was designed to allow for a smooth flow from question to question. The interview questions and the procedure were refined through a pilot test (Creswell, 2007). The pilot test will help determine if the interview questions are arranged appropriately for the study (Seidman, 2013).

Informed Consent Form and Confidentiality

The informed consent form discussed the participants' rights, the potential benefits, the participants' identity were confidential, and the researcher's contact information (Seidman, 2013). The participants were notified via email or by phone to confirm their assigned date. The participants were informed that the records will be kept and secured for the maximum time of three years after the research has been completed. The information collected will be shredded and destroyed. The participants' identity will be confidential and not linked to the data collected.

Determining Location to Conduct the Interviews

I became familiar with the interviewing settings. The designated places that the interviews were conducted were the Houston Community College or a public library meeting rooms that are quiet locations free from distractions. The meeting rooms were available at no cost to the researcher. The invited interviewers will go to a convenient location near them. The equipment and supplies consisted of an interview guide, a consent form, a digital audio – recorder, extra batteries, a microphone, 2 large note tablets, 5 pens, 2 highlighters, post-it sticky notes, and water.

Collecting, Managing, and Analyzing Data

Moustakas (1994) outlined the data collection process as part of a systematic process that includes (a) developing questions to direct the interview process (p. 103) and (b) conducting and recording an extensive one-on one interview on specific topics and questions (p. 104). I was interested in the information provided by the participants (Bryman, 2012). I recorded the interviews with a digital audio-recording device. The device has the capability to play, pause, record, stop, back up and transfer to be transcribed. I used two digital audio recorders in the event one goes out while interviewing the participants and to validate the information.

I chose this type of data collection method to be able to draw on the respondents' attitudes, beliefs, and experiences. I reviewed the other qualitative methods which were not feasible, such as observations, or a quantitative method such as a questionnaire survey (Rabiee, 2004). The superior sound of a digital audio recorder versus a cassette recorder allowed for the transcribing process to be simpler for analysis (Corbie-Smith et al., 1999). I kept the audio recorder device on as long as possible so that I was able to capture the participants' afterthoughts (Bryman, 2012). I stored the confidential digital files in two locations such as a file folder on a desktop personal computer with a secure login and a backup drive that's password protected (Bryman, 2012).

I took notes during each session to record verbal and nonverbal cues (Corbie-Smith et al., 1999). The notetaking consisted of handwritten notes describing the key points made by the participants, observations and reflections on what happened during the study. I used the notes to record any apparent bias that I noticed and any emotional

situations that appeared during the study. The notes were labeled with the date and location which I transferred onto my computer as part of the study data. I maintained the written notes in a locked file cabinet solely designated for this research.

Managing the Data

I tracked the data provided by the participants by digitally labeling the audio files with a date and time stamp throughout the entire process (Seidman, 2013). The raw data and analyze data separate is stored separately. I completed all of the one-on-one interviews prior conducting an in-depth analysis of the data. I needed to make sure that the other interviews will not be comprised on the data (Seidman, 2013).

After each one-on-one interview, I dated and time stamped each recording, listened to and transcribed the recordings verbatim. The process took from 4 to 6 hours to transcribe 90 minutes of information per participant (Seidman, 2013). Each transcript will have the initials of the participants, instead of full names in the event someone accidentally comes across the document (Seidman, 2013). I will have the transcripts reviewed and validated by each participant. I obtained the data and reduced instead of deductively (Seidman, 2013).

Prior to the data being analyzed, I profiled the participants into specific categories. I protected the identity and faithful to words of the participants when creating profiles. I titled each profile with a pseudonym whereas the individual's age and livelihood reflected that participant. I had the participants' responses individually marked and grouped in the categories of thematic connections (Seidman, 2013).

I made two copies of the labeled transcript. The storage of the transcript is stored in a secured computer file. The second transcript was reviewed of all its passages, and the pertinent responses will be marked. I took all of the pertinent responses and transfer them to a single transcript. I labeled each passage as a reminder of its original place in the transcript (Seidman, 2013). The software NVivo allowed for the audio to be transcribed and the transcript to be uploaded and stored (Merriam, 2009).

Analyzing the Data

The purpose of data analysis was to have the collected information from the study converted into findings. This entailed being able to scrutinize trivia from significance, identified certain patterns, and developed a framework that will communicate the core of what the qualitative data revealed (Patton, 2002). Quantitative research entailed non-text data collection to be analyzed through a formalized process (Creswell, 2009) and qualitative research is unique whereas the analytic approach used will be exceptional (Patton, 2002).

Each participant's transcribed data set was reviewed for meaning and then a list of the topics was emerged. I marked specific text written verbiage that related to the emerging topics and were related to the perceived communication barriers and trust issues of Black women seeking preventive health services research study. I coded the data before analyzing the themes and meanings with the assistance of a qualitative software called NVivo 10. I reduced the interview data to what was important, label specific themes, and sort the tagged files that are easily retrievable during the study (Seidman, 2013).

Prior to using the NVivo 10 software for coding and themes, I hand coded the information first on paper. I compared with the NVivo 10 coding in order to reach defensible conclusions and recommendations. I came across other passages that may be in the same category whereas it may not be prevalent on a computer screen (Seidman, 2013).

I collected the data on the scheduled interview dates. There was a backup digital recorder in case the other one fails. I coded and categorized the data so that it will allow for meaning to the script of notes. I developed specific codes to allow for categorizing the responses. The data analysis will include phenomenology. The approach to the analysis of qualitative data was to generate the data and then modify and compare the data. Throughout the study, each transcript will be reviewed for consistency and accuracy.

I used Microsoft Word and NVivo 10 to transcribe the audio recordings into documents. I transferred the transcribed data into the NVivo 10 software. This software is located on a desktop computer with a secured password. I stored the documents in two different areas such as the desktop computer and a backup drive. The digital recorders are locked in a file cabinet in the researcher's home office. The transcripts, signed consent forms, and the interview guide are kept in a sealed envelope so that only the researcher has access. I used NVivo 10 software to uncover subtle themes and be able to drill down into the data (QSR International, 2015) manually. For example, I searched for words that are similar in meaning to test the HBM (QSR International, 2015).

Measures for Ethical Protection of Participants

I obtained Walden University's Institutional Review Board (IRB) approval to conduct research involving human subjects. I completed a National Institute of Health (NIH) online human subject's research online training. This project did not involve discomfort to the potential participants. The participants were informed about why the study is being conducted, prior to obtaining their consent. The raw data was stored in two secure places such as in a file folder located on a desktop personal computer and a backup drive stored in a locked file cabinet. The raw data was coded to maintain confidentiality. However, it was anticipated that discomfort might be encountered in one's daily lifestyle, for instance being asked an uncomfortable research question

Summary and Transition

In Chapter 3 discussed the importance of the qualitative methodology for this study. The researcher role was explained, recruitment and sampling process. The methodology consisted of 10 one-on-one interviews led guided by 8 -10 research questions. The participants freely discussed perceived communication barriers and trust issues when seeking preventive health services. In addition, in this chapter, I discussed the rationale of how the research questions were used throughout the guide. This chapter highlighted the target population, criteria, and detailed was collected, transcribed and stored in a secured place. Lastly, this chapter presented how I addressed validity, reliability and ethical procedures.

In Chapter 4, I discussed the how the research results.

Chapter 4: Results

Introduction

In this study, Black women with public health or health care backgrounds participated in one-on-one interviews in order to share their perceptions of communication barriers and trust issues when seeking preventive health services in Houston, Texas. The collected data answered the following guiding research questions:

Research Question 1 – Qualitative: What communication barriers do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 2 – Qualitative: What trust issues do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 3 - Qualitative: What approaches are identified by Black women to help enhance communication and trust relationships with health care providers?

The research focus was on perceived communication barriers and trust issues of Black women seeking preventive health services as it related to five discussion topics: (a) Black women's beliefs and culture, (b) health care providers and culture, (c) communication barriers, (d) patient and provider trust issues, and (e) approaches to enhance communication and trust relationships with health care providers.

The purpose of this chapter was to describe the data collected during the one-on-one interviews and the emerging themes. The themes reflected the participants' beliefs,

insights, and attitudes about the barriers and trust issues when seeking preventive health services.

Demographic Data

Ten Black women were recruited for this study. Each read and signed an informed consent form and completed a demographic questionnaire prior to the one-on-one interviews. Half of the participants worked in health care and half in public health and 90% had degrees that were beyond a high school diploma. No participant left any blank questions (see Appendices F and G). See Table 1 for demographic data on the participants (see).

Table 1

Participants' (N) Demographic Profiles

	N = 10	%
Organization type		
Public Health	5	50
Health Care	5	50
Other	0	0
Education Level		
High School	1	10
Associate's	1	10
Bachelor	2	20
Master	5	50
Doctoral	1	10

Note. *N* = 10.

Research Procedures

The one-on-one interviews for this study were conducted at the Houston Community College study rooms or Houston Public Library conference rooms. There were a total of 10 one-on-one interviews conducted.

Interview Date	Number of Interview
April 23, 2016	First one-on-one interviews
April 26, 2016	Second one-on-one interview
April 28, 2016	Third one-on-one interview
April 29, 2016	Fourth and fifth one-on-one interviews
April 30, 2016	Sixth thru eighth one-on-one interviews
May 3, 2016.	Ninth and tenth one-on-one interviews

Figure 2. Number of interviews and dates by M. Shelton, 2016.

All participants were recruited from a recruitment flyer that was emailed to the organizations to either forward through email to interested persons or post to their bulletin board. The participants responded to the flyer by sending an email directly to the researcher of their interest to participate in the study.

I began the data analysis by listening and transcribing the audio recordings of the one-on-one interviews. The audio recordings were transcribed into a Microsoft Word Document and later imported into software called NVivo 10. During transcribing the data, there were key points noted in the document. The notes were recorded in a column format. Upon conclusion of transcribing the data, a copy of the transcripts were saved into another document without the notes in the column. The typed transcripts were

printed and copied. I cut individual strips for each response to each of the interview questions. Each response was taped on a poster board under the assigned discussion topic and one-on-one interview question at the top of the board. Each response was assessed for the context of responses; multiple codes were identified and assigned into smaller analysis units that became the themes. The process was completed for the five discussion topics that guided the one-on one interview questions. This process permitted me to manually categorize each individual's statements that corresponded to each question on the interview guide; each response was counted and provided a total number of responses per question. The total allowed for the calculation for the frequency per question was based on the number of responses.

Trustworthiness of the Data

In qualitative studies, it was extremely important that the study was reliable, manageable, trustworthy, and supportable (Creswell, 2009). This study exemplified these qualities that were ensured in the aforementioned in this research study that was conducted.

Credibility

The study's credibility was established in different ways. First, each participant was allowed equal time to share their beliefs, perceptions, and experiences without being interrupted. Second, notes were taken during the one-on-one interviews and validated by the transcriptions. The transcripts were reviewed and validated by each participant. Third, there were two audio recording devices used to record the one-on-one interviews. The first audio recorder was used to create transcripts. The second audio recorder was used to

confirm the accuracy of the transcript and to validate the transcribed information. This triangulation confirmed the validity and reliability of the data. Finally, the participants verified their transcribed transcripts. One participant made a statement clearer on the transcript that was uncertain due to unexpected noise on the recording.

Transferability

The transferability standards (Bloomberg & Volpe, 2010) were fulfilled through the process of the participant's selection and the one-on-one interview setting. The study can be replicated by employing the same protocols to reach comparable results.

Dependability

The triangulation process included two audio recorders, written notes, and the study participants who verified their transcribed data that helped ensured the standard of dependability was met. The transcripts produced from the audio recordings showcased the participants' words exactly. My written notes included different codes of the participants' responses to each question. The codes were taken from the notes and transcripts and then transcribed into themes.

Confirmability

The participants' statements were confirmed by reviewing and confirming the transcripts. The transcriptions from the first audio recorder was checked and validated with using the backup recorder to confirm the integrity of the data. The statements clarity was confirmed by the participants.

Interview Data

The presentation of the interview data was shown by using exact statements from the participants' and through manual coding and identifying themes generated by different statements provided from the participants. The exact responses were used to enhance and provide credibility to my interpretation of participants' experiences. The themes were generated from the collected data. Each participant discussed her experiences verbally during this research study. Black women with public health or health care backgrounds were engaged in one-on-one interviews to share their experiences in perceived communication barriers and trust issues when seeking preventive health services to answer the following research questions:

Research Question 1 – Qualitative: What communication barriers do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 2 – Qualitative: What trust issues do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 3 - Qualitative: What approaches are identified by Black women to help enhance communication and trust relationships with health care providers?

The data was reviewed in the following five discussion topics:

- Black women beliefs and culture
- Health care provider and culture
- Communication barriers

- Patient and provider trust issues
- Approaches to enhance communication and trust relationships with health care providers.

The frequency of responses for each discussion topic was tabulated by taking the total number of responses and divided by each identified theme of the total number of responses. Each discussion topic yielded the percentile reflected in the interview data.

Discussion Topic 1: Black Women Beliefs and Culture

Discussion Topic 1 was composed of two main statement questions. The first statement question asked for participants to share any type of beliefs, situations or an incident that your mother, guardian or a close female relative may have in regards to or experience when receiving preventive health services from her health care provider. And the second question entails described how their culture is defined and to discuss whether or not they think a health care provider should have some knowledge or be familiar with Black women's culture as it relates to their health. An overwhelming majority (80%) of participants with a bachelor degree and higher reported that a health care provider should be familiar with the Black American culture as well as other cultures. A few participants (20%) stated that their health care provider was already familiar with their culture because they came from a similar racial/ethnic background which Black.

The participants provided various perspectives when it came to type of beliefs, situations or an incident that a close female relative may have experienced when receiving preventive health services from their health care provider. Fifty percent of the participants discussed how their family members did not believe in receiving preventive

health services. Twenty percent reported their mother rarely share information after a doctor appointment; whereas 20% reported that were no discussions about preventive health services. Finally, 10% of the participants preferred not to discuss an example of a close female family relative as it relates to preventive health services.

Participant 1 stated that her family members did not think that preventive health care or annual preventive services were important:

> My mother and my grandmother did not really believe in receiving health service or annual preventive services. Only when they were sick or feeling ill. Or they were told that they need to seek health care services. And I just think it's their generation. The time they were raised or the time that they, their generation. And I think it's just their culture back then to help others but not to really take care of themselves.

Participant 4 shared that a health care provider trust among family and friends are questionable:

> Well, one issue that I have heard quite a bit from family and family friends. Is that they don't always trust health care providers. And that is ill respective of education level they don't always trust health care providers. Now when they are among them they will say certain things but once when they leave the office they will say, "Oh, I didn't believe that" or "I'm not going to take that medicine."

However, P8 other perceptions were discussed:

> As it turns out I grew up in an all African American community for the first twelve years of my life. So, my mother who was actually very trusting of her

> healthcare provider. There was only one from miles around. My grandmother did live in a small town. She lived in Waco, Texas. They were segregated for so long. Her provider was also African American. I think a lot of those people knew each other, so I think a lot of those people did trust their providers. However, we moved to a different part of the country, so we move to a part of the country where the African American community was very small. And as we know different things about culture. I was very adamant about having an African American provider, a dentist, doctor, and gynecologist. I felt they will know about our community, especially in Portland Oregon.

Beliefs and perceptions discussed by the participants echoed that some black female family members were not opened to discuss doctor appointments, preventive health services and health matters because that was not a primary concern for them, this may be generational and a sub-culture within the Black community. Fifty percent of participants stated that their close female relatives did not discuss preventive health care services situations or share health information among family members.

Discussion Topic 2: Health Care Provider and Culture

Discussion Topic 2 was centered on the health care provider and culture. Each participant was asked how she chose her your health care provider when seeking preventive health care services. And, think back on her last or most recent preventive health service visit, can she recall her health care provider asking questions about her family culture as it related to their health.

P4 shared that close family and friends provide recommendations for a health care provider:

> I usually look for someone whose office is in a locale that's going to be relatively easy for me to access. I also ask for a referral from friends, people I know. And I found some healthcare providers that way. And I also had been told to avoid certain people that way. You know I just do a toss-up at the first visit. Then you know I switch. I have done that before.

Therefore, P5 shared how she chose her health care provider:

> I try to choose a health care provider that is near me. And so far, it has been ok. But, if I had to choose a particular health care provider that I really want. I may have to travel to a longer distance. The finances may not be there. Making the best of the situation, I have gone to physicians who had all kinds of experiences."
>
> Another P8 similarly chooses her health care provider based on recommendations: "I chose my provider usually based on contacts that I have. So, I ask different people that I know about the providers that they use and how they respond to those providers. These people will tell you about a provider they don't particularly like but use them of insurance or they have been going to them for a long time. So I have family, friends, and coworkers and ask them.

Likewise, P7 shared the type of health care provider that she seeks "a lot of times are closest to my house. The type of services that I am looking for like is it a routine. I may go for a woman or man depending on the services that I am looking for." The participants were asked if their doctor or health care provider asked them about their family culture.

This is not their family medical history. One hundred percent of the participants shared that their health care provider has never asked about their family culture. A couple of the participants commented that they think their health care provider did not ask because their race or culture was similar to theirs. Another theme was identified as it relates to health care provider and culture.

Discussion Topic 3: Communication Barriers

Discussion Topic 3 focused on how the participants communicate with their health care provider and the types of communication barriers perceived when seeking preventive health services. The one-on-one interview dialogue was created by asking the participants how they like to communicate with their health care provider, if they have experienced any communications barriers, and what those communication barriers were when seeking preventive health services. Some participants shared some of their uncomfortable communication experiences they had with their health care providers while others have a comfortable relationship with their health care providers.

The participants used the following communication mechanisms when seeking preventive health services: face to face, phone/nurse, and web email/patient web portal. A frequency tabulation for each communication mechanism identified was calculated by taking the number of responses per theme and dividing the number by the total number of participants' responses for all the communication mechanisms (See Figure 3).

Face to Face

Participants noted that communicating with their health care provider face to face was important. They want to see their doctor in person to ask questions and obtain upfront responses on a particular health issue.

P3 expressed how she wants to communicate with her health care provider when it comes to her preventive health needs:

"Any questions that I have I want to have face-to-face contact with my doctor. Answers face to face. I want them to see me."

One hundred percent of the participants stressed that they want to see their health care provider in person.

Phone/Nurse

Participants shared several scenarios about communicating with only the nurse by phone about health questions and concerns when the health care provider was not available to talk with the patient in person. The participants stressed the importance of receiving feedback.

P4 discussed: If I call and have a question the practitioner does not get on the phone. The nurse comes on the phone takes my questions and goes and asks the practitioner. And once they get an answer they will call me back with a response.

P8 stated that during the health care provider visit that:

> Usually through the nurses, because I find that a lot of providers won't or don't seem to like to talk to you directly. I had one time, he did. My OB/GYN when I lived in another city he would talk to me on the phone. But, a lot them they don't want to. It is either in person or through their nurses. Sometimes, if they think it is important enough they will call me back.

Web Email / Patient Portal

Participants expressed using in web mail and patient portal to communicate with their health care providers. Sixty percent of the participants said that it was important to have an online resource to access preventive health services.

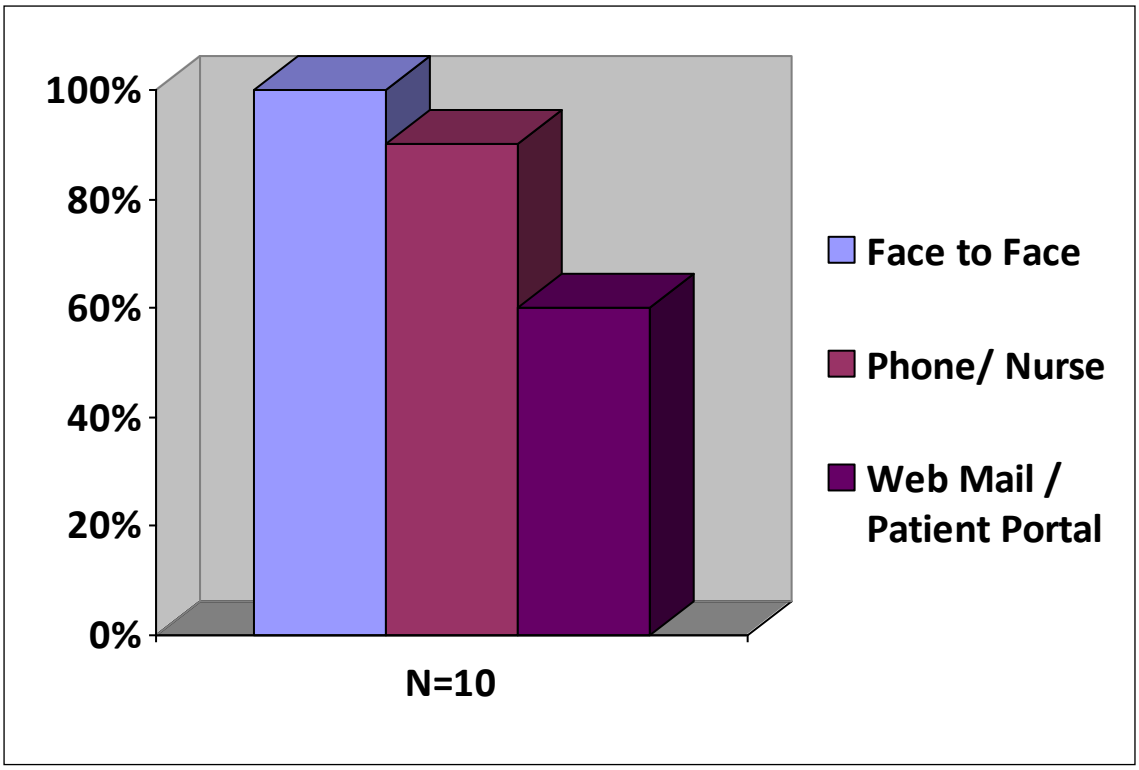

Figure 3. Participants' communication mechanisms.

P3 stated that we do have access to websites to download medical information.

P10 echoed that in person or through a web portal for questions and results.

P1 mentioned that she does have access to a web portal for both PCP and OB/GYN. I can see my lab results, where I can pull my lab results. I can ask questions of them. I can always get in touch.

P5 discussed the importance of chatting online. Things are changing. It's getting more comfortable talking online. Times are changing and it is becoming normal to chat, text or via email.to the health care provider.

Participants one-on-one interview questions entailed asking them what communication barriers perceived or experienced when seeking preventive health services. Participants identified the following communication barriers experienced when seeking preventive health services or following up with questions and concerns about their health care provider lack of attentiveness and lack of communication with the patients. Participants expressed the importance of how a health care provider should have a good bedside manner.

Lack of Attentiveness

P4 shared that a health care provider can be a communication barrier when they are less attentive to a patient, especially if there are questions or inquiries about a health concern or issue:

> Some health care providers in the past have not really been attentive or communicated well. Or they just brush you off when I asked questions or indicated that I heard this or I read that about a medical problem. It's more of an attitude, well you know there is a lot stuff out there and you can't believe what you read. Blah, Blah. You know just brush you off. Like they are so busy. But as I said earlier, those are the health care providers we have a very short relationship with. I don't go back and see them again.

P8 shared strong views regarding how the health care provider did not spend enough time with during her medical visit:

> I have to go through a couple of layers to talk to a provider, number one. Number two, I find that with my last provider that this is one of the reasons why I left him. And he is actually an African American provider, that he used a computer to input medical information and the provider did not spend a lot time with me. I didn't feel like he put that much in my sessions. He did not want to entertain too many questions. I didn't feel like he was that interested in my medical concerns. He uses a tablet to submit most of the information. Before and after that he does not put it down to look at you.

P10 shared similar views as it pertains to health care providers not being attentive:

> The doctor's sometimes really do not take time to get to know you. I feel that I am on an assembly line. It is like time is money and money is time.

P9 voiced how health care providers are not making it convenient to see their patients this is another communication barrier:

> "When I cannot get an appointment when I need an appointment, I usually ask them to put me on a standby list. And call me when they get any cancellations."

Discussion Topic 4: Lack of Communicating with a Patient

P8 shared that a health care provider comes across resisting communicating with the patient:

> I find that a lot of providers won't or don't seem to like to talk to you directly. I had one time, he did. My OB/GYN when I lived in another city he would talk to me on the phone. But, a lot them they don't want to"

P3 shared the same views:

> Well, that particular one that I had. She is sitting looking at me like she wanted me to give her answers. I am like no, I am telling you my problem and you are not giving me feedback. That was my signs she was not the one.

P9 discussed the challenges to see her health care provider by appointment:

> The only barrier that I perceived it's sometimes hard to get an appointment with folks.

Discussion Topic 5: Patient and Provider Trust Issues

Discussion Topic 4 focused on the patient and health care provider trust issues perceived when seeking preventive health services. Eighty percent of the participants clearly stated that they trust their health care provider. The one-on-one interview question created by asking participants what a healthcare provider can do to gain their trust.

Participants discussed three major areas where health care providers can improve upon: listen, bedside manner and health literacy/communication terms to the patient:

Listen/Give More Time

P2 shared why it is important for patient to have more time:

> I think they took a little more time and really try to listen and hear what that patient is saying. And be familiar with that patient's history at least some of it. You know you go to the doctor and they don't know what or can remember or can't recall what was done at the last visit. Sometimes they don't recall the reason you are here for the follow-up visit."

P4 shared:

"Well, they can listen. They can provide information; they can take time as if to say they are not on an assembly line. Well, I have 10 minutes to spend with this patient and I have ten minutes with the next. I have to jump, jump. The healthcare provider should take their time to genuinely get to know their patient and if the patient has an issue to discuss."

Atmosphere/Bedside Manner

P10 shared:

Bedside manner and time is most important to me. I feel like they just want to rush through and get to the next patient. I feel it's about seeing a certain number of patients. Managed care has really done something to this.

P8 shared:

My trust is how they interact with me. A provider has to ask people how are you doing.it is very rare in the healthcare field, unless it is in a survey. They have to ask how the service to you is. It's about the hold atmosphere, the transaction from the staff to the doctor. Otherwise my trust level is kind very low.

P9 shared:

"I think he needs to work on his bedside manner."

Discussion Topic 6: Approaches to Enhance Communication and Trust Relationships with Health Care Providers

Discussion Topic 5 focused on approaches to enhance communication and trust relationships to help reduce barriers with health care providers. Participants felt that it is the health care provider's role and their staff to make a patient feel welcome and comfortable

when coming to their facility to be seen. The one-on-one interview question created by asking participants what type of approaches will help them build or enhance a trusting relationship with their healthcare provider?

Participants identified the following approaches that can improve relationships between the health care provider and patient: extended time, feedback, health literacy and comfort level.

Extended Time

P2 shared how having more time with the health care provider can enhance trusting relationships with the health care provider:

> I think having more time, if it's an appointment where, I don't want to say if there is a serious health issue. Given more time. The option of two types of appointments how much time will this require. It's an issue when you feel rushed. I like having access to reviews of that physician, patient and colleague's reviews. Honest and unbiased reviews. Being able to look at that, I think that would help.

P5 shared the importance of time:

Increase their amount of time that they spend with the patient, such as from 15 minutes to 30 minutes for the same price. Enhance the communication and increase the amount of time because they have decreased the time.

P8 echoed similar views:

They have to give me a little bit of time to ask questions, or let me know that they are interested in what I have to say. I realized that they have a short margin of time based on the insurance. I need them to show me that they have a little bit of time.

P9 stressed:

I think just knowing the doctor allotted time, to get my questions answer and I don't feel like I am being rushed. They are trying to see another patient.

Feedback

P7 shared why it is important to know what is going on with a patient:

Making sure that they are aware of what's going on with your health. Don't just skim over things. If you have a questions, make sure that they explain it thoroughly so you can feel comfortable. You know, what's going with our bodies because even though we always feel things that are this and that. I want to ensure that there is nothing serious and don't just kind of blow it off.

P6 shared: If she would have giving me a reminder or have someone from her office calling reminding me that you need preventive services such as a mammogram, or yearly exam.

P8 shared:

I think that any mechanism that a provider uses is an important, and then I have to know that there is follow-up on that thing. So if I give you feedback on if it's great or not that great. It needs to be acknowledged that they got that feedback. They need to let me know that something is being done about it. I got to have a way to get the feedback, either personally or by a computer and that it doesn't go into a black hole.

Health Literacy

P5 shared:

Well, I will say that is for them to know that I not a physician. Explain what it is that I am going through. So that I can understand and recognized that I am emotional. And assist me when I am emotional. So I would say be understanding when the patient is in shock as they are seeking medical treatment.

P4 echoed similar view:

As long as the doctor is upfront and what is going on with the person medically. I think that will enhance with the person. Explain it with care and not like a text book. I understand that they have to do their job. They are focused on that patient and the situation and not on the next patient.

Comfort Level

P1 shared:

It needs to be on the doctor. The doctor's office. You are being exposed to them, so personally, mentally and physically. They need to make me feel comfortable.

> Because one person wants it one way I may want it another way. It's the same way as coming to someone house. It was a time where you could interview a doctor. I remember doing that when I was pregnant with my daughter. You get a list; your insurance gave you a list. The doctor had a consultation time. That was back in the 80s.That was a free service that you received. I think that what it got away from. They don't if that doctor is right for the job. They never were interview for the job.

P3 shared:

> Just making sure that I having a positive attitude as well as making sure that I am doing whatever I am told to do. To understand that I respect their treatment and methods. I have to make sure that I am following through on my end. I take my health serious and I take their recommendations serious. Having a positive approach to them I think I will have a positive result.

P10 mentioned that bonding between a patient and doctor is important. Taking time to know the patient. That way the patient can get to know them.

Results and the Research Question

The themes lifted from the qualitative data in this study directly addressed the research questions asking about the communication barriers and trust issues perceived by Black women seeking preventive health services in Houston, Texas. A dialogue from the one-on-one interviews yielded eight identified communication barriers and trust issues that were successful in engaging Black females in a conversation about their perceptions on communication barriers and trust issues between them and their health care providers. The themes included: (a) lack of attentiveness, (b) lack of communication, (c)

atmosphere/bedside manner, (d) extended time, (e) feedback, (f) health literacy and (g) comfort level. These themes may be used to enhance public health education and health literacy strategies and programs to improve communication and trust issues between Black women and health care providers.

Summary and Transition

During the interviews, participants shared their thoughts and experiences when seeking preventive health services in Houston, Texas. These interviews were recorded, transcribed, coded, and analyzed as the data is related to guided research questions which led the one-on-one interview questions. The themes were identified with respect to communication barriers and trust issues. Most importantly, the participants suggested ways to enhance communication and trust relationships with health care providers.

In Chapter 5, I cover the following topics: the findings (interpreted from the perspective of the conceptual framework), recommendations, conclusions, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore communication barriers and trust issues perceived by Black women when seeking preventive health services in Houston, Texas. This chapter begins with the purpose of the study, reviews the research questions, discussed the study findings and recommendations for future study. The next section, I covered the analysis of the study findings, how the findings relate to the literature review, and the conceptual framework. The conclusions of the study are expected to contribute to the research on communication barriers and trust issues as perceived by Black women. This final section discusses positive social change and recommendations for further research.

Study Overview

Black women may have barriers from seeking preventive health services, for example, perceived communication barriers, trust issues, racial discrimination, and the lack of quality health care (Smedley et al., 2003). According to the literature, among Black women perceived communication barriers and trust issues are associated with health disparities (Asch et al., 2006; Smedley et al., 2003; Kreuter & Haughton, 2006), but little is known about how a health care provider's bias may impact the health outcomes of Black women. A study conducted by AHRQ (2011) indicated that 12.1% of Black women reported that their health care provider may listened carefully, explained things thoroughly, or respected what they had to say.

The mortality rates of Black women suggest the importance of identifying perceived communication barriers and trust issues when these women seek preventive health services. The mortality rates for Black women in comparison with White women were highest in the following three diseases: heart disease, cancer, and stroke (CDC, 2012). Black women, between ages 45 and 64, were diagnosed with hypertension at twice the rate for White women in the same age range (Price, 2005). Thus, the health disparities in the aforementioned may be impacted by the perceived contribution of communication barriers and trust issues of Black women seeking preventive health services.

According to Smedley, Stith, & Nelson (2003) the findings compared with White women, Black women perceive (a) a higher level of race discrimination in health care settings than non-minorities and (b) inequitable access to specialty care, and (c) a lower chance of being treated in a facility with the state of art technology. The HBM was used as a guide to develop the research questions. The construct of each question was based on perceived susceptibility and perceived severity of communication barriers and trust issues (Duran, 2011). The three research questions guiding this study were: What communication barriers do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers? What trust issues do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers? What approaches are identified by Black women to help enhance communication and trust relationships with health care providers? To answer these research questions, a phenomenology qualitative methodology was determined to be the

best approach for exploring communication barriers and trust issues of Black women seeking preventative health services.

. The HBM identifies public attitudes and actions about health issues (Changing Minds, 2015), used for this phenomenology qualitative research helped explore Black women's perceptions of communication barriers and trust issues when seeking preventive health services. Ten Black women, between 25 and 64 years of age, from the Houston metropolitan area, who work or have worked in public health or the healthcare field, participated in the research. The participants were invited to partake in one-on-one interviews and provide additional information through a demographic survey and the researcher notes. The participants were asked to share their preventative health experiences as it related to perceived communication barriers and trust issues. The data collected was in the based on the five discussion topics: (a) Black women beliefs and culture, (b) health care provider and culture, (c) communication barriers, (d) patient and provider trust issues, and (e) approaches to enhance communication and trust relationships with health care providers. The data collected were analyzed by using a manual process and NVivo software until the core of the perceived experiences with communication barriers and trust issues were refined.

The themes were identified based on the Black women experiences are (a) lack of attentiveness, (b) lack of communication, (c) lack of comfortable atmosphere / bedside manner, (d) extended time with health care provider, (e) feedback, (f) health literacy and (g) comfort level with health care providers. The themes may be used to enhance public health education and health literacy strategies and programs to improve communication and trust

issues between Black women and health care providers. These seven themes will be discussed as it relates to the conceptual framework for this study shown in Chapter 1.

Interpretation of Findings

The research participants were able to use a platform to be able to express their perceived communication barriers and trust issues when seeking preventive health services. The experience of identifying communication barriers and trust issues for the Black women was positive, in part due to their sharing their personal and female family members' experiences when seeking preventive health services. Given that the participants were between 25 and 64 years of age, the experience being interpreted in this section as being bounded to the Black women who received health services.

The research questions for this study were:

Research Question 1: What communication barriers do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 2: What trust issues do Black women perceive when seeking preventive health services in Houston, Texas, from health care providers?

Research Question 3: What approaches are identified by Black women to help enhance communication and trust relationships with health care providers?

To answer the guiding research questions, there were five discussion topics used to collect data. The five discussion topics were (a) Black women beliefs and culture, (b) health care provider and culture, (c) communication barriers, (d) patient and provider trust issues, and (e) approaches to enhance communication and trust relationships with

health care providers. The data analysis yielded five themes: (a) lack of attentiveness, (b) lack of communication, (c) atmosphere / bedside manner, (d) extended time, and (e) health literacy. These themes may be used to enhance public health education and health literacy strategies and programs to improve communication and trust issues between Black women and health care providers.

Findings and the Literature

I interpreted the findings as it related to the literature that followed the order of the themes illustrated in Chapter 4 to confirm that all of the data were discussed. The data analysis yielded five themes: (a) lack of attentiveness, (b) lack of communication, (c) atmosphere / bedside manner, (d) extended time, and (e) health literacy. These themes may be used to enhance public health education and health literacy strategies and programs to improve communication and trust issues between Black women and health care providers.

Lack of Attentiveness

The first theme, lack of attentiveness, was based on four (40%) percent of the Black women participants who expressed their belief that their healthcare provider was somewhat apathetic when it came to addressing their health care needs. Based on their beliefs, the data suggests that the participants felt that they can play a role in what happens when seeking preventive health care services. This concept seems to give the women a sense of control and the influence on what happens during the visit with their health care provider. The first theme also showed in this study that the participants indicated that in order to receive more attention from their health care provider that face time should be increased with the patients.

Three (30%) of the Black women in the study who visited a doctor's office within the last 12 months reported expressed limited to poor communication with their health care provider. In addition, the participants indicated two challenges were the lack of attention and communicating with their health care provider who was of a similar racial/ethnic background. Banerjee & Sanyal (2012) confirmed that attentiveness and communication issues seemed to be consistent when a health care provider and patient are from a similar racial/ethnic background. The health information provided may not be related to a patient who can fully comprehend the information (Banerjee & Sanyal, 2012).

Lack of Communication with Patient

The second theme was developed from the data based on participants articulating their health care provider came across as resisting communicating with them directly. The participants indicated that the communication was either by the phone or through the nurse. In addition, the participants discussed the challenges of getting an appointment and how when they do see their health care provider, the participants felt as if the health care provider is looking to the patients for answers.

The data collected indicated that a health care provider might prejudge a Black female patient before communicating with her and may routinely make an assumption that the patient has a particular diagnosis. In addition, the second theme also related to the way that the participants expressed how the factors such as cultural competency of health care providers, racial/ethnic situations between the patient and doctor, and language

barriers (AHRQ, 2011) were an influence to the lack of communication as it relates the healthcare provider.

The first two themes showed how the black women in the study have tried to control their circumstances. According to Banerjee and Sanyal (2012) indicated that communication issues and lack of attentiveness could also be impacted by the way health information is conveyed and not related to a patient who can fully comprehend the information.

Atmosphere/Bedside Manner

The third theme was developed from the data collected from the Black women participants who expressed the importance of bedside manner of the health care provider and the atmosphere of the clinic time from their health care provider. Throughout the data collection, the participants expressed how managed care has impacted the bedside manner of the health care provider. The participants indicated that trusting their health provider was determined how their doctor interacted with them. One of the most important indicators of building trust was the atmosphere of the clinic. The participants expressed that it was imperative that the health care provider clinical atmosphere was welcoming.

Wiltshire, Person, & Allison (2011) confirmed that a patient expects for their health care provider to act in her best interest. The trust for health care providers can still be challenging whereas Wiltshire et al. (2011) further confirmed that some of the participants were less trusting of their health care providers due to past experiences of inequity and abuse with the health care system. Black women's lack of trust continual to

be associated with minimal health care interaction, limited relationships with a clinician, and reduction of using health care services (Musa et al., 2009). Black women with distrust of health care-related effects are perceived to be different from White women who may be perceived as an institutional distrust versus interpersonal distrust (Musa et al., 2009).

Participants identified the following approaches that can improve relationships between the health care provider and patient: extended time, feedback, health literacy and comfort level.

Extended Time

The fourth theme identified indicated that sixty percent of the participants expressed the importance of having more time with the health care provider can enhance a trusting relationship to achieve a positive and healthy outcome (Musa et al., 2009). This identified theme should be included in further research to assess how the extension of time with a health care provider may impact the health outcomes and trusting relationships of Black women seeking preventive health services.

Health Literacy

The fifth theme identified showed that 50% of the participants shared how it is important for them to understand the information and not be rushed by their health care provider. This identified theme should be included in further research to assess how health literacy may impact the healthy outcomes of Black women seeking preventive health services.

Conceptual Framework

The findings of this study can offer support for an Ecological Model of the Communication Process (Foulger, 2004) was used as a framework for the consumer/patient constructs as it pertains to communication barriers and trust issues. The HBM (Duran, 2011) theory served as the balance in the design of the questions for this phenomenology qualitative research (Creswell, 2007) to aid in exploring the participant's perceptions of communication barriers and trust issues when seeking preventive health services.

Limitations of the Study

The study explored communication barriers and trust issues of Black women seeking preventive health services in Houston, Texas. The data reported was self-reported and biases may be presented. The limitations of this study limitations to literature and finding Black women who currently work in public health or healthcare and had preventive healthcare services in Houston, Texas, that relates to their lived experience of the phenomena. This sample size used in the dissertation is not generalizable to all Black women (Polit & Beck, 2008).

Recommendations for Future Research

The lack of Black women receiving equitable preventive health care services is a crucial issue in improving health disparities. The participants identified and shared their experiences in communication barriers and trust issues when seeking preventive health services. There are still concerns with the lack of attentiveness from some health care

providers and the limited communication that occur between the Black women and their doctor.

The recommendation for future research such as a quantitative study can help expand the impact on how perceived communication barriers and trust issues are hindering Black women's future health. The research questions would be developed from the study's based on the five areas on the following themes: (a) lack of attentiveness by health care providers, (b) lack of communication between health care provider and patient, (c) facility atmosphere and bedside manner, (d) extended patient care time, and (e) health literacy. These five recommendations for future research may inform how strategies and evidenced based practices can be developed geared refining approaches to enhance communication and trust relationships with health care providers.

Implications for Positive Social Change

The study findings can be applied to move forward with taking steps toward a social change in improving communication barriers and trust issues through a culturally-appropriate patient and health care provider education program. The concept of the education program to be presented on various platforms ranging from webinars, outreach education, multimedia platform, to include personal empowerment seminars and workshops made available in various settings that offer tools and resources to help improve patient and health care provider relationships (Chen, Kim, & Merriam, 2008). Recommendations for developing a curriculum that will assist universities, professional organizations and health care and public health entities that will encourage health care providers to best understand Black women and their needs as it pertains to seeking

preventive health care services. The needs ranged from communication, enhancing relationships between the Black women and health care providers by having a better understanding or being more familiar with Black women's culture and health needs as it relates to the preventive health services.

I discovered the experience of perceived communication barriers and trust issues of Black women seeking preventive health services may embrace the idea that individuals can shape their life circumstances through their positive thoughts, words, and behaviors. If larger groups of Black women and health care providers are educated on how to communicate and how to enhance trust, the positive attitude and effects would spread across society. The study results identified how key communication barriers impact on Black women who seek preventive health services.

The anticipated social change as a result of this study is to bring attention and awareness on the approaches to enhance communication and trust relationship between Black women and health care providers. This study results may lead to (a) establishing best practices in being proactive to learn different Black women cultures as it relates to her community, personal and work like, (b) developing an educational campaign on the importance seeing your patients as they are and not what a health care provider assumes, and (c) empowerment of Black women to take a more active role in educating the health care provider about her family culture, emphasizing that Black women's culture is not cookie cutter, it is individual.

Finally, this may result in an increase of healthy outcomes in Black women's health.

Conclusion

This study utilized one-on-one interviews to explore communication barriers and trust issues of perceived by Black women seeking preventive health services. One participant emphasized more time and knowing your patient "I think they took a little more time and really try to listen and hear what that patient is saying. And be familiar with that patient's history at least some of it. You know you go to the doctor and they don't know what they can remember or can't recall what was done at the last visit. Sometimes they don't recall the reason you are here for the follow-up visit." The results of this study suggest that more health care providers be engaged with Black women and their health.

Researcher's Reflections

Conducting a phenomenology qualitative study requires powerful participation as being the researcher. While there were some parts that challenged me in unexpected ways, I found this research process to be more purposeful than had I chosen quantitative research. This study allowed me to learn several things about myself, in particular as a researcher and as an individual. First, as a researcher, I showed several strengths. I learned that by having prior experience with conducting one-on-one interviews has allowed me to be able to capture in-depth information from the participants. I probed the participants when there may have been times of limited information obtained from the participants, which allowed me to collect more data from the participants. Subsequently, after transcribing the first two interviews myself, I was able to readily notice any

limitations and make modifications. The participants reviewed, provided feedback and approval their transcription.

During the research process as the researcher I worked to maintain control over the interviews, this prevented the participants from going off on tangents and losing precious time. Additional strengths, I revealed about myself as a researcher included my outgoing personality and sense of truthfulness. I was able to rapidly build a relationship with each woman and obtained their personal information. Each woman expressed that they were comfortable around me and were able to open up based on the way I presented myself. The interview process may have been successful based on the process of repeating the steps I made sure to guard the participants' identity before, during and at the conclusion of each interview, as well as the follow-up emails sent prior and after the interview process.

Showing empathy and valuing each participant showed another aspect of my character that helped me become a better researcher. The recordings that I heard showed how I continued to express interest and respect of the participants who shared their information. Another strength I observed was my persistent documentation and record keeping. Every participant's contact information, each documentation received or sent, and the data were logged and securely filed so that the information will be tracked. The recorded researcher notes provided me a source of valuable insights related to the research data collection and analysis. In addition, I demonstrated my flexibility when conducting the data analysis by manually coding and using NVivo to interpret the data.

This data were reviewed from more than one perspective and to arrive at a set of findings that addressed each research question. The inquiry of how I transformed as a result of the research study will continue to be answered in the months to come, but during this time, I can define in two ways. As a researcher, I have enhanced my skills than I had at the start of the research and allowed to be more aware of areas that I need to be more observant. I am better able to interpret the participants shared information with objectivity. The women in the research study moved me with their thoughts about how the communication barriers and trust issues can be approached through additional research. The women expressed after the one-on-one interviews that the research was a valuable and positive experience. I began this research making sure it was not intrusive or a burden on the participants. Although I am comfortable speaking to large groups, this study has improved my ability to communicate one-on-one.

The process of completing the research has impacted my experience as a researcher, produced data that can be useful in conducting future research and developed programs or communication and trust techniques to help improve Black women health and reduce health disparities.

References

Abdou, C., & Fingerhut, A. (2014). Stereotype threat among Black and White women in health care settings. *Cultural Diversity & Ethnic Minority Psychology*, *20*(3), 316-323. doi:10.1037/a0036946

Akinyemiju, T. F., Soliman, A. S., Yassine, M., Banerjee, M., Schwartz, K., & Merajver, S. (2012). Health care access and mammography screening in Michigan: a multilevel cross-sectional study. *International Journal for Equity in Health, 11*(1), 16-26. doi:10.1186/1475-9276-11-16

Agency for Healthcare Research and Quality (2011). Disparities in health care quality among minority women. Retrieved from http://www.ahrq.gov/research/findings/nhqrdr/nhqrdr11/minority-women.htmland

Agency for Healthcare Research and Quality (2013). 2012 National Healthcare Disparities Report. Retrieved from http://archive.ahrq.gov/research/findings/nhqrdr/nhdr12/2012nhdr.pdf

American Cancer Society (2013). Breast cancer facts & figures for 2013-2014. Retrieved from http://www.cancer.org/acs/groups/content/@research/documents/document/acspc-042725.pdf

Amsteus, M. (2014). The validity of divergent phenomenology method. *International Journal of Qualitative Methods*, *13*71-87.

Asch, S., Kerr, E., Keesey, J., Adams, J., Setodji, C., Malik, S., & McGlynn, E. (2006). Who is at greatest risk for receiving poor-quality health care? *The New England*

Journal of Medicine, *354*(11), 1147-56. Retrieved from http://search.proquest.com/docview/223937173?accountid=14872

Ashton, C., Haidet, P., Paterniti, D., Collins, T., Gordon, H., O'Malley, K., . . . Street, R. (2003). Racial and ethnic disparities in the use of health services. *Journal of General Internal Medicine, 18*(2), 146-52. doi:http://dx.doi.org/10.1046/j.1525-1497.2003.20532.x

Asur, S. & Huberman, B. (2010). Predicting the future with social media. Retrieved from http://arxiv.org/pdf/100.5699v1.pdf

Banerjee, A., & Sanyal, D. (2012). Dynamics of doctor-patient relationship: A cross-sectional study on concordance, trust, and patient enablement. *Journal of Family & Community Medicine*, *19*(1), 12-19. doi:10.4103/2230-8229.94006

Betancourt, H., & Lopez, S. (1993). The study of culture, ethnicity, and race in American psychology. *American Psychologist, 48*(6), 629.

Bennett, I., Switzer, J., Aguirre, A., Evans, K., & Barg, F. (2006). 'Breaking it down': Patient-clinician communication and prenatal care among African American women of low and higher literacy. *Annals of Family Medicine*, *4*(4), 334-340. doi:10.1370/afm.548

Bigby, J., M.D., & Pérez-stable, E. J., MD. (2004). The challenges of understanding and eliminating racial and ethnic disparities in health. *Journal of General Internal Medicine, 19*(2), 201-3. doi:http://dx.doi.org/10.1111/j.1525-1497.2004.40103.x

Bloomberg, L. & Volpe, M. (2010). *Completing your qualitative dissertation: A road map from beginning to end.* Thousand Oaks, CA: Sage.

Pajares (2002). Overview of social cognitive theory and of self-efficacy. Retrieved from http://www.emory.edu/EDUCATION/mfp/eff.html

Brinkman, S. & Kvale, S. (2015). *InterViews: Learning the craft of qualitative research interviewing.* Thousand Oaks, CA: Sage.

Brown, J., Carroll, J., Boon, H., & Marmoreo, J. (2002). Women's decision-making about their health care: Views over the life cycle, *Patient Education and Counseling, 48,* 225-231.

Burns, N., & Grove, S. K. (2009). *The practice of nursing research: Appraisal, synthesis, and generation of evidence* (6th ed.). St. Louis, MO: Saunders Elsevier.

Changing Minds (2015). Health belief model. Retrieved from http://changingminds.org/explanations/belief/health_belief_model.htm

Cegala, D., & Post, D. (2006). On addressing racial and ethnic health disparities: The potential role of patient communication skills interventions, *The American Behavioral Scientist, 49* (6), 853-867.

Centers for Disease Control and Prevention. (2005). Health Disparities experienced by Black or African Americans- United States. *Morbidity and Mortality Weekly Reports, 54*

Centers for Disease Control and Prevention (2012). Health, United States, 2012. Retrieved from http://www.cdc.gov/nchs/data/hus/hus12.pdf

Centers for Disease Control and Prevention (2012). Health disparities. Retrieved from http://www.cdc.gov/minorityhealth/populations/REMP/black.html#Disparities

Centers for Disease Control and Prevention (2014). Women and heart disease fact sheet. Retrieved from http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_women_heart.htm

Charmaz, K. (2006). Constructing phenomenology: *A practical guide through qualitative analysis*. Thousand Oaks, CA: Sage.

Chen, L., Kim, Y. S., & Merriam, S. B. (2008). A review and critique of the portrayal of older adult learners in adult education journals, 1980-2006. *Adult Education Quarterly, 59*, 3-21.

Chou, W., Hunt, Y., Beckford, E., Moser, R., & Hesse, B. (2009). Social media use in the United States: Implications for health communication, *Journal of Medical Internet Research*, *11*(4), e48. doi:10.2196/jmir.1249

Corbin, J., & Strauss, A. (2008). *Basics of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

Corbie-Smith, G., Thomas, S. B., Williams, M. V., & Moody-Ayers, S. (1999). Attitudes and beliefs of African Americans toward participation in medical research. *JGIM: Journal of General Internal Medicine*, *14*(9), 537-546. doi:10.1046/j.1525-1497.1999.07048.x

Creswell, J. W. (2007). *Qualitative inquiry & research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2009). R*esearch design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Cuevas, Adolfo G., O'Brien, K., & Saha, S. (2016). African American experiences in healthcare: I always feel like I'm getting skipped over. *Health Psychology, 35*(9), 2016, 987-995. Retrieved from http://dx.doi.org/10.1037/hea0000368

Dixon, L. D. (2004). A case study of an intercultural health care visit: An African American woman and her white male physician. *Women and Language*, *27*(1), 45-52. Retrieved from http://search.proquest.com/docview/198818846?accountid=14872

Duran, E. (2011). Examination with the health belief model of women's attitudes to cervical cancer and early diagnosis in Turkey: A qualitative study. *Asian Pacific Journal of Cancer Prevention 12*, 1179-1184. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/21875262

Ettner, S. (1996). The timing of preventive services for women and children: The effect of having a usual Source of Care. *American Journal of Public Health*, *86*(12), 1748-1754.

Feldman, R.S. (2003). *Development across the life span*. (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Foulger, D. (2004). An ecological model of the Communication Process. Retrieved from http://davis.foulger.info/papers/ecologicalModelOfCommunication.htm

Fund for Southern Communities (n.d.). What is social change? Retrieved from http://www.fundforsouth.org/social_change.htm

Gamble, V. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health*, *87*(11), 1773-1778.

Ganesan, K., Teklehaimanot, S., Akhtar, A. J., Wijegunaratne, J., Thadepalli, K., & Ganesan, N. (2003). Racial Differences in preventive practices of African-American and Hispanic Women. *Journal of the American Geriatrics Society, 51*(4), 515-518. doi:10.1046/j.1532-5415.2003.51160.x.

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenological and psychological research* (add page range). Pittsburgh, PA: Duquesne
University Press.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of phenomenology. New Brunswick, NJ: Aldine Transaction.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1). Article 4. Retrieved from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/groenewald.pdf

Hawkins, B. D. (1995). A study in trust: Black women's health subject of $4 million NIH study. *Black Issues in Higher Education, 12*(2), 26.

Higginbottom, G., & Lauridsen, E. I. (2014). The roots and development of constructivist phenomenology. *Nurse Researcher, 21*(5), 8-13.

Kamble, S., & Boyd, A. S. (2008). Health disparities and social determinants of health among African-American women undergoing percutaneous coronary interventions. *Journal of Cultural Diversity, 15*(3), 132-42.

Kogan, M.D., Kotelchuck, M., Alexander, G.R., & Johnson, W.E. (1994). Racial disparities in reported prenatal care advice from health care providers. *American Journal of Public Health, 84*(1), 82-88.

Kreuter, M. W., & Haughton, L. T. (2006). Integrating culture into health information for African American women. *The American Behavioral Scientist, 49*(6), 794-811. Retrieved from http://search.proquest.com/docview/214764227?accountid=14872

Houston Department of Health and Human Services (2008). The city of Houston health disparities data report. Retrieved from http://www.houstontx.gov/health/disparity.pdf

Jacobs, E., Rolle, I., Ferrans, C., Whitaker, E., & Warnecke, R. (2006). Understanding African Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine, 21*(6): 642–647. doi: 10.1111/j.1525-1497.2006.00485.x

Johnson, B., & Christensen, L. (2004). *Educational research: Quantitative, qualitative, and mixed approache*s. Boston: Pearson Education.

Johnson, R.., Somnath, S., Arbelaez, J., Beach, M., & Cooper, L. (2004). Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine, 19*(2), 101-10. doi:http://dx.doi.org/10.1111/j.1525-1497.2004.30262.x

Krueger, R. A., & Casey, M. A. (2000). *Focus groups: A practical guide for applied research.* (2nd ed.). Thousand Oaks, CA: Sage.

Kreps, G. L. (2006). Communication and racial inequities in health care. *The American Behavioral Scientist, 49*(6), 760-774.

Kreuter, M. W., & McClure, S. M. (2004). The role of culture in health communication. *Annual Review of Public Health*, *25*(1), 439-455. doi:10.1146/annurev.publhealth.25.101802.123000

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.

Moustakas, C (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Medical Dictionary (2015). Health care provider. Retrieved from http://medical-dictionary.thefreedictionary.com/health+care+provider

Merriam-Webster (2014). Trust. Retrieved from http://www.merriam-webster.com/dictionary/trust

MMWR: CDC Health Disparities and Inequalities Report — United States (2013) Supplement / Vol. 62 / No. 3 November 22, 2013. Retrieved from http://www.cdc.gov/mmwr/pdf/other/su6203.pdf

Moustakas, C. E. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

O'Malley, A., Sheppard, V., Schwartz, M., & Mandelblatt, J. (2004). The role of trust in use of preventive services among low-income African-American women. *Preventive Medicine*, *38*(6), 777-785. Retrieved from http://dx.doi.org/10.1016/j.ypmed.2004.01.018.

Patton, M. Q. (2002). *Qualitative research & evaluation methods.* Thousand Oaks, CA: Sage Publications.

Perloff, R. M. (2006). Introduction: Communication and health care disparities. *The American Behavioral Scientist, 49*(6), 755-759. doi:10.1177/0002764205283799.

Polit, D. F., & Beck, C. T. (2008). *Nursing research: Generating and assessing evidence for nursing practice* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Prince, L. M. (2013). Self-perceived health care needs for African American women in street-level prostitution: Strategies for interventions. *ABNF Journal, 24*(1), 5-9.

QSR International (2015). NVivo 10. Retrieved from http://www.qsrinternational.com/products_nvivo_features-and-benefits.aspx

Rabiee, F. (2004). Focus-group interview and data analysis. *Proceedings of the Nutrition Society, 63*, 655-660. doi:10.1079/PNS200439

Reference.MD (2014) Communication barriers. Retrieved from http://www.reference.md/files/D003/mD003144.htmlhttp://www.reference.md/files/D003/mD003144.html

Rhoades, D., McFarland, Finch, W. & Johnson, A. (2001). Speaking and interruptions during primary care office visits. *Family Medicine, 33*(7), 528-32.

Royak-Schaler, R., Passmore, S., Gadalla, S., Hoy, M., Min, Z., Tkaczuk, K., & ... Hutchison, A. P. (2008). Exploring patient-physician communication in breast cancer care for African American women following primary treatment. *Oncology Nursing Forum, 35*(5), 836-843. doi:10.1188/08.ONF.836-843

Rudestam, K.E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process*. (4th ed.). Thousand Oaks, CA: Sage Publications.

Sadler, G., Ko, C. M., Cohn, J. White, M., Weldon, R., & Wu, P. (2007). Breast cancer knowledge, attitudes, and screening behaviors among African American women: the Black cosmetologists promoting health program. *BMC Public Health, 7*57-8. doi:10.1186/1471-2458-7-57

Seidman, I (2013). *Interviewing as qualitative research: A guide for researchers in education & social sciences.* (4th ed.). New York, N.Y.: Teachers College Press.

Siegel, M. & Lotenberg, L. (2007). *Marketing public health: Strategies to promote social change*. Sudbury, MA: Jones and Bartlett Publishers.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, methods and research*. Thousands Oaks, CA: Sage.

Smedley, B., Stith, A. & Nelson, A. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care.* Washington, D.C.: The National Academies Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Phenomemology procedures and techniques*. Newbury Park, CA: Sage.

Stewart, M. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian Medical Association Journal = Journal De L'association Medicale Canadienne, 152*(9), 1423-1433.

Street, Richard (2002). Gender differences in health care provider–patient communication: are they due to style, stereotypes, or accommodation? *Patient Education and Counseling*, 48(3), 201-206. doi.org/10.1016/S0738-3991 (02)00171-4.

Texas Best (2011). Houston geography. Retrieved from: http://www.texasbest.com/houston/geograph.html

Thabane, L., Thomas, T., Ye, C., & Paul, J. (2009). Posing the research question. Not so simple. *Canadian Journal of Anesthesia, 56*(1), 71-79. doi:10.1007/s12630-008-9007-4

The University of Texas of Public Health (2011). *Health of Houston survey: HHS 2010 a first look, Houston, TX*. Retrieved from https://sph.uth.edu/content/uploads/2010/09/HHS-8.5x11-Sep30_cover.pdf

Thompson, T., Dorsey, A., Miller, K. & Parrott R. (Eds.). (2003). *Handbook of health communication*. New Jersey: Lawrence Eribaum.

U.S. Census Bureau (2013). American fact-finder: Houston. Retrieved from: http://factfinder2.census.gov/faces/nav/jsf/pages/community_facts.xhtml

U.S. Department of Health and Human Services. (2012). *Minority women's health: African-Americans.* Retrieved from https://www.14womenshealth.gov/minority-health/african-americans/index.html

Wiltshire, J., Person, S., & Allison, J., (2011). Exploring differences in trust in doctors among African American men and women. *Journal of the National Medical Association, 103*(9), 845-51. Retrieved from http://search.proquest.com/docview/922054961?accountid=14872

Worobey, J & Angel, R.J. (1990). Poverty and health: Older minority women and the rise of the female-headed household. *Journal of Health & Social Behavior, 31*(4), 370-383.

Appendix A: Walden University IRB Approval

Gmail by Google

Melissa Shelton <melissa.shelton@waldenu.edu>

IRB Materials Approved - Melissa Shelton

2 messages

IRB <irb@waldenu.edu> Wed, Apr 20, 2016 at 6:44 PM
To: "Melissa Shelton (melissa.shelton@waldenu.edu)" <melissa.shelton@waldenu.edu>
Cc: Saran Wilkins <saran.wilkins@waldenu.edu>

Dear Ms. Shelton,

This email is to notify you that the Institutional Review Board (IRB) has approved your application for the study entitled, "Identifying Communication Barriers and Trust Issues of Black Women Seeking Preventive Health Services in Houston, Texas."

Your approval # is 04-20-16-0178165. You will need to reference this number in your dissertation and in any future funding or publication submissions. Also attached to this e-mail is the IRB approved consent form. Please note, if this is already in an on-line format, you will need to update that consent document to include the IRB approval number and expiration date.

Your IRB approval expires on April 19, 2017. One month before this expiration date, you will be sent a Continuing Review Form, which must be submitted if you wish to collect data beyond the approval expiration date.

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

If you need to make any changes to your research staff or procedures, you must obtain IRB approval by submitting the IRB Request for Change in Procedures Form. You will receive confirmation with a status update of the request within 1 week of submitting the change request form and are not permitted to implement changes prior to receiving approval. Please note that Walden University does not accept responsibility or liability for research activities conducted without the IRB's approval, and the University will not accept or grant credit for student work that fails to comply with the policies and procedures related to ethical standards in research.

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

Both the Adverse Event Reporting form and Request for Change in Procedures form can be obtained at the IRB section of the Walden website: http://academicguides.waldenu.edu/researchcenter/orec

Researchers are expected to keep detailed records of their research activities (i.e., participant log sheets, completed consent forms, etc.) for the same period of time they retain the original data. If, in the future, you require copies of the originally submitted IRB materials, you may request them from Institutional Review Board.

Both students and faculty are invited to provide feedback on this IRB experience at the link below:

http://www.surveymonkey.com/s.aspx?sm=qHBJzkJMUx43pZegKlmdiQ_3d_3d

Sincerely,

Libby Munson

Research Ethics Support Specialist

Office of Research Ethics and Compliance

Email: irb@waldenu.edu

Fax: 626-605-0472

Phone: 612-312-1283

Office address for Walden University:

100 Washington Avenue South, Suite 900

Minneapolis, MN 55401

Information about the Walden University Institutional Review Board, including instructions for application, may be found at this link: http://academicguides.waldenu.edu/researchcenter/orec

Shelton Consent Form.pdf

Appendix B: Recruitment Invitation Letter

Recruitment Invitation Letter

Date

Dear (Potential Participant):

My name is Melissa E. Shelton, a public health doctoral candidate student at Walden University, and I am working on my dissertation research study. The purpose of this study is to identify and explore communication barriers and trust issues of Black women when seeking preventive health services in Houston, Texas by utilizing a qualitative research design. The study will consist of one-on-one interviews to collect data. The participant criteria for this study are: 1) Black women, 2) 25 - 64 years of age, 3) minimum high school education, 4) works or previously worked in public health or health care profession, and 5) received preventive health services within the last 12 months.

You are invited to participate in a one-on-one interview, composed of open-ended questions that should last approximately an hour and a half long (90 minutes). The interview will be audio recorded to accurately reflect your ideas and input. The information discussed in this one-on-one interview session will not be shared with anyone. There will not be any identifying information included in the study reports. The files will be kept in a secured locked file cabinet and password protected electronic file. The dates, times, and locations are forthcoming. During this one-on-one interview, you will have the opportunity to share your views, opinions, and experiences on communication barriers and trust issues a Black woman may perceive to experience when seeking preventive health services. As a Black woman, your experiences and voice are critical in helping to provide a pathway to identify and understand the social implications of communication barriers and trust issues that may impact Black women's health.

If you have questions or concerns, please do not hesitate to contact me in regards to the study at melissa.shelton@waldenu.edu. I hope that you will be able to participate in this important research interview.
Thank you for your time and consideration.
Best regards,

Melissa E. Shelton, MPA, MCHES
PhD Candidate
Walden University

Appendix C: Recruitment Flyer

Please forward the invitation to individuals or post on your organization's bulletin board.

VOLUNTEERS NEEDED FOR RESEARCH STUDY

Phenomenology Qualitative Study

Recruitment: April 21, 2016 – April 29, 2016

The research is being conducted by a PhD candidate to identify and explore communication barriers and trust issues of Black women when seeking preventive health services in Houston, Texas.

The study's potential benefits of this study is to provide insight for addressing the perceive communication barriers and trust issues of Black women when seeking preventive health services in Houston, Texas.

Eligibility Criteria

- Black women in Houston, Texas (Metropolitan Area)
- Received preventive health services within 12 months
- Ages 25 to 64
- Minimum high school education
- English speaking
- Willingness to take part in a 90-minute interview (audio-recorded)
- Work or have worked in public health or a healthcare field

Procedure

Participants will be asked to:

- Read and sign the informed consent form that explains to the participant that this is voluntary.
- Complete a screening demographic survey approximately 5 minutes.
- Engage in a 90-minute dialogue (one-on-one) audio recorded interview composed of semi-structured open-ended questions perceived communication barriers and trust issues when seeking preventive health services.
- Review their interview typed summary provided via email or in person by the researcher, provide feedback, if needed, and signed the summary for validation.

Study Risks

Being in this type of study may involve some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress or becoming upset. Being in this study would not pose risk to your safety or wellbeing.

An incentive of a $15.00 gift card will be provided to the participant upon completion of the one-on-one interview study.

Individuals interested, please contact melissa.shelton@waldenu.edu.

Appendix D: Request for Organizations to Forward Invitation or Post to Bulletin Board

A Kind Request to Organization's via email to either forward the flyer via email or post to their bulletin board

(Please note: This request will be sent via email to organizations asking them kindly to forward the flyer via email to individuals who may be interested in participating and/or post the flyer to their bulletin board).

Date

Dear _____(Organization's Name)

My name is Melissa E. Shelton, a public health doctoral candidate student at Walden University, and I am working on my dissertation research study. The purpose of this study is to identify and explore communication barriers and trust issues of Black women when seeking preventive health services in Houston, Texas by utilizing a qualitative research design. The study will consist of one-on-one interviews to collect data. The participant criteria for this study are: 1) Black women, 2) 25 - 64 years of age, 3) minimum high school education, 4) works or previously worked in public health or health care profession, and 5) received preventive health services within the last 12 months.

This is a kind request to please forward the attached flyer to individuals who may be interested via email and/or post the flyer to your organization's bulletin board.

If you have questions, please do not hesitate to contact me in regards to the study at melissa.shelton@waldenu.edu.

Thank you for your time.

Best regards,

Melissa E. Shelton, MPA, MCHES
PhD Candidate
Walden University

Appendix E: Interview Guide

Interview Guide

Communication Barriers and Trust Issues of Black Women Seeking Preventive Health Care Services One-on-One Interview Guide:

Thank you for coming this afternoon / evening. This is a great opportunity for you to share your viewpoints, opinions and experiences in regards to the communication barriers and trust issues perceived by Black women when seeking preventive health services.

My name is Melissa E. Shelton and I will conduct the one-on-one interview. My role is to listen and follow-up on points that are made during the discussion.

This one-one-one interview will be much like an intimate conversation that is driven by semi-structured open-ended questions. This interview is an open dialogue which there is no right or wrong responses. I am interested in hearing your perspectives and experiences of communication barriers and trust issues perceived when you receive preventive health services within the last 12 months.

The information discussed in this one-on-one interview session will not be shared with anyone. Please remember that this interview will be recorded to accurately reflect your ideas and input. We will address each other by our first names written on the name tags. As mentioned in the email notification, there will not be any identifying information included in the study reports. The files will be kept in a secured locked file cabinet and password protected electronic file.

As a participant, you have agreed not to share any information discussed at study today. During this interview, it is important for you to speak loud enough and directly into the audio recorder. Do you have any questions before we begin?

Please introduce yourself by stating your first name only. I would like to talk about your experiences when you have received preventive health care services within the last 12 months.

Questions

Researcher Que: Be mindful to emphasize approaches to enhance communications and/or trust of your health care providers, after each experience discussed. Probe: How do you handle/deal with this?

Researcher: Throughout this interview, please feel free to ask questions if you need clarification. You are not limited to responding only to the questions I ask.

Discussion Topic 1) Black Women Beliefs and Culture

- Please share any type of beliefs, situations or an incident that your mother, guardian or a close female relative may have in regards to or experience when receiving preventive health services from her health care provider?

- Please describe how you define your culture and discuss whether or not you think a health care provider should have some knowledge or be familiar with your culture as it relates to your health? **Probe**: Discuss whether or not you think your culture play a role in the way you seek preventive health services?

Discussion Topic 2) Health Care Provider and Culture

- Explain how do you choose your health care provider when you are seeking preventive health care services? **Probe**: Describe the type of relationship you have with your health care provider?

- Think back on your last or most recent preventive health service visit, can you recall your health care provider asking questions about your family culture as it relates to your health (Hint: this is not your family medical history)? **Probe**: If so, please describe.

Discussion Topic 3) Communications Barriers

- Please describe how you communicate with your health care provider about your health information (Hints: Is it in person, at the doctor's office or medical facility? Email? Text Message? Voicemail?)

- Describe any type of communication barriers you perceive or experience when seeking preventive health services?

Discussion Topic 4) Patient and Provider Trust Issues

- Please discuss whether or not you trust your provider? If you do trust your health care provider, please explain why. If you do not trust your healthcare provider, please explain why not. **Probe: How do you handle/deal with this?**

- Please describe what a healthcare provider can do to gain your trust?

Discussion Topic 5) Approaches to Enhance Communication and Trust Relationships with Health Care Providers

- Please describe the types of mechanisms you feel comfortable using to enhance communications with your health care provider to reduce barriers when receiving your health information (Hint: open secured portal through website, in person, etc.)?

- Please explain what type of approaches will help you build or enhance a trusting relationship with your health care provider?

This is the end of the one-on-one interview questions. Do you have anything else that you would like to share? Do you have any questions?

The next step, this interview data will be transcribed. You will then be email the transcript for review and signed for validation. Upon analyzing the data, an information sheet will be developed to provide the research results in a responsible, respectful manner for dissemination to the participants.

Thank you for participating in this research study.

Appendix F: Demographic Questionnaire

Study: Identifying Communication Barriers and Trust Issues of Black Women Seeking Preventive Health Services in Houston, Texas

Demographic Survey

Please complete the following:

1. **What is your gender? (check one)** _____ Male _____ Female
2. **What is your age?_____**
3. **How do you identify your race/ethnicity?**

   _____ Caucasian or White

   _____ Black or African American

   _____ Asian/Pacific Islander/Native Hawaiian

   _____ American Indian or Alaska Native

   _____ Multiracial (please specify) _____

   _____ Some other group (please specify) _____
4. **Are you Hispanic/Latino?**

   _____ Non-Hispanic/Latino

   _____ Hispanic/Latino
5. **Are you currently employed?**

   _____ Yes

   _____ No

6. **What type of organization do or did you work for?**

   _____ A Public Health (Which type _____local, _____state or _____national)

_____ A Healthcare Clinic (Which type _____non-profit or _____for profit?)

_____ A Hospital (Which type _____non-profit or _____for profit?)

_____ A Health Care Provider (Which type _____non-profit or _____for profit?)

_____ Other (please specify) _____ (Which type _____non-profit or _____for profit?)

7. **What is your highest educational level?**

_____ GED

_____High School Education

_____ Associate's Degree

_____ Bachelor's Degree

_____ Master's Degree

_____ Doctoral Degree

_____Other (please specify_____)

8. **Did you receive preventive health services within the last 12 months?**

_____ Yes, please provide date_____

_____ No