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Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men

Lavetta W. Lopez
Walden University

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Walden University

College of Health Sciences

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Lavetta Washington Lopez

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Walden University
2019

Abstract

Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among
African American Men

by

Lavetta Washington Lopez

MSN, Walden University, 2009

BSN, Harding University, 1983

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

May 2019

Abstract

African American men are more likely to have diagnosed or undiagnosed diabetes than non-Hispanic White Americans and are less likely to adhere to treatment. Culture in the African American community plays a key role in how this community copes with illness and the health care system. The purpose of this study was to examine the lived experiences of social and cultural determinants of Type 2 diabetes self-management among African American men. Bandura's social cognitive theory provided the theoretical framework for the study. The research question sought to identify cultural and social factors that contribute or protect how African American men manage Type 2 diabetes. The study had a qualitative research design with a phenomenological approach. A purposive sample of 11 African American men ages 48 to 76 with Type 2 diabetes volunteered to participate in in-depth interviews. Interviews were audiotaped, transcribed, inductively coded, and analyzed for emergent themes using NVivo 12 software. Thematic analyses led to the development of 8 themes and 8 subthemes. The lived experiences of the participants were classified into personal factors (self-efficacy, knowledge, outcomes, expectations, and attitudes); environmental factors (modeling, social norms, perceived support, facilitation, dietary choices, and accessibility); and behavioral factors, which differed in terms of consumption, goal setting, and behavior toward health care. Positive social change implications of the study may include further education on disease management, recommendations to healthcare professionals, community stakeholders, and African American families on specific factors that can enhance knowledge, attitudes, and behaviors to improve management of Type 2 diabetes among African American men.

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Dedication

This work is dedicated to the loving memory of my brother, Bebly James Washington, Beb, as he was affectionately known by family and close friends. Beb was a wonderful brother and friend, and he was compassionate. He loved his family and always made sure that they knew that were loved. He was respected by his community as a leader, providing guidance and employment for those who needed it most. As one of the few African American men to graduate from Harding University with a degree in Business, he stressed the importance of education and/or trade. He affectionately greeted me with “What’s up Dr. Lopez.” He believed in me when I did not believe in myself. His legacy of love lives on in our family and community. He was a true example of bringing positive social change to the community in which he lived.

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I would like to acknowledge the following Walden faculty who have worked diligently and patiently with me. Dr. Mary Lou Gutierrez, my committee chair, not only shared her guidance and knowledge but also served as a life mentor who reminded me "if you want it, you got to work and get it." Dr. Jeanne Connors, my committee member, offered her expertise and insight regarding qualitative research.

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Chapter 1: Introduction to the Study

Introduction

Diabetes is the seventh leading cause of death in the United States and is a major cause of heart disease and stroke (Centers for Disease Control and Prevention [CDC], 2010). The age-race-gender-specific prevalence rate of diagnosed diabetes in the noninstitutionalized population is highest among persons 65 years and older and lowest among persons younger than 45 years of age (CDC, 2015). This age difference is regardless of gender and race, which includes people both from both Hispanic and non-Hispanic origins (CDC, 2015). In addition, the American Diabetes Association ([ADA], 2013) estimated in 2013 that people diagnosed with diabetes have 2.3 times higher medical expenditures than those without diabetes.

According to the ADA (2013), African Americans are disproportionately affected by diabetes, and 13.2% of all African Americans aged 20 years and older have diagnosed diabetes (p. 1). African Americans are also 1.7 times more likely to have diabetes as non-Hispanic Whites (ADA, 2013, p. 1). African Americans are significantly more likely to suffer from medical complications caused by diabetes (ADA, 2013) and have a higher likelihood of disability due to these complications, such as amputations, adult blindness, kidney failure, and increased risk of heart disease and stroke (CDC, 2016). The mortality rate among African Americans with diabetes is 27% higher than for Whites (CDC, 2016). Type 2 diabetes causes health problems as well as death due to complications, and the disease is very costly (ADA, 2013).

The purpose of this qualitative study was to explore and examine the lived experiences of social and cultural determinants of African American men and their self-management of Type 2 diabetes. Understanding the impact of cultural factors can assist with identifying and removing barriers that prevent this population from managing diabetes. While a few studies have been carried out in both qualitative and quantitative research designs to describe factors affecting poor diabetes self-management, most of the samples were among African American women. Little to no literature exists offering explanations or reasons as to why poor adherence to medical regimen exists in African American men. To understand the role cultural factors play in the management of Type 2 diabetes in this population, a qualitative study was designed using the social cognitive theory to gain insight into this behavior.

Background of the Study

According to the CDC 2014 statistical report, there are 29.1 million people in the United States with diabetes. Of those, 8.1 million are estimated to be undiagnosed (CDC, 2014, p. 1). The World Health Organization (WHO, 2016) defined diabetes as a chronic disease that occurs when either the pancreas is unable to produce Insulin, or the body is not able to efficiently use the insulin produced. The level of insulin production results in three types of diabetes that occur among individuals: Type 1 diabetes, Type 2 diabetes, and gestational diabetes. Type 2 diabetes or “adult onset” diabetes is the most common type of diabetes, and approximately 90% of the people who have diabetes have Type 2 diabetes (ADA, 2010). Type 2 diabetes is usually a result of excess body weight and poor physical activity (ADA, 2010). Type 2 diabetes makes it very difficult for the cells in the

body to use and absorb insulin. Within this population, African Americans have a higher incidence of and greater disabilities from diabetic complications (Twombly et al., 2010). Those complications include blindness and eye problems, kidney disease, and amputations (Twombly et al., 2010; National Health Institute [NIH], 2014). Hurt, Seawell and O'Connor (2015) confirm that "the risk of diabetes is more than twice for blacks than whites and the rate of complication is two to four times higher in blacks" (p. 1).

Looking even further into this facet of the population, African American males are one group that has been impacted by the increase of Type 2 diabetes. Compliance and adherence problems in the management of diabetes in this population are potentially related to cultural factors, demographics, and psychological issues as well as problems within the medical and health care community (Delamater, 2006). Even though African American men have 2 to 4 times the rate of renal disease, blindness, amputations, and amputation-related mortality compared to non-Hispanic Whites, there is little research on diabetes management for this population (Jack, Gross, & Troutman, 2010). Although diabetes Type 2 has been studied for years, Black men have not been adequately represented in these studies (Hurt et al., 2015).

Another major issue at play is the health care plans that have been, and in some cases have not been, used by the growing populace. In some places, African Americans continue to bear a disproportionate burden of the morbidity and mortality associated with diabetes (Liburd, Namageyo-Funa, & Gregg, 2004). Researchers have confirmed that limited research has been conducted on African American males and their management of Type 2 diabetes (Liburd et al., 2004). Due to this gap in research, little is known about

the impact this disease has on African American males' sense of self/understanding or lifestyle as well as how this disease affects their families and/or significant others (Liburd et al., 2004). Diabetes intervention programs have found that black men have “poorer outcomes than black women and men from other racial groups” (Hurt et al., p. 2). Due to the poor participation in the study by black men the outcomes of the study were limited (Hurt et al., 2015). Men often attribute their role in society as risk-taking, perceived invulnerability, and endurance for pain, and these attributes worsen poorer health outcomes, especially in self-care and management of Type 2 diabetes (Jack et al., 2010). While some of this research maybe dated, this is among the most up to date information on the topic. Further, this underlines the need for more research on this subject.

As shown in Figure 1, from 2004 to 2014, there was an overall increase in the rate of diabetes by gender and race. African American men and women had a higher rate of diabetes in 2004 (6.3%, 7.2%) compared to White men (5.3%) and women (4.9%). Although all four groups had increases in diabetes rates, African American women increased by 2.8%, with the highest prevalence at 10.0%. African American men rates increased by 1.8% to 8.1%. Unlike their African American counterparts, the gender pattern among Whites is higher for men (7.2%) than women (6.4%). While the rates of diabetes are lower among African American men compared to women, African American men are at higher risk of being hospitalized due to Type 2 diabetes.

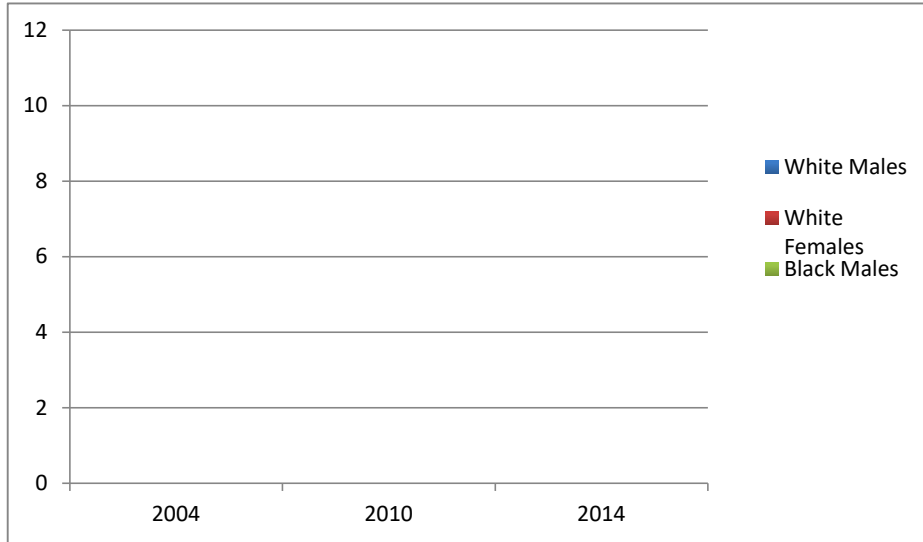


Figure 1. Rates of diagnosed diabetes per 100 civilian, noninstitutionalized population. (CDC, 2015)

Data from the CDC (CDC, 2015) indicated race differences in hospitalizations for uncontrolled diabetes and gender and race differences in hospitalizations for lower extremity amputations. African Americans are 5 times more likely (53.1%) than non-Hispanic Whites (11%) to be hospitalized due to uncontrolled diabetes (CDC, 2015). Adult men are 2.5 times more likely (24.5%) than women (10%) to be hospitalized for lower extremity amputations, a complication of long-term uncontrolled diabetes. African Americans with diabetes are 3.5 times (44.2%) more likely than non-Hispanic Whites (12.5%) to be admitted to a hospital for lower extremity amputations (CDC, 2015). Although African American females are the population with the highest rate of diagnosis, African Americans males are more likely to be hospitalized than their counterparts (CDC, 2015). African Americans also have a higher rate of complications such as renal disease,

amputations, blindness, and eye disease (Cabello et al., 2013; Twombly et al., 2010). This suggests that special attention needs to be paid to African American men with diabetes.

Problem Statement

The number of African American men with Type 2 diabetes is increasing, and management of this disease is poor (Liburd, Namageyo-Funa, & Jack, 2007; Sherman & McKyer, 2015). Compliance and adherence in the management of diabetes among African American men are potentially related to cultural factors such as body image, cultural competence, depression, educational level, fears, general family integration, and support (Liburd et al., 2007; Sherman & McKyer, 2015). There are other factors that also could have played a role in compliance and adherence to diabetes management such as health literacy, individual and social interaction, judgment and beliefs about the disease, knowledge about the disease, language, myths, nutritional preferences, other types of medicine (alternative), physical activity, quality of life, religion and faith, and socioeconomic status (Liburd et al., 2007; Sherman & McKyer, 2015).

Along with these cultural factors, there are problems with the medical and healthcare community, demographics, and psychological issues (Caballero, 2007; Delamater, 2006; Sherman & McKyer, 2015). Due to the dearth of research on racial/ethnic minorities and diabetes, little is known about how this disease impacts the sense of self-worth or understanding of African American men as well as its impact on lifestyle, and how the disease affects their families and significant others (George, Duran, & Norris, 2014; Liburd et al., 2007). According to Sherman and McKyer (2015), research regarding self-management of Type 2 diabetes among African American men has been

scarce. This study addressed the lived experiences related to social and cultural factors on the management of Type 2 diabetes among African American men. The study may fill the existing research gap in social and cultural determinants of diabetes self-management by describing the lived experiences of African American men. Past researchers have explored the relationship between diabetes and smoking, health literacy, and depression (Pan et al., 2010). However, African Americans also have a higher rate of complications such as renal disease, amputations, blindness, and eye disease (Cabello et al., 2013; Twombly et al., 2010).

Purpose of the Study

The purpose of this qualitative study was to examine the lived experiences of social and cultural determinants of Type 2 diabetes on self-management among African American men.

Research Question

What are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men?

Theoretical Base

The theoretical framework that guided this study was the social cognitive theory. The social cognitive theory provides insight as to why people have certain behaviors and why those acquired behaviors are maintained (Bandura, 2004). The theory assumes that their environment, others, and their own behavior affect a person's behavior pattern (Bandura, 2004). The concepts of the social cognitive theory include the physical environment as well as social support in that environment. The theory explores the

individual's perception of the environment, the expectations of the behavior, behaviors learned through observation, and assumptions about the individual's self-control (Bandura, 2004). Positive and negative reinforcement of behavior causes the behavior by the individual to continue or be discontinued based on the responses received from that behavior (Bandura, 2004). The social cognitive theory can be effective at improving self-management behaviors of patients with chronic diseases such as diabetes (Jang & Yoo, 2012).

Nature of the Study

The nature of this study was qualitative. Qualitative research is aimed at understanding how cultural factors influence behavior. The intent of the study was to examine the influence that cultural factors have on the management of Type 2 diabetes in African American males. I used a qualitative research design with a phenomenological approach in order to describe the meaning of the lived experiences of the selected population about a concept or phenomenon. The social cognitive theory guided the study, as it is an interpersonal level theory developed by Bandura that emphasizes the dynamic interaction between people (personal factors), their behavior, and their environments (Bandura, 2004).

The participants were recruited from three churches in Memphis, Tennessee. The data collection process consisted of 11 in-depth interviews with African American male participants. The study was open to African American males 18 years and older to talk about their lived experiences regarding diabetes management. As the investigator, I asked questions and took notes during each interview. With their consent, a digital recorder was

used to record each participant's responses. Qualitative data analysis involves identifying, examining, and interpreting patterns and themes in textual data, and this determines how these patterns and themes help answer the research question sought in the study (Creswell, 2009). NVivo qualitative data analysis software was used to analyze data collected.

Definitions of Terms

Adherence: Also known as compliance, this term describes the degree to which a patient follows medical advice (Farlex Partner Medical Dictionary, 2012).

African American: An American born person of African descent (Farlex Partner Medical Dictionary, 2012). It is a self-identified racial and cultural label.

Compliance: Conformity in fulfilling official requirements.

Culture: The beliefs, customs, and arts of a society or time.

Cultural factors: Beliefs, values, traditions, and ethnicity (such as family, languages, behavior, and religion) held by a group of people (D. James, 2004).

Education equity: A measurement of achievement, fairness, and opportunity in education.

Health literacy: The person's ability to obtain, comprehend, and "communicate" information about health (Bakers, 2006).

Manhood: The state or time of being a man or adult male person; male maturity. Traditional manly qualities.

Medical mistrust: A lack of assurance in the treatment and services provided by the medical community and/or systems as well as the information provided by these entities (Thompson et al., 2004).

Obesity: Excess amount of body fat (United States Department of Health and Human Services, 2012, p. 1).

Overweight: Refers to an excess amount of body weight that may come from muscle, bone, fat, and water (USDHHS, 2012, p. 1).

Perceived barriers: “The potential negative aspects of particular health actions” that may act as an obstacle to following recommended behaviors (Glanz et al., 2008, p. 47).

Self-care management: Medical care undertaken by the patient, after being given instructions by some doctor or other medical personnel (Mosby’s Medical Dictionary, 2009).

Type 2 diabetes: Also known as adult onset diabetes. The body is unable to use insulin properly, and this is called insulin resistance (ADA, 2016). The pancreas does not have the ability to make the insulin needed to keep blood glucose within normal limits or range.

Assumptions

There are certain assumptions present due to the type of research design of the study, which in this instance was qualitative with a phenomenological tradition as the approach. There was an assumption that the study participants would be honest and not say what they perceived I wanted but what they really felt. The second assumption is that

the management of chronic diseases, such as diabetes, is a struggle for African American men. The third assumption is that there is a correlation between cultural factors and the management of diabetes in African American males 18 and older. The fourth assumption was that there was also a correlation between social factors and the management of diabetes in African American males 18 and older. I used these assumptions to evaluate how much they were demonstrated through the experiences of the participants.

Scope and Delimitations

In this study, I focused on the relationship between cultural factors and the management of Type 2 diabetes among African Americans males 18 and older. The purpose of the study was to determine whether cultural factors influence how African American males ages 18 and older manage Type 2 diabetes. I also sought to determine whether cultural factors affect adherence to a diabetic maintenance regimen.

The delimitations of my study include the criteria that the population is African American, male, member of the participating churches, and ages 18 and older. My hope is to be able to generate more information for this racial group and subsequently generate more solutions. I chose to use a qualitative study instead of a quantitative one, knowing that I was sacrificing the opportunity to learn specifics as to which cultural factors had the most impact in individual case studies.

Limitations

According to Rudestam and Newton (2007), limitations of a study are defined as the restrictions in a study over which the researcher has no control. Limitations associated with qualitative studies are related to validity and reliability. Some of the limitations of

my study included sample size, length of the study, and methodology constraints. The study was open to African American men ages 18 and older with Type 2 diabetes. Those who volunteered to participate in the study were ages 48 to 76, and the findings may not be applicable to men of other ethnicities or in other geographic locations.

Significance

In this study, I aimed to understand the relationship between cultural factors and the impact those factors have on African American males and their ability to manage Type 2 diabetes. Diabetes is one of the most complex chronic diseases facing the United States and leads to major medical risks and complications in the African American community (ADA, 2014). According to Chow, Foster, Gonzalez, and McIver (2012), approximately 4.9 million (18.7%) African Americans have diagnosed or undiagnosed diabetes compared to 7.1 % of non-Hispanic White Americans. The risk for developing diabetes is 77% higher among African Americans than among non-Hispanic White Americans (Chow et al. 2012). The National Diabetes Statistics Report (2017) stated that “compared to non-Hispanic Whites, the age adjusted prevalence of diagnosed and undiagnosed diabetes was higher among Asians, non-Hispanic Blacks, and Hispanics during 2011-2014” (p. 2). The fastest growing ethnic group to develop diabetes is the African American male, with an estimated 363% increase from 2000 to 2050 (Boyle et al., 2001). Furthermore, in 2006, African American men were 2.2 times more likely to start treatment for end-stage renal disease and more likely to develop complications and have greater disabilities from complications than non-Hispanic White men with diabetes

(Chow et al., 2012; Grace, 2011). Some of the complications include amputations, kidney failure, blindness, and cardiovascular disease (Grace, 2011).

Understanding how the impact of cultural factors can help to reduce barriers that prevent this population from managing diabetes may assist in reducing health care disparities that exist among this population. Cultural factors can be an important part in understanding healthcare education. Culture can also affect how comfortable a population is with the way healthcare providers communicate information (Grace, 2011). Reducing and addressing factors that cause barriers to quality health and health care in the African American male population may help prevent or delay chronic diseases such as diabetes. Understanding how African Americans males view the relationship between cultural factors and the management of their Type 2 diabetes may help public health stakeholders understand how to address these factors and reduce barriers and misconceptions about management of this disease. This can be a contribution to the field of public health because it can promote a healthy population/society, reduce healthcare disparities, and lead to a reduction of the economic burden on society that the poor management of diabetes has caused. A healthy population can contribute to a healthy society and economy.

To better understand human and social circumstances, it is necessary to have positive social change (Walden, 2012). Understanding how African American men view the relationship between cultural factors and the management of their Type 2 diabetes may help public health stakeholders understand how to address these factors and reduce barriers and misconceptions about the management of this disease. Addressing the

relationship between cultural factors and the management of diabetes Type 2 in African American men can lead to changing health care outcomes in this population. This study can contribute to the field of public health because it can assist with promoting a healthy population/society, reducing healthcare disparities, and reducing the economic burden on society that the poor management of diabetes has caused. A healthy population can contribute to a healthy society and economy.

Summary and Transition

African Americans are more likely to be affected by the diabetes epidemic, not seeking health care, and suffering complications that put them at a disproportionate rate of hospitalizations and amputations. Overall, research on African American men with Type 2 diabetes is lacking. African American males are less likely to properly manage this disease. Through Bandura's social cognitive theory, I examined the lived experiences that cultural factors play on the management of Type 2 diabetes among African American men. In Chapter 2, I present an overview and synthesis of the literature review, applications of the theoretical framework, and review of methods used in qualitative research.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to examine the lived experiences of social and cultural determinants of Type 2 diabetes self-management among African American men. The focus of the search for literature was on articles written in English because it is the native language of the population studied. Key words and the specific search strategy may have resulted in relevant articles being omitted. In this chapter, I describe the literature search strategy as well as the theoretical framework, report on present and past data related to the study, explain key concepts (beliefs, ethnicity, family, tradition, languages, behavior, and religion) and their relationship to Type 2 diabetes disease management, and give a summary of the literature review.

Literature Search Strategy

The literature search was conducted electronically using the following databases: Google Scholar, MEDLINE, PubMed, CINAHL, Walden Library database, and EBSCOHOST. The following terms were searched: *cultural factors, management of diabetes, black and/or African American males and diabetes, diabetes education, self-efficacy, education, trust, self-care behaviors, self-management of Type 2 diabetes, beliefs about diabetes, attitudes about diabetes, and cultural competency/chronic diseases*. Recognized health organization websites were also used to obtain data and information. They were the American Association of Diabetes Educators, World Health Organization, CDC and the U.S. Department of Health and Human Services, and Office

of Minority Health. Articles up to 5 years old were preferred, but historical articles were also accepted.

Theoretical Framework

The theoretical framework for this study was the social cognitive theory. This theory provides insight as to why people have certain behaviors and why those acquired behaviors are maintained (Bandura, 2004). The social cognitive theory assumes that the environment and other people's behavior affect a person's behavior pattern (Bandura, 2004). The concepts of the social cognitive theory include the physical environment as well as the social support in that environment. The theory explores the individual's perception of the environment, the expectations of the behavior, as well as behaviors learned through observation and assumptions about the individual's self-control (Bandura, 2004). Positive and negative reinforcement of behavior causes the behavior by the individual to continue or be discontinued based on the responses received from that behavior (Bandura, 2004).

The social cognitive theory is also an effective theory to improve self-management behaviors of patients with chronic diseases, such as diabetes (Jang & Yoo, 2012). The three main factors that comprise social cognitive theory affect the likelihood that a person will change health behavior, and they include self-efficacy, goals and outcomes expectancies (WHO, 2012). The author of the social cognitive theory also proposed that individuals with a sense of self-efficacy are able to change their behavior even when faced with obstacles (Bandura, 2004). The social cognitive theory is based on "vicarious learning and promotes the idea that behavior is learned by observation,

imitation and positive reinforcement” (Raingruber, 2013, p. 58). The theory asserts that behavioral change is based on “environmental, social, personal and behavioral elements” (Raingruber, 2013, p. 58). The social cognitive theory defines the nature of the relationship among individuals and their environment along with reinforcing the importance of social support in changing behavior.

Bandura (2004) used the social cognitive theory to focus on health promotion and disease prevention. Social cognitive theory has specific core determinants that include knowledge, perceived self-efficacy, outcome expectations, health goals, and perceived facilitators (Bandura, 2004). Knowledge of health risks and benefits of different health practices create a prerequisite for change (Bandura, 2004). Perceived self-efficacy is the belief that a person can implement control over health habits while outcome expectation concerns the expected costs and benefits of different health habits (Bandura, 2004). Health goals are defined as goals people set for themselves. They are also characterized as the plans put in place to achieve a healthy lifestyle and include the perceived facilitators and social structural impediments that have the capability to either help or hinder achievement of this goal (Bandura, 2004). According to Bandura, to promote effective change in people, the individuals must have high-perceived efficacy for self-management as well as positive expectations that changes will bring about positive health outcomes. According to Glanz et al. (2008), the social cognitive theory focuses on “people’s potential abilities to alter and construct environments to suit purposes they devise themselves” (p. 170). People have the power to change their behavior and their environment.

Heydari, Dishtgard, and Moghadam (2014) studied the effect of Bandura's social cognitive theory implementation on 60 clients who had been referred to an addiction-quitting clinic for an opium dependency. Demographics, addiction-quitting self-efficacy questionnaires, and interventions were implemented using Bandura's social cognitive theory (Heydari et al., 2014). The interventions consisted of a 5-step program, with the first step being to provide information, the second being to inspire vulnerability (or fear), the third to cultivate social self-efficacy, and the fourth to promote the use of a social support system. The final step was simply a review of everything that they had learned and developed up to this point (Heydari et al., 2014). A 1-month posttest indicated that the test group was more successful in quitting their addiction than the control group, and a relapse was less likely in the test group. This was determined by using a paired *t* test, with the mean scores of the self-efficacy before and after the intervention used as the data source (Heydari et al., 2014). The test group also had a considerable difference between self-efficacy scores before and after the intervention (Heydari et al., 2014). Thus, the social cognitive theory appeared to be successful in the treatment of addiction (Heydari et al., 2014).

Cultural Determinants of Type 2 Diabetes

Cultural factors are defined as established beliefs, values, traditions, laws, and languages of a nation or society, and these factors can also include religious beliefs and ethnicity (Alarcon, 2009). To provide effective health care, promote self-management and self-efficacy, and promote change in attitudes and behaviors in populations, it is important that cultural factors be understood (Alarcon, 2009). Comprehensive

information can be obtained when there is an understanding of how language is acquired in a population, the role of religion and spirituality in the participants' lives, and an understanding of traditions, beliefs, and ethnicity. Understanding cultural factors assists with understanding the way people learn and how they process and use information. Prior life experiences and support networks are part of culture (American Association of Diabetes Education, 2015). The more invested individuals with diabetes have in their care, along with supporting members, the more likely they are to achieve desired outcomes and improve their quality of life (AADE, 2015).

Caballero (2006) conducted a study concerning Latino/Hispanic culture and diabetes along with social and cultural factors associated with Type 2 diabetes. The results showed that there was a great quantity of evidence that social and cultural factors such as “body image, educational level, fears, general family integration and support, health literacy, language, myths, and nutritional preferences, among others, may affect the success of physician patient relationship and influence patient’s adherence to treatment” (Caballero, 2007, p. 80). Caballero concluded that improving health care providers “cultural competency” might improve the quality of care to minority groups (p. 80).

Health Beliefs

While defining illness as a part of a population’s belief system, cultural factors have a significant impact on this system (Reimer, T.T, Choi, E. Kelley, Skemp, K., and Enslin, J.C. 2001), and, as such, it is necessary to delve deeper into what role they play in achieving a healthy lifestyle. According to Reimer et al. (2001), some members of

minority groups do not initially seek help for diabetes care because the disease symptoms are not readily identifiable. Patients do not seek help unless the condition affects social and personal life. Often these members fear seeking professional help (Reimer et al., 2001). One belief held by rural southern African-Americans is that “sugar or sweet blood” is caused by eating too much sugar and is made worse by stress and worrying (Reimer et al. 2001). As can be seen in this demonstration, the word *sugar* is used instead of diabetes to decrease the seriousness of the disease (Reimer et al., 2001). Instead of seeking medical attention, treatment of the disease is solely dependent on prayer, trusting in God, and using bitter foods and herbs (Reimer et al.. 2001).

Grzywacz et al. (2012) conducted a cross-sectional study on older adults (aged 60 years and older) with diabetes in rural North Carolina. The participants were equally divided by ethnicity (White, African American, American Indian) and gender ($N = 593$). The aim of the study was to improve understanding of the cultural basis for variations in diabetes beliefs (Grzywacz et al., 2012). Grzywacz et al. found that African Americans and American Indians with low education had consistently different beliefs about the causes of diabetes, comparative to Whites with low education and those with high education in all ethnic groups (. They concluded that when developing and implementing culturally appropriate diabetes education programs, educational attainment and ethnicity should be well thought-out.

Grace (2011) discussed ways to overcome barriers in treating African Americans. One of the beliefs held by many African Americans is that health care professionals cannot be trusted (Grace, 2011). Many times, questions posed by physicians and

healthcare staff appear intrusive, and patients do not understand why certain information is necessary (Grace, 2011). According to Grace, often times the responses to these questions (due to distrust and suspicion) are interpreted as opposition, and this in turn leads to a failure to understand and comply with treatment plans. Delay in seeking medical treatment can result in late diagnosis and start of treatment and care, which could cause greater difficulty in managing the disease, resulting in life threatening conditions (Grace, 2011). It is imperative, however, to note that these fears are not unfounded. Historically, mistreatment by the health care system has fostered and cultivated the vein of nontrust in the medical community (Grace, 2011).

The Tuskegee Syphilis Study conducted at the Tuskegee Institute from 1932 to 1972 by the U.S. Public Health Services involved 399 African American sharecroppers who were left untreated for syphilis to observe the natural course of syphilis in the absence of treatment (Grace, 2011). As a result, many African Americans distrust their health officials and physicians. The legacy of the Tuskegee experiment combined with the low representation of African Americans in clinical trials and routine preventative care is felt to contribute to the high number of untreated individuals in this community (Grace, 2011).

Cultural factors may also affect the population beliefs as to the roles of gender within that family or community. According to Liburd et al. (2004) and Sherman (2015), masculinity influences how African American men manage Type 2 diabetes. Liburd et al. conducted an exploratory study to look at and comprehend the psychosocial and behavioral perspectives of African American men with diabetes. Many of the study

participants described diabetes as a form of “social inequality that they could not escape and it was robbing them of their identity as proud, robust, sexual, independent, and invincible” (Liburd et al., 2004, p. 224). The men in the study associated this disease with “weakness,” and it was a challenge to their masculinity (Liburd et al., 2004). Liburd et al. concluded that greater understanding is needed regarding men and their perception of masculinity, health, and chronic diseases.

According to Matthew, Gucciardi, De Melo and Barata (2012), men are more concerned about diabetes constraining their lifestyles and affecting their provider roles. Men tend to be more private about their diagnosis of diabetes and are less likely to be observant of nutrition recommendations in social settings (Mathew, et al, 2012). The authors also found that men concealed their illness potentially due to the preservation of “traditional male values such as independence, autonomy, and ownership over decision making” (Mathew, et al, 2012. p. 8).

Successful self-management of diabetes can decrease as well as prevent complications caused by this disease, such as blindness, amputation, and renal disease. For people to take responsibility of their care it is important that barriers preventing management of their disease be addressed. Liburd et al. (2007) conducted an in-depth study to explore the experiences of African American men living with diabetes and challenges of self-management of the disease. The study was composed of 16 African American men who discussed their problems with diabetes self-management. The study concluded that gender identity is a key cultural factor that influenced health related behaviors. Liburd et al. (2007) discussed that the requirements for successful diabetes

self-management in African American men can be in opposition to the customary sex roles and learned behaviors of African American men (p. 550). Due to this conflict, there can be a tendency toward nonadherence to medications and poor glycemic control (Liburd et al., 2007). To assist African-American men with diabetes management, “health care providers, medical institutions, national men’s organizations, national diabetes organizations and the African-American community” will need to play a huge part (Liburd et al., 2007, p. 557).

Sell et al. (2016) conducted an integrative review to evaluate research that utilized Albert Bandura’s SCT in self-management programs for older adults with chronic diseases. In this study, chronic diseases are defined as “incurable, lasting longer than 3 months, as well as not confined to one specific age, sex, culture or economic status” (Sell et al., 2016). The authors evaluated current research to explore whether the core concepts of Bandura’s theory were used. The purpose of the review was to identify whether there were gaps in self-management research due to employing the social cognitive domain as well as to determine if incorporating the social cognitive domains in the future might improve self-management. The authors concluded that self-management in short term interventions show an improvement in outcome measures but more inquiry was needed, using larger sample sizes, population specific participants, and at risk populations. While researchers stated that demographic characteristics (education, gender, and race) and social support could be related to the development of chronic diseases, there were few studies in the integrative review that focused on these specific issues as sample characteristic in the older adult population (Sell et al., 2016, p. 219).

Rovner, Casten, and Harris (2013) conducted an observational study with the purpose of describing the associations between cultural beliefs that are common in older Americans and adherence to diabetes self-management behaviors. The study was comprised of 110 older African Americans with Type 2 diabetes. The participants completed surveys that assessed present and future time orientation, religiosity, and adherence to three components of diabetes self-management (physical activity habits, reading food labels, and blood glucose monitoring) (Rovner et al., 2013, p. 29). The authors found that older African Americans who are future oriented are more likely to engage in health promoting behaviors, whereas people who were present oriented were not. In their description of the link between religiosity and self-care, they were vague on the type of relationship present, asserting simply that there was a relationship. Rovner et al. concluded that cultural diversity within older African Americans may influence diabetes self-management behaviors and this could contribute to disparities in diabetes outcomes in high-risk populations. The biggest takeaway from this research is that cultural factors should be considered to prevent complications of diabetes (Rovner et al., 2013).

Race/Ethnicity

Diabetes places a huge economic burden on the health care system and the quality of life for the patients especially racial/ethnic minorities is poor (Chow et al., 2012). Racial and ethnic minorities have a higher occurrence of diabetes compared to whites due to disparities (Chow et al., 2012) and research has shown that the health care system is a

significant contributor to the health care disparities related to unsatisfactory quality care (Peek, Cargill, & Huang, 2007).

Peek et al. (2007) conducted an electronic database search to obtain studies of interventions published from 1985 to 2006 designed to improve diabetes care for minorities living with Type 2 diabetes. Articles pertaining to patient-targeted intervention were divided into a generic program and programs that were culturally tailored interventions. The study concluded that culturally tailored programs with interventions specific for that racial/ethnic group could improve diabetes health outcomes (Peek et al., 2007).

Zeh, Sandhu, Cannaby and Sturt (2013) conducted a systematic review of observational studies with the intent to identify as well as investigate cultural barriers as basis for improvement in care. 316 articles were obtained and only 22 were included in the review. The study concluded that cultural barriers could affect the “quality of life of ethnic minority groups with diabetes control, communication problems, religion, health literacy levels and beliefs about health and illness” (Zeh et al., 2013, p. 19). Reimer et al. (2001) concluded that ethnicity is a significant indicator of how people with diabetes are “perceived and treated by their family and how their family, in turn is viewed by their community at large” (p. 16). Ethnicity also has the potential to influence how the family communicates and interacts with health care providers (Reimer et al., 2001).

Family Support

Women are more likely to take the lead role in initiating healthcare interventions as part of the family support structure. A survey by Kaiser (2013) concluded that women

played a huge role in the management of health care needs for their families. Women's health is intimately connected to their roles as mothers, partners, and daughters (Kaiser, 2013). Many women also help manage their partners' health needs, and over one in 10 women are taking care of an aging or chronically sick relative, often a parent (Kaiser, 2013).

Miller and DiMatteo (2013) conducted a review on existing research about the impact of social and family support on treatment adherence in patients with diabetes. The study concluded that social and family support, when provided in positive interventions, could promote adherence in maintaining diabetes self-management in patients with diabetes. Diabetes programs that offer training to educate the patients and the support families provide techniques and tools to deal with stress, cope with issues, and promote self-esteem (Miller & DiMatteo, 2013). Family and social support promote relationships that assist the patient with maintaining dietary and self-management compliance (Miller & DiMatteo, 2013).

Powers et al. (2015) provided a position statement from the American Diabetes association which support the importance of diabetes educational programs "that address the patient health beliefs cultural needs, current knowledge, physical limitations, emotional concerns, family support, financial status, medical history, health literacy, and any factors" that may influence the person's ability to self-manage diabetes (p. 1372). The American Diabetes Association has elevated their stance on diabetes education. The association realizes that to treat this devastating disease, many factors must be addressed.

Chelsa et al. (2004) conducted a study to identify characteristics of family life that are linked to disease management in African American patients with Type 2 diabetes. In the study, which was comprised of 159 African American patients with Type 2 diabetes, three facets of family life were assessed. Three key dimensions of disease management were also assessed within the study. The family domains included structure/organization, worldview, and emotional management. The three-disease management dimensions were morale, management behaviors, and glucose regulations. The study concluded that the two strongest associations with disease management in African American patients was the family domain of emotion management and family beliefs, respectively, and that patient morale was related more with family context (Chelsa et al., 2004).

Language and Literacy

Diabetes is a chronic disease that requires patients to have effective self-management skills. Positive patient outcomes depend on the patient's ability to manage care. Diabetes education must be culturally appropriate and values, beliefs, customs and language must be understood (AADE, 2015). It is important to look at and address cultural influences on self-efficacy to motivate the patient to change behavior. For diabetes education to be effective for ethnic minorities then the material must be culturally appropriate and language must be addressed (AADE, 2015). Literacy level, along with a readiness to learn, must be assessed along with setting culturally appropriate goals, and ensuring that the patient understood the message as intended.

According to the AADE (2015), the first step in providing culturally sensitive and competent education involves health care providers being knowledgeable about the

populations they serve. Health care provider and patient must be able to communicate effectively. Campos (2006) conducted a search on English –language articles using the search terms prevalence, diabetes, Hispanic/Latino populations with diabetes mellitus. Findings revealed the importance of diabetes providers communicating effectively with patients and the importance in improving health literacy. Improving health literacy in patients can assist in improving healthcare outcomes and the patients are more likely to adhere to guidelines and in the end diabetes and its related complications can be reduced or even prevented (Campos, 2006).

According to a study conducted by Kirk et al. (2014), there is strong evidence indicating that “some health care outcomes disparities are due to ineffective patient-provider communication” (p.22). Kirk et al. (2014) conducted a study to assess whether clinicians considered the “impact of culture on diabetes management” (p. 22). Three hundred randomly selected patients’ age 50 years or greater were administered surveys, with a 51% response rate. African American participants reported varied understanding of what causes diabetes (Skelly et al., 2006) as reported by (Kirk et al., 2014). The African American patients showed a lack of understanding about Type 2 diabetes and its relation to their “health beliefs, nutritional practices, religious beliefs, and socioeconomic issues” (Gavin & Wright, 2007) as reported by Kirk (2014). The study pointed out that poor patient education regarding the management of diabetes can lead to poor treatment adherence and the patient’s health outcome. Effective communication is necessary in the management of this disease.

Lynch et al. (2014) conducted a study on sixty-one participants who were at random placed into an intervention or control group. The 6-month intervention with 18 group sessions focused on diet, physical activity, and peer support. The purpose of the study was to determine the effectiveness of an intensive community based group intervention program. The results showed that the interventions were effective in short-term diabetes education. The study showed that African Americans (high-risk population) achieved changes in lifestyles. The study showed that providing appropriate education and strong behavioral support, along with peer support, could be clinically significant in the reduction in hemoglobin A_{1c} (test to monitor how well blood glucose is controlled) (Lynch et al., 2014).

Hopkins (2017) concluded that the study done in May 2006 in the Journal of Health Care for the Poor and Underserved suggested that “poor or lack of physician support, as well as not perceiving the condition as serious and not having knowledge of how to treat diabetes contributed to higher rates of the disease”(p. 14).

Religion and Spirituality

Religion, medicine and healthcare are connected in one way or another for a long time (Koenig, 2012). Koenig (2012) conducted a comprehensive study to examine religion and spirituality in relation to mental and physical health. The study found that religious doctrines could influence decisions about health and health behavior and even promote better health behaviors. Those behaviors include less alcohol, cigarette and drug use, more activity that is physical, safer sexual practices, and a better diet (Koenig, 2012). It is very important to understand and assess patient’s beliefs, taboos and current

practices concerning conditions. The information obtained can be used to build a foundation for individualized care programs or treatments. Tripp et al. (2001) found that rural southern African-Americans used prayer, trusting in God and bitter foods and herbs to treat diabetes. Health care providers must develop trusting relationships with the minority population and use cultural sensitivity to assist with changing health care beliefs that are contrary to health care adherence. For example, using folk remedies instead of prescribed meds. Dixon (1997) also concluded that if churches and other organization participated in educational seminars about diabetes and healthier eating habits it would help the community to make healthier choices in their food selections.

Watkins, Quinn, Ruggiero, Quinn, & Choi (2013) conducted a cohort study using a cross-sectional design to examine the relationship among “religious beliefs and practices, social support and diabetes self-care activities in African Americans with Type 2 diabetes.” There were 132 participants mostly female involved in the study. Study results concluded that spiritual and religious beliefs and practices and social support in diabetes self-care activities were important (Watkins, et al., 2013). The study also found that spiritual and religious beliefs aided individuals in coping with stress and they provided support, confidence, and hope. Religious beliefs can also aide in social change.

Summary and Conclusions

Diabetes can cause serious and sometimes life threatening complications. African Americans are significantly more likely to suffer from blindness, kidney disease and amputations (ADA, 2014). Males in this group continue to be impacted by the increase of

diabetes Type 2. Compliance and adherence problems appear to be a major factor in managing this deadly disease in this population.

Cultural factors are defined as established beliefs, values, traditions, laws, languages of a nation or society and these factors can also include religious beliefs and ethnicity. The literature review suggests that cultural factors may affect beliefs based on gender roles within the African American family or community. Along with these cultural factors, research on masculinity indicates a strong influence on how African American men manage their Type 2 diabetes.

Overall, in the African American community there are major barriers to diabetes self-management. Previous studies appear to support the finding that social cognitive theory may have a positive effect on the management of Type 2 diabetes. The intent of this review was to synthesize the research literature on the relationship between cultural factors and the impact that those factors have on the management of diabetes Type 2 in African American males. Research literature was examined for the inclusion of African American men in research, with an emphasis on identifying cultural factors specific to inclusion and analysis of research approaches used. Implications of this study are that it offers comprehensive analysis of various points of concentration for how cultural factors relate to the management of diabetes Type 2 in African American men and identifies gaps in the knowledge base in this area. Chapter 3 describes the research design and approach to the study as well as details of the methodology.

Chapter 3: Research Method

Introduction

The purpose of this qualitative study was to examine the lived experiences of social and cultural determinants of Type 2 diabetes self-management among African American men. In Chapter 3, I describe the research design and rationale, role of the researcher, methodology, participant selection logic, instrumentation, procedures for recruitment, sample size, participation, data collection, data analysis, issues of trustworthiness, threats to validity, credibility, transferability, dependability, conformability, ethical procedure, research questions, and summary and transition.

Research Design and Approach

The research design of the study was qualitative with a phenomenological approach. A qualitative research approach is applicable because this type of study can provide details about human behaviors, emotions, personality characteristics, underlying values, beliefs, lived experiences, and assumptions (Choy, 2014). Qualitative approach inquiry is broad and open-ended, and it allows the participants the opportunity to discuss concerns that matter most to them (Choy, 2014). Participants could explain their feelings through answering open-ended questions posed by researcher. Open-ended questions allow the participants to provide the researcher with data that is descriptive and rich in nature and culturally grounded (Choy, 2014).

The study's qualitative research design and phenomenological approach allowed me to examine the cultural factors to understand whether these cultural factors affect the management of Type 2 diabetes among African American men. The qualitative

tradition selected for this study was the phenomenological approach (Creswell, 2013). Managing and living with diabetes is personal, and to understand the phenomenon and answer research questions, it is imperative that data that focus on lived experiences are collected. I conducted open-ended individual interviews. Open ended interviews allow the participants and the researcher the opportunity to have an open and free dialogue (Creswell, 2013). The phenomenological approach facilitated an accurate examination of the cultural factors and the role they play in the management of Type 2 diabetes. I developed an interview guide that was reviewed by a panel of two experts on qualitative research methods and Type 2 diabetes.

Research Question

What are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men?

Role of the Researcher

In this qualitative study, I assumed an active role of interviewer and observed the participants under study. I participated in data collection, taking field notes, recording and transcribing data, as well as conducting data analysis (Creswell, 2013). I had no predetermined hypotheses or expectations; instead, I started the process of data collection to develop guiding concepts. Due to the potential internal and external biases that may occur, expert panel members were enlisted to review the interview guide, and corrections to the interview guide were made based on their feedback (Appendix A). Expert panel members had a background on qualitative research on African Americans. A final interview guide was edited according to the feedback provided by the expert panel. The

interview guide consisted of open-ended questions that were focused on answering and understanding the “central phenomenon in the study” (Creswell, 2013, p. 163). The interview guide started with an icebreaker and then contained broader questions pertaining to the topic. Asking specific or probing questions allowed the participants to answer more in-depth with the opportunity to explain or expound on answers. Participants were selected through volunteer participation. I did not have a personal relationship with participants nor a supervisory or relationship of power over participants.

Prior to the interviews, I introduced myself and the title and purpose of the study. I then asked if I could answer any questions they may have and permission to tape and write notes during the interview process. Participants were then provided a copy of the institution informed consent where information about how confidentiality and anonymity would be maintained. The interview was digitally recorded, and notes were taken throughout the interview process. Probing questions were kept simple and short, allowing participants the opportunity think further about the topic and expand on their answers. I tried to remain attentive to the participants, keeping them on track. I cleared up inconsistencies through clarification.

Researcher Bias

Researcher bias can contribute to inaccuracy and lack of reliability of study outcomes (Regoniel, 2013). Researcher bias can happen when a researcher does something that favors or skews toward a certain direction (Regoniel, 2013). Bias can be purposeful or accidental. Researcher bias can be the result of poor methodology, such as not reaching saturation with the sample size from a given population (Regoniel, 2013).

Sometimes study results can be steered toward the position of the researcher. It is important for the researcher to maintain accurate data interpretation and never manipulate the results (Regoniel, 2013). To avoid this type of bias, I used an expert panel of evaluations in order to develop and implement an adequately prepared interview guide. Having open-ended interview questions for my in-depth interviews increased the participants' ability to express themselves the majority of the time so that I did not dominate the interviews. My dissertation committee chair reviewed each digital recording of the interviews as they took place to be able to provide immediate feedback on how I handled the interviews. Leading and lengthy questions can also lead to poor data collection (Regoniel, 2013). To further address poor data collection, it is important to convey to the participants how much of their time will be needed to complete the interview and how important it is that they participate fully (Regoniel, 2013).

To prevent the researcher and interviewer from forming bias toward the credibility of participants based on physical appearance and characteristics, the researcher and interviewer should focus on participants' responses (Regoniel, 2013). All participants received the same standard questions, especially as they related to demographics and research topic questions. I only varied the questions in cases of follow-up and clarification. If the participant refused to answer when the audio recording was on, written notes were taken while the recorder was turned off. Refusals to be audio taped during the formal part of the interview did not take place. However, many of the men interviewed felt more comfortable saying what they really felt after the tape recorder was turned-off.

Research bias was decreased or eliminated through the use of scholarly articles and data. More than one source of information was used to prevent biased data. One source may bias a study, so triangulation can assist in preventing this error. Triangulation refers to using three types of qualitative methods to obtain data, which can assist with reducing errors.

I was directly involved with the participants. Flyers were placed in African American churches in the city of Memphis, Tennessee. There was no conflict of interest, and no study participants were recruited from my place of employment. No monetary incentives were offered.

Methodology

Participant Selection

The study was conducted in Memphis, Tennessee, an urban metropolis and home to Tennessee's largest African American population. Participants were recruited from three of the largest African American churches. This population was selected for the study because little to no information exists on diabetes management and the African American male. Participation was voluntary. Memphis, Tennessee has African American communities with a high prevalence of diabetes. Prior to posting information about the study, I met with the pastors of each congregation and attended several services with members from each congregation. At the church services, I explained the intent and purpose of the study I was conducting. The sample was selected from the participants responding to information about the study posted on flyers within the selected African American churches. Participants who met the inclusion criteria signed the consent form.

Participants were able to give consent for participation and were able to verbalize experiences of self-management of Type 2 diabetes. Although the majority of those with Type 2 diabetes are older than 40, to be inclusive of age, the study's inclusion criteria allowed those 18 years and older to be in the study. The study screening criteria was also inclusive of older adults 65 years of age and older because diabetes incidence increases with age and their participation was relevant to the research study.

Sample Size

The number of participants used in a qualitative study is not subject to such stringent rules as a quantitative research design but is based more on what the researcher is interested in trying to understand and explain. My purpose was to understand and explain the meaning and lived experiences of the study population's (African American men) perceptions about managing their Type 2 diabetes. According to Walden (2017) and Creswell (2013), the sample size rule of thumb for phenomenology studies is ≤ 10 . Sample size in qualitative studies depends on what is needed to obtain saturation or identification of consistent patterns (Creswell, 2013; Walden 2017). Saturation is achieved with data collection or when the collection of new data does not yield any additional information about the phenomena being studied (Creswell, 2013). I recruited 11 participants, and all participants completed the study.

Instrumentation and Operationalization of Constructs

Based on the literature and general techniques for developing qualitative instruments, I designed a new interview guide for this study. The interview guide protocol was used as the strategy of inquiry for collecting data. Expert panel members

reviewed and critiqued the interview guide. The protocol for the interview process included location of the interview, time of interview, date of interview, identifying the participants by number, and introduction to the study. The interview guide was semistructured with 10 lead questions and several probes (Appendix B).

Interview Guide

Instrument development and expert panel. I developed the interview instrument and requested a panel of researchers with expertise in phenomenology and research on African Americans with diabetes to critique the reliability and validity of the instrument. The expert panel was given a structured evaluation form (Appendix A) to rate validity and reliability. Validity included ratings on instrument construction, content validity, construct validity, face validity, item bias, and consequential validity. The evaluation form also included ratings on reliability, which included internal consistency and potential for reliability. The expert panel members could check one of three rating categories: Yes, No (if no, please explain), and Yes provided the following actions are taken. Thus, there was ample availability for the expert panel members to provide specific suggestions for changing the wording of questions or probes or to indicate the type of reliability and validity that was missing. In support of content validity, further revisions were made based on the critiques from two expert panel members. The revisions were made to address clarity and wording.

Study protocol. The protocol consisted of instructions for entering the specifics of the time and location of the interview and the study identification number of the participant and interview. The protocol also consisted of five invitational questions where

participants were welcomed and thanked for their participation, and the duration of the interview session was confirmed. In addition, there were five questions pertaining to why the research was being conducted, how the data would be used, and how the data would be kept confidential and in a safe location.

My dissertation chair and I reviewed the interview guide numerous times, and with the input from the expert panel members, some of the wording of the interview guides was changed as well as the format of the guide. Part II is the semistructured interview guide. Probing questions were developed as open-ended questions to encourage the participant to give complete meaningful answers, which revealed the participants' own knowledge as well as feelings.

Procedure for Recruitment and Data Collection

Participants were purposefully recruited because of their racial background, age and diagnosis of Type 2 diabetes. Informed consent was obtained from the participants and the purpose of the qualitative study was again provided. I explained to the participants that the purpose of the study was to explore the social and cultural lived experiences that determine management of Type 2 diabetes among African American men. That the data collected may be used to help health care professionals and professional health care decision makers develop and implement culture-based tools to assist African American men with managing Type 2 diabetes.

The participants were told that the information in the study would be confidential. I explained to the participants that they would be asked approximately 10 questions and they would be digitally recorded. The interviews lasted approximately 60-

90 minutes. The interviews took place at a church conference room or a designated area in the church. The interview process was risk free and participants were told that they could decline any question that made them feel uncomfortable or were sensitive. All measures were taken to protect the participants' privacy and all responses were kept confidential. The participants were told that they could withdraw from the study at any time. Participation was voluntary and no payment for participation was provided. Refreshments were provided for the participants.

During the data collection in-depth interview, a digital recorder and note pad were used to collect lived experiences from the participants. An interview guide was utilized to ask participants questions and the participants were provided ample to time to answer the questions in their own words. To ensure consistency each participant was asked the same questions in equal sequence. The participants were provided ample to time to answer the questions in their own words. The interview guide was followed to ensure that the list of qualitative questions and topics were completely covered. Follow up questions as well as probing questions were asked to obtain rich data and answers to research questions. The interview guide was followed to ensure that the list of qualitative questions and topics were covered. Follow up questions as well as probing questions were asked to obtain rich data and answers to research questions.

Data Analysis

Data analysis in qualitative research involves preparing and organizing data, then reducing the data into themes. According to Creswell (2013, p. 180), themes are arrived at through a method of "coding and condensing the codes and presenting and

making comparisons in the data.” Data analysis involves organizing data; describing, classifying, or categorizing data, and then interpreting data into codes and themes (Creswell, 2013). The data created by qualitative methods yield a very large set of transcriptions and the use of programs; NVivo 12 assisted greatly with data management.

Once data collection began with the first participant, recruitment efforts were constant until all participants were interviewed. The words of the participants were transcribed to make sense of the participants’ perceptions of what are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men. Colaizzi’s (1978) seven steps of analysis for phenomenological studies were followed. The steps included the following:

Step 1: Transcribing data. I transcribed each participant’s interview from the digital recording. I listened to each of the participant’s recording three to four times as I transcribed. After transcribing the data, I then took the hard copy of the transcript and followed along with the audio recording to make sure that nothing was missing. I transcribed the data as stated by the participants, being careful not to interject my feelings regarding past or present literature. The goal of transcription was to capture the lived experiences of the participants feeling regarding the study.

Step 2: Extraction of significant comments. Each transcription was carefully read, and comments associated with the participant’s phenomenon of interest under investigation were extracted (Colaizzi, 1978). NVivo 12 the qualitative software was used. Using the research question posed in the study, I extracted significant statements from each participant’s transcription that had significance to the study question. Verbatim

quotes from the interviews supported the significance of the statements to the research question.

Step 3: Verbalizing each participant's significant statement or comment. In this step, the meaning of significance statements made by the participants were composed. Significant statements were coded using the bottom up approach; none of the codes were prearranged. The themes emerged from the data.

Step 4: Grouped the meaning into themes. I used the auto theme function from NVivo 12 to categorize the participants' responses into nodes. Themes and subthemes were identified as a result of this process.

Step 5: Researcher writes an exhaustive description. Results were writing up in a complete and all-encompassing description of the phenomenon and this include verbatim statements, expressed meanings, nodes, themes, and subthemes of the study (Colaizzi, 1978).

Step 6: Researcher validates exhaustive descriptions with the participants. I visited with each participant after their interview and played each recording, and reviewed field notes taken to ensure clarity of data and to validate data.

Step 7: Researcher confirms no new data. In this step, the researcher is confirming that no new data was revealed during validation of the findings (Colaizzi, 1978). Validation of the findings was done as I compared the findings with the participants' descriptions of their experiences with managing their Type 2 diabetes.

I arranged the data to develop nodes that were connected with emerging patterns and thoughts. In order to provide validation of data analysis. Themes are patterns that

recur and are important to the narrative of an experience and are associated to a specific research question. NVivo 12 is the tool used for data management. This software is used to test theories and identify trends. NVivo 12 has been used previously in many qualitative studies and although it is a very tedious process, there have been no reported problems with it. The process of data collection begins with hand-written notes and audio recordings of interview sessions. These data were then downloaded to the NVivo software on my computer. All the audio recordings were imported into NVivo in the chronological order of their retrieval. Each participant's recorded session was placed in individual audio electronic files.

Research Question

What are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men?

I used thematic analysis in this qualitative study. Thematic analysis is a simple way of organizing qualitative data in a way that extracts the themes noticeable in a "text at different levels" (Stirling, 2001). The three classes of themes are a) basic themes, b) organizing themes and c) global themes (Stirling, 2001). Working from the inside out, global themes is the starting point. These themes are the overarching metaphors that provide the basis for the research. Underneath this umbrella lies the organizing themes that are organized by clusters beneath like metaphors. The lowest level, the basic themes, act as belief statements that help to explain the encompassing motifs.

Issues of Trustworthiness

To provide validity to the research findings, different types of sources were used to assist with providing documentation of codes and to provide or “shed light on a theme or perspective” which is called triangulation (Creswell, 2013, p. 251). An external check of the research was conducted through peer review and researcher’s bias is disclosed at the onset of the study (Creswell, 2013, p. 251). Expert panel members reviewed the research interview guide. The two expert panel members were emailed the “Walden’s Expert Panel Review Form” (Appendix B) to complete after reviewing and examining the research guide for instrument construction, content validity, construct validity, face validity, item bias, consequential validity, internal consistency, and potential for reliability. Both expert panel members provided written feedback and one expert panel member also followed up with phone discussion.

The feedback from the first expert panel member, a qualitative senior faculty in nursing, was excellent, and she recommended that I pay close attention to the question being asked under item bias. The questions asked, “Does the wording or placement of an item avoid affecting someone’s response”? The expert panel member stated no because she suggested that the ‘yes-no’ questions could be reworded to more open-ended questions. For example, “How do you feel about the instructions that health care professionals have given you to manage your diabetes? After participant responds, you could ask, “Were the instructions specific enough to help you?” Depending on response, ask participant to explain their yes or no response. Based on the excellent advice of this

expert panel member, the interview guide was revised to ensure questions were open-ended and allowed participants the opportunity to elaborate.

The evaluation of the second member of the expert panel, a community school health nurse director, was conducted over the telephone and followed with a written evaluation. She expressed the importance of not making questions too long. She suggested that questions be more open-ended with probes asked when the participant needed the opportunity to express their lived experiences in more detail. She also provided information about practicing audio taping interview questions to make sure voice projection was good, and time limits were adhered to. All of the experts' feedback was used to improve the instrument.

Ethical Procedures

Permission was obtained from three large African American churches to post study flyers. An invitation to participate in the study was made requesting participation from the facilities, and or members. The invitation included the name of the study, the purpose of the study, and use of study information and results.

An IRB approval was obtained through Walden University. Participants were assured that participation was voluntary without coercion and that they could withdraw from the study without any pressure. Prior to signing consent forms, I made sure that each participant understood their role in the study, how information would be used, how information would be stored, and who would see the information. All data pertaining to the study will be maintained in a lock storage for five years (Walden, 2011). I explained how all audio taped, written, and observation (verbal/nonverbal) data would be

documented. Participants were assured that all data written, spoken and observation data/notes would be confidential. Participants were told that their identities and information would be kept private and confidential in a safe place and only shared with professors. Finally, I assured the participants that they would be treated with dignity and respect regardless of opinions, and beliefs. Participants did not receive compensation for their participation. Refreshments in the form of water, juice, and snacks were available. The IRB number for this study was 03-07-18-0069150.

Summary and Transition

In Chapter 3, I described the process of developing the interview guide for this qualitative design study and followed the phenomenology tradition as the approach. The interview guide was newly developed and reviewed for reliability and validity by an expert panel of qualitative researchers with experience conducting research among African Americans and diabetes. The guide consisted of five personal factors, three behaviors, and two environmental factors in order to deductively obtain the lived experiences of how African American men manage their diabetes. The sample consisted of 11 African American men recruited and interviewed at three of the largest African American churches in Memphis. In addition to specific procedures for recruitment and screening of participants, this chapter also includes the procedure for thematic data analysis using NVivo 12.

Chapter 4 includes an introduction, setting of research, demographics, data collection, data analysis, evidence of trustworthiness, results, and summary.

Chapter 4: Results

Introduction

The purpose of this qualitative study was to examine the lived experiences of social and cultural determinants of Type 2 diabetes self-management among African American men. Understanding the impact of social and cultural factors can assist with identifying and removing barriers that prevent this population from managing diabetes. I conducted this study to determine the lived experiences of social and cultural factors on the management of Type 2 diabetes among African American men. I used in-depth interviews to gather data for the study. In Chapter 4, I describe the characteristics of the participants, data collection, data analysis, discrepant cases, evidence of trustworthiness, and summary and transition statement to Chapter 5.

Population and Setting

I selected the target population from three of the largest African American churches in Memphis, TN. The sample was self-selected from church members who answered announcements about the study from flyers distributed in the churches, met the inclusion criteria, and signed the consent form. To be inclusive of age, the study was open to African American men ages 18 and older. This included elderly individuals 65 and older because the incidence of Type 2 diabetes increases with age, and their participation was relevant to the research study. Denial of participation of individuals 65 and older is discrimination and unethical. Face-to-face interviews were conducted in a church setting. The areas provided by the church were safe, comfortable, and personal.

As far as personal or organizational conditions that might have affected participants at the time of this study, nothing was observed or mentioned during the interview process.

Characteristics of Participants

The sample of participants consisted of 11 African American men with Type 2 diabetes living in Memphis, Tennessee. The demographic characteristics for the 11 participants interviewed are presented in Table 1. Nine of the participants were married, one single, and one lived with a partner. The age of the men ranged from 48 to 76, and the mean age was 63.18 years. The duration of the interviews ranged from 11 to 99 minutes, with an average interview lasting 31.18 minutes.

Table 1

Participant Demographic and Interview Characteristics

ID	Married, single, or partner	Age in years	Interview site	Interview time
P1	Married	65	Church 2	11 minutes, 20 seconds
P2	Married	64	Church 1	19 minutes
P3	Married	67	Church 2	99 minutes
P4	Partner	48	Church 3	60 minutes, 6 seconds
P5	Married	76	Church 3	20 minutes, 7 seconds
P6	Married	63	Church 1	29 minutes
P7	Single	60	Church 3	29 minutes, 53 seconds
P8	Married	58	Church 3	15 minutes, 49 seconds
P9	Married	72	Church 1	32 minutes, 15 seconds
P10	Married	52	Church 2	11 minutes, 1 second
P11	Married	70	Church 1	17 minutes, 44 seconds

Data Collection

Because I had limited experience as a researcher in conducting qualitative interviews, some training was required by my dissertation mentor. Training was in the

form of leading an interview and modeling how to engage the participant and gain their trust, paying close attention to opportunities to probe and clarify, and listening to the interview recordings within 2 days and providing feedback. The following interview protocol was used in each session with all participants: (a) The consent form was read, discussed, and reviewed with participant; (b) the participant signed the consent form that provided permission to audio record and take field notes of the session; (c) the invitational portion of the interview guide was reviewed with the participant; (d) the face-to-face in-depth interview was performed. The initial proposed interview time stated in the consent form was projected to last 60 to 90 minutes. Each participant was given the option to end the interview at any time during the session without any consequences.

Each of the interviews was conducted at one of the selected churches involved in the study after initial phone contact with the participant to set up interview. With the permission of the participants, I digitally recorded each interview as well as took field notes. All interviews were conducted in English (part of inclusion criteria). All topics were covered with each participant, and open-ended questions were used along with occasional probing questions as needed (Appendix B). The use of open-ended questions allowed the participants the opportunity to discuss and elaborate on the topics that were important to them. I recorded each interview session with a hand-held digital recorder. Credibility was enhanced by replaying the tape interview for the participants as well as reviewing field notes to ensure that I was capturing the lived experiences of what they had said and to check for accuracy and obtain validity. The data obtained from the audio tapes (transcripts) were uploaded to NVivo 12 software for thematic analysis.

The digital recordings and transcribed files were transferred and uploaded to my personal computer (hard-drive) using a password protected code. The hard drive along with personal computer is locked in my office. In compliance with the IRB, all the data will be maintained for 7 years in a locked file cabinet after the study is completed. Once the study is completed, the data linking the participants to the study will be destroyed by deleting all electronic copies from computer files and computer trash can.

Nine of the 11 participants were able to make the appointment initially scheduled. Two of the participants required multiple rescheduling of appointments because of their personal schedules, but once they arrived at the designated area, the interview was completed. Factors that may have influenced general scheduling of the interviews included the availability of participants due to work schedules and other personal responsibilities and commitments the participants had.

Two unusual circumstances were encountered during the data collection process. One circumstance was that many of the participants appeared to be in a rush although they committed to the initial time allowed of 90 minutes for the interview. The second unusual circumstance that occurred during one of the interviews was that one of the participants (P5) was interviewed outside on the church grounds because the church electricity went out during the interview. The building was dark, and it was still light outside with a summer breeze. The interview was moved outside because the participant did not want to move to a secondary location and wanted to be interviewed outside. We moved two chairs outside (no one was around), and we completed the interview. Upon completion of each interview session, participants were offered snacks, water, and the

guarantee that after the completion of the study, each participant would receive a copy of the results.

Data Analysis

The process of data analysis starts at the beginning of each interview. Sutton and Austin (2015) wrote that qualitative studies “seek to convey why people have thoughts and feelings that might affect the way they behave” (p. 226). Creswell (2013) described the steps of data collection in phenomenological studies as epoch or bracketing, listing significant statements retained from the data and combining the statements into themes. Bracketing or epoch is a method used in qualitative research to decrease the effects of those factors that may cause the research process to be tainted, for example, factors such as personal assumptions and feelings. Uncovering the meaning of lived experiences for each participant is the responsibility of the researcher. I had the opportunity to think and reflect on my research study and to put aside my own perspective and assumptions about the research topic. The overall goals were to have an open mind and dialogue with the participants, recognize assumptions, and set aside prior knowledge in an effort to enhance the data collection process.

In order to ensure that I followed the principles of phenomenology and produce concise and comprehensive descriptions of the phenomena under study according to how the participants created it, I followed the guiding principles of Colaizzi (1978). In Step 1, the researcher reads the transcriptions as many times as needed to get familiar with data. The interviews are transcribed during this step. I transcribed each of the participant’s recordings (interviews). After transcribing the data on the tape, I relistened to the

recording and followed along with the transcribed data to double check for accuracy. I made sure that I did not interject my feelings into the recordings and transcribed them as stated by participants. I also wanted to ensure that I was capturing the experience of the participants. Listening to the audio interviews and while transcribing the recordings, I had the opportunity to be an active listener. Transcribing and taking notes during the interview provided the opportunity to become more familiar with the participants' lived experiences and their data as a deductive process.

In Step 2, it is important for the researcher to identify important statements that are relevant to the experience under exploration (Colaizzi, 1978). I read each transcript with awareness to ensure that the significant statements that were directly associated with the phenomenon of interest under exploration were extracted (see Colaizzi, 1978). The statements that had significance to the research question were identified by the software. The statements that had significance were confirmed by word-for-word quotes from the interview. This improved the accurateness of the interpretations. NVivo 12 is a computer assisted data management tool designed to manage qualitative research data (QRS International Ltd., 2018). Researchers use the software to facilitate determining codes and themes. Prior to uploading the 11 files into NVivo 12, each participant's data were recoded again for anonymity (double coding). The transcription data were uploaded into NVivo12, and a new project in the data management tool was created within NVivo 12.

In Step 3, meanings are formulated. This is the stage where the researcher effectively communicates the meaning of each significant statement (Colaizzi, 1978). In this stage, interpretation from significant statements disclosed by the participants were

formulated as they related to the constructs of the social cognitive model (personal, environment, and behavior). Significant statements were coded into themes using nodes into NVivo 12. I allowed the themes to occur from the data by using a bottom up approach, which allows the codes to be created rather than having an already arranged list of codes.

Thematic analysis is a simple way of organizing qualitative data in a way that extracts the themes noticeable in a “text at different levels” (Stirling, 2001). According to Braun and Clark (2006), a “theme is something that is important to data in relation to the research question and it represents some level of a patterned response” (p. 82). Creswell (2007) stated that “codes can emerge not only as expected patterning, but also what you find to be striking, surprising, unusual or conceptually captivating” (p. 153). NVivo was used to move inductively from coded units to larger representations, including categories and themes.

In Step 4 of Colaizzi’s (1978) descriptive phenomenological method, the researcher groups the meaning into themes. I used the auto theme function from NVivo to categorize the participants’ responses into nodes according to the interview questions. Each thought and feeling pertinent to each participant’s experience was examined for its connection to the purpose statement and the research question of the study. Themes and subthemes were identified as a result of this process.

In step 5 of Colaizzi (1978) method, the researcher writes an exhaustive description. Results were writing up in a complete and all-encompassing description of

the phenomenon, including all the themes created in step 4. These include verbatim statements, expressed meanings, nodes, themes, and subthemes of the study.

In step 6, the researcher validates exhaustive descriptions with the participants to ensure that aspects that are demanded to be crucial to the structure of the phenomenon are captured (Colaizzi, 1978). I visited with each participant after their interview and played each recording, and reviewed field notes to ensure clarity of data and validate data.

In step 7, the researcher asks the participants if the data obtained captures their experiences. In this step, the researcher is confirming that no new data was revealed during validation of the findings (Colaizzi, 1978). Each participant was debriefed after listening to the audio tapes and the written field note and there were no modifications needed based on participants feedback.

NVivo 12 software was used to condense the collected phenomenological data (transcripts). Once the data was coded and condensed the NVivo analysis software program reduce the coded data into themes. Using an output of words, it formed a word cloud, a visual representation that represented the number of times the words emerged in answers to open-ended questions from the interview guide. The size of the word was a representation of the frequency word was used. The larger the word in the word cloud for a particular question the higher the level of the words used by the participants. I performed a preliminary grouping of all expressions that were pertinent to the interview and research question of the study. The grouping was conducted by reviewing all the responses and classifying applicable information. Additional nodes were created as themes developed through both word frequency and data review (Table 2).

Table 2

Nodes Derived From Transcripts and Mapped to Themes

Nodes	Themes
Information sharing between Support of family, friends, church	Role of the Black women Family and social cohesion Manhood
Independence verses autonomy Switching from fried to bake	Dietary changes
God gives strength Black men eat certain foods	Role of religion Manhood
Payoff to managing disease Fear of needles, pills fixable	Living well Education
Reaction to initial diagnosis	Life-death sentence

Invariant constituents were performed by grouping themes. These themes were cross-referenced with the participants complete interview record, to create a description of participants' perception on their experience with managing Type 2 diabetes. Each expression was checked for its relationship to the invariant constituents, as well as to both the purpose statement and research questions of the study.

Discrepant Cases

Discrepant cases refer to data contradicting or opposing emerging patterns of the study. A discrepant case is one in which a participant's experiences or views differ from the main body of evidence. In qualitative research, many times the data can present or provide many potential aspects of a study. This should not be a hindrance because this can allow for detailed and precise analysis (Hslung, 2010). Inconsistencies in the data cannot only give rise to things that are unexpected but, in many ways, can strengthen theories (Hslung, 2010). Several of the participants lived experiences or viewpoints differed when it came to education, family, doctors, and foods.

All the study participants agreed that education regarding diabetes management was available to them and they stated that they had access to diabetes care. One of the participants (P07) stated that the disease was “too expensive and impossible to afford”. Two of the participants (P03, P11) felt that poor diabetes management was due to the lack of people taking responsibility for their disease. One of the participants (P07) did not feel that family or friend support was necessary, but diabetes was a disease that you handled alone. One participant (P06) felt that the physicians at the clinic (the only participant whose primary physician was clinic-based) was “not totally on board with his care”.

Discrepancies may exist because some of the participants did not know whether diabetes was in their family medical history. The participant (P07) who felt that the disease was too expensive to manage did not complete nutrition management with dietary consult. Dietary option in his mind was limited and this may have been a result of not completing dietary classes. The two participants (P03, P011) felt that people did not take responsibility for their disease management. Both of these participants attributed their military background for their ability to stay focused on tasks and responsibility for their health. The participant who stated that diabetes was a disease you handled alone admitted that his family never really discussed diseases or had the medical background to understand them. The participant (P06) that received primary care from a clinic setting stated that the issue was seeing “multiple doctors and not having a relationship with one physician”.

Evidence of Trustworthiness

To provide validity to the research findings, different types of sources were used to assist with providing documentation of codes and to provide or “shed light on a theme or perspective” which is called triangulation (Creswell, 2013, p. 251). An external check of the research was conducted through peer review and researcher’s bias was disclosed at the onset of the study (Creswell, 2013, p. 251). Bias can occur in all phases of research and it is important to establish trustworthiness to improve the results of the study.

In order to establish trustworthiness and improve study outcomes the following must be addressed; credibility, dependability, confirmability, and transferability. Credibility has to do with how the researcher knows that the research findings are truthful. Triangulation can be used to show that the research findings are credibility (Creswell, 2007). Dependability makes certain that the findings in the research study are reliable and can be repeated. Audit trails and records on how the study was conducted must be maintained and field notes, audio tapes; transcriptions must be secured and maintained. Confirmability has to do with how well the research findings are supported by the participants. In order to make sure that the principles of confirmability were followed, I made sure that the data were objectively collected using checking and rechecking of data to check for inconsistencies. Transferability of the study means the results of the study may be used by other researchers studying the same phenomena to assist and develop other theories. This is known as the concept of generalizability.

To confirm verification of this qualitative study the participants signed an agreement and consent form before starting the interview. Each participant was advised

that they could withdraw from the study at any time without any type of penalties or repercussions. Their participation was voluntary. Data were collected objectively, direct quotes from participants were adhered to and checking and rechecking of data was done to improve the quality of this study. The participants had the opportunity to listen to the audiotaped interview as well as read filed notes for accuracy. The participants were asked and allowed to clear up any misunderstandings. Field notes were read multiple times, and the audio tapes were reviewed three times prior to transcribing. The study sample was adequate for the type of study conducted. Saturation was obtained at the sample size estimated for this qualitative study. Study findings were accurate based on the rich description of the research. Participants also had access to my mobile telephone number in the event they did not want their data used in the study.

Credibility

The credibility of the data was ensured by having three expert panel members that critiqued the interview guide and reviewed the interview question to make certain that there was no bias. The expert panel members were not a part of the study team or involved or had any stake in the outcome of the study. The filed notes as well as the audio recordings were accessible to the participants to review and each participant was notified that audio-recordings had been transcribed and they could read the transcripts for authentication and accuracy. All audio and written data are securely stored in a safe with a combination that only I have access to.

Adjustments to credibility strategies included being aware of my own specific background and how this may have impacted my interpretation of the data. In an effort to

prevent or decrease this bias I asked the participants to listen to the audio-recording as well as read the field notes to make sure that I had recorded and interpreted the data accurately.

Transferability

Transferability was accomplished by ensuring that there was a clear account of the sample and data collection procedures. Quotations from the interview process were transcribed directly from the transcripts. The results of this study may be used by other researchers studying the same phenomena to assist and develop other theories. In addition, the study could also be used to help with this and other populations with the management of chronic diseases. This study can also be used to gain insight about the lived experiences of African American Men with Type 2 diabetes.

Adjustments to transferability strategies included making sure that I explained in the details the framework and or context of the research study and any assumptions made during the study. Informed consent was obtained from each participant and confidentiality and anonymity were assured.

Dependability

Dependability was based on consistency in following the analysis process for the phenomenology research design. The analysis process began with collecting data through face to face interviews using audio taping and manual field notes. The audio tapes were transcribed and uploaded to NVivo a software program that helps organize and analyze non-numerical or unstructured data. Coding and categorizing were used to organize the

descriptive rich data. Themes were developed to describe the experience from the perspective of those that lived it.

To increase dependability clear research and interview questions were developed and implemented. A panel of expert members critiqued the interview guide and changes were made based on their critique. The role of the researcher was clearly discussed with the participants as well as how data would be used.

Confirmability

Confirmability was attained when the study participants reviewed the results of their audio tapes, field notes and a copy of the transcripts with the data collected. Confirmability is supported by an audit trail (Creswell, 2007). The results of the data were provided to ensure that the participants agreed with the study results. As stated in the consent form the data will be stored for five years according to Walden's policy. All data collected were based on the lived experiences of African American Males with Type 2 diabetes.

Adjustments to consistency strategies were made to increase confirmability by ensuring that the methodology used, data collection methods and analyzing of the data was presented in a clear and concise manner. I explained in detail the theory selected for my study as well as why qualitative method was selected using a phenomenological approach.

Results

The research question and the resulting themes drove the study findings. The responses from each individual participant were credited to several themes, although the

themes were reported individually. The focus of the question in the study was “What are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men?” Completion of thematic analysis revealed the emergence of the following themes: role of Black women, family and social cohesion, manhood, dietary changes, role of religion, living well, education, life and death sentence. The perceived role of the black woman was one of leadership in the management of Type 2 diabetes. Many of the participants perceived that family and social cohesion served as a resource managing Type 2 diabetes. Perceptions about the characteristics of manhood and what defines “real Black men” was addressed by the research question. Perceptions regarding living well, religious, education about the diabetes as a disease and future outcomes were also addressed by the research question. Table 3 presents the themes and subthemes according to the research question.

Table 3

Themes and Corresponding Subthemes for Research Question

Research question	Themes	Subthemes
What are the social and cultural lived experiences that determine the management of Type 2 diabetes among African American men?	Role of the Black woman	Family healthcare responsibility
	Family and social cohesion	Resource
	Manhood	Black men
	Dietary changes	Fried or baked
	Role of religion	Christian belief
	Living well	Lifestyle behavioral changes
	Education	Lack of knowledge
	Life and death sentence	Future

Theme 1: Role of the Black Woman

Ten of the 11 participants noted the importance of having the support of a female to assist them with managing their Type 2 diabetes. The participants agreed that they were better able to achieve goals and have better health outcomes due to the support of Black women in their lives. The following quotes from the 10 participants reflect lived experiences of how Black women impacted their life.

P01 stated, “My wife supported me and we just sat and talked. She had relatives with diabetes and my mother also had diabetes. I understood a lot about the disease from watching my mother take care of herself.”

P02 stated,

My wife supported me and she is a nurse so she knew a lot about the numbers to keep in control and she is always saying “all right, what are you eating over there”. She can always tell when my sugar is up. She makes sure that I eat right, “look get up and eat your bread or put peanut butter on toast, and drink water.

P03 commented,

I grew up in a single parent home and my mother was there and supported me.

My work ethics and discipline came from her. When I was diagnosed with diabetes my wife supported me sometime a “little too much”. She is always looking at articles about diabetes and recipes to help with managing my food.

When I was going up my mother did not make a lot of money, so we did not eat a lot of fried foods or sweet. We had fried chicken on Sundays.

P03 also stated that dinners are the worst, but “we still try to slow down when my wife is with us. When she or the wives are not around that is when I and we push control, yes.”

P04 mentioned that his fiancée had been in charge of his diabetes for the past two years. “She is a nurse too. When my blood sugar is elevated she states, ‘You may want to this or that to get you sugar under control’. I argue with her a lot about it, but I listen, and we are walking more.

P05 also commented,

I told my wife about my diabetes. It is no body's business except me and "mama" (wife). My wife do the cooking, she is a dietician (nurse) she knows what to cook. She packed my lunches "good stuff" when I was on the road. No fast foods.

P06 stated, "When I was diagnosed with diabetes my wife helped me because her mother had diabetes. When I was first diagnosed with diabetes she was with me and she supported me. My wife does the cooking in the home."

P08 mentioned that his wife went to the doctor with him and to the nutritionist. "My wife prepares the meals and I eat more vegetables now. My wife will tell you that I have no problems going to the doctor."

P09 also mentioned that his wife supported him, but his daughter really stayed on top of his blood sugar numbers. He stated that his daughter and he still have fights about his blood sugars. The daughter would like for him to "maintain a blood sugar of a 100 but my doctor did not want me to consistently stay on 100 if my blood sugar dropped to be walking around here with a blood sugar of 100 and on a consistent basis because if you get a blood sugar drop, you will be at into 70 or lower and I could potentially start having trouble."

P10 commented that his wife is supportive. "We do eat differently because she is not diabetic, and she does like her rice and potatoes. My wife and I sometimes prepare the foods I need."

P11 stated,

My sister has Type 2 diabetes and she took some training about diabetes for eight weeks. She knows everything about the disease and I always call her, and she tells

me what I am doing wrong. She tells me what to eat and what not to eat. She even tells me how many calories I should have including carbohydrates.

Discrepant case. One participant (P07) stated that as far as support systems “personally, I do not think it helps to talk about it with anyone. What can they do, I don’t need that.” His lived experience was contrary to the perceptions of the other participants.

Theme 2: Family and Social Cohesion

Nine (9) of the eleven (11) participants agreed the family and social cohesion served as resources to managing their Type 2 diabetes. The participants saw the influence of family and friends as a positive influence on their eating habits. P01 noted the following:

It was encouraging to see how my mother managed her Type 2 diabetes. I realized that I could manage my diabetes without a lot of medication. Eating right, playing basketball with my friends and exercising.

P02 mentioned that diabetes runs in his family. He has brothers and sisters with diabetes, so it is a family affair. “We share information. I have friends with diabetes also and they walk around with their blood sugars in the 150’s and it does not bother them. When I get to 120’s I go to the bathroom and I get fidgety. We talk about learning to pay attention to the sign your body is giving you.”

P03 also mentioned

My wife helps me manage my diet but I have a group of friends and we talk about eating the right things. We try to help each other out. On Sundays, a group of us guys go out to eat on Sundays. Here is a table of guys who are really into it

talking to each other and getting onto each other about what the other one should or should not eat. We all have diabetes.

P04 commented that he has coworkers who are friends and have diabetes. “They are always trying to counsel me on what to eat and what not to eat. We are always talking about whose diabetes is the worst and who takes or do not take their medicine.”

P06 also commented that, “I have told my sister and my cousin know that I have diabetes and they encouraged me to eat healthy. My wife supports me also.”

P08 noted that

I have family support, support from friends and my doctor is very supportive. I feel comfortable with speaking to anyone about diabetes and how to manage it. I have had friends that have died from diabetes because they did not manage it. I feel like I am “ahead of the curve with some men” because I do believe in going to the doctor and following advice.

P09 commented, “My dad had it, my brother had it, my grandmother had it, and her brother had it, a couple of her brothers. I have been blessed to share information with others due to my job. My daughter and I argue about my numbers, but I listen.”

P10 also commented

I did not keep my diagnosis a secret I told everybody. Family and friends were aware of my diabetes. My grandmother had diabetes and controlled it with medication. Family support is very important because they tend to help you manage your diet by telling you what you cannot have. Somebody is always going to smack your wrist and tell you what you do not need.

P11 noted

My sister really helped me manage my diabetes. I lot of people thought it was going to be hard to be on a diet and eat the proper foods. It was not hard. I listened and saw friends in wheelchairs, having strokes and dying from diabetes because they would not listen.

Discrepant Cases. Two participants, P04 and P07 did not believe in family or social cohesion. P04 made contradictory statements in his interview. He talked about the welcome support of his finance but then stated that he did not involve family in his diagnosis of diabetes. He stated that he was going to do it by himself. P07 stated that as far as support systems personally, I do not think it helps to talk about it with anyone”. What can they do, I don’t need that.

The findings were contrary to the perceptions of the other participants.

Theme 3: Manhood

The majority of the participants (N=10) suggested that masculinity influenced the way they managed their Type 2 diabetes. Some of the men associated diabetes as a sign of weakness that challenged their masculinity. P02 noted the following;

I stopped playing a lot of sports, basketball and stuff but I stopped. I also worked on cars, but I stopped doing all of that because I was afraid of getting cuts. This disease has been life changing.

P02 also stated that I kept thinking, “you have a house means, it’s like you’re not suppose to get sick, you’re not suppose to be all this”.

P03 also noted

I kept the diagnoses of diabetes to myself, I only told a few of my peers that had diabetes because they were trying to encourage me because I was feeling down about my health. I tried to hide it and not show that I had it. I have friends who do not go to the doctor because they are afraid that the doctor will find something. We have a tendency not wanting to show weakness. We always want to be strong or appear to be strong. I remember when my son use to think I could whip King Kong.

P03 commented, "Men are real stubborn about going to the doctors". Many of my friends would ask why do you let your wife tell you what to do? I tell them she is looking out for me."

P03 also stated, "I would try to hide it. Not show it, I wouldn't-- I'd share it with just certain people, you know. Fellow diabetic-- It's not something like, we have a tendency when we get a testimony what God did. I give a testimony about my recovery from heart disease and everything, but the diabetes-- Well, I told a story about how the ketoacidosis episode and how they found that. They couldn't believe I was even conscious and everything. I was thankful that God didn't take me out then".

P04 commented that when he was first diagnosed with diabetes and people asked him what was wrong he stated that "I haven't got cancer no more, but I got it, diabetes". You're mad but cannot be mad at anyone but yourself. Man, I have not had a beer in so long.

P05 also comment that no one knows he has diabetes but his wife. I called that "personal just me and my wife".

P06 noted that he has only shared his diagnoses of diabetes with his sister and a cousin. There was no discussion, I told them and that was it. No discussion.

P07 noted that there is nothing anyone can do for him so why bother telling them. He stated that the best thing to do is leave him alone and let him deal with it. There is nothing family or friends can do.

P08 also noted that he has six brothers and sisters and he was the first one to get diabetes.

I was in denial. I had a hard time believing it because I was the one who was the runner, the thin one, not overweight and always doing something physical. I did not fit into some of the categories that people with diabetes fit.

P09 commented

you never know how you look when you are trying to follow orders regarding diabetes. My doctor had me to lose some weight and when my sister saw me she thought I was dying. I did not look healthy like I use too. She thought I had cancer. I did not look like the picture of health when I lost weight.

P10 noted that my wife is not diabetic and because I have diabetes you cannot rule everybody else out because of my disease. So, we eat differently. You got to have “willpower.”

P11 commented,

I did not handle the diagnoses of diabetes well at first. As a black man, “I ate everything, soul food, fried this, and fried that, fried shrimp, chicken, fish, chitlins, candy”. Of course, “I was a drinker back then”. The participant stated that it could be

“everything, it didn't matter and if I wanted to eat it then I would eat as much as I wanted and of course, that's what blew me up.

Discrepant Case. Participant (P01) did not mention anything related to manhood or masculinity. There were no discrepant findings.

Theme 4: Dietary Changes

All 11 participants noted that they made major dietary changes when they were diagnosed with diabetes. The participants felt that managing their diets continue to be a day-to-day ongoing struggle. Eating the right foods at the right time and making food choices was a battle for all of the study participants. All eleven participants noted that managing their diets have been a very daunting task. Although they all showed some apparent knowledge concerning food choices they still had issues with dietary selections appropriate for diabetes management. All eleven participants agreed that fried food needed to be limited or stopped and replaced with baked choices. P01 noted the following:

I had a problem with canned meat and sauces. Spaghetti was my weakness. I stopped with fried foods and changed to grill or baked foods. I only had a problem with managing my diabetes when I went too far with food and drinks.

P02 commented

My doctor took me off of fried foods when I was diagnosed with diabetes. Before I was diagnosed with diabetes, I was eating whatever I wanted. I ate fried chicken, taco bells, steaks, candy and grape and orange sodas. Once I was diagnosed with diabetes I

got away from red meat, left the sodas alone and now drink unsweeten' tea. I also cut back on my portion of spaghetti.

P03 also noted that he loved Chinese fried rice.

I would go to the buffets because you can eat your money worth. I would splurge sometimes and get fried chicken but now I stick to bake fish and baked chicken. I also now enjoy grill chicken. I now drink mostly water.

P04 also stated I like doughnuts and potato chips. I would always say, "I am going to eat what I want". I would eat a pound or two of grapes in one setting. I am trying to be a vegetarian, but I still indulge in fried chicken. I do eat a lot of salads.

P05 commented

Before I was diagnosed with diabetes, I was eating everything, greasy burgers, and fried foods. I was also drinking. I seldom eat fried chicken. I eat a lot of baked chicken and fish. No fast foods like burgers or hot dogs. I eat a lot of vegetables now.

P06 commented

I loved French fries. I may eat fried chicken sometimes, but I mostly eat baked meats now. I even bake my barbecue in the oven. Spaghetti does not elevate my blood sugar but macaroni (pasta form) send my blood sugar through the roof. I realize in reading stuff I have to watch out for certain things. My blood sugar and sores that do not heal.

P07 also stated prior to be diagnosed with diabetes he enjoyed his fried chicken.

I just came off “my fried chicken”. I now bake my chicken and my pork chops. I do not do seafood. I loved rice and smothered potatoes. I have not had rice or smothered potatoes in over five or six years. I can’t eat spaghetti. If I like it, I do not eat it.

P08 noted that prior to being diagnosed with diabetes he would skip meals and when he did eat it was always fast foods.

When I was diagnosed with diabetes, my doctor had me to stop the fried foods and I got on a scheduled meal plan. I stay away from buffets. I eat more home cooked meals like greens, leafy vegetables. I eat smaller portions.

P09 also stated

Before I was diagnosed with diabetes, I would get and eat the biggest fried chicken bucket. I could eat a whole fried chicken by myself. I loved French fries; I did not control my portion size. Now I control my portions, eat more vegetables and eat more baked foods.

P10 noted that prior to being diagnosed with diabetes he ate more fast foods, fried chicken and anything fast. “I love French fries, potatoes, rice and gravy. After being diagnosed with diabetes, I stopped the fried foods, potatoes and rice. I eat more salads and green vegetables now.”

P11 also stated that prior to his being diagnosed with diabetes, as a black man

I ate everything, soul food, fried this, and fried that, fried shrimp, chicken, fish, chitlins, candy”. Of course, “I was a drinker back then”. The participant stated that it could be “everything, it didn't matter and if I wanted to eat it then I would eat as much as I wanted and of course, that's what blew me up”. After being diagnosed with diabetes, I

changed my diet. I do not eat fried foods except for occasional fried fish. I eat a lot of vegetables. If I want chicken, I boil it or bake it.

Discrepant Cases. There were no discrepant findings.

Theme 5: Role of Religion

All of the participants (N=11) were members of the church. Only five of the participants' statements indicated that the belief in God and going to church was intricate in management of Type 2 diabetes. P01 stated the following:

There were some church members who had it also (diabetes). When you've been around people who "believe that God can do anything but tell a life, you're going to get some help praying to Him and spending time with others who trust God for whatever we have to go through".

P03 also stated that "God is watching over me because I've got friends that didn't survive". Also, when we get a testimony about what God has done we should share. I thank God for not taking me.

P04 commented, "I thank God".

P05 also commented, "I thank God"

P06 God prepared me for this time by letting me see how other people died from not managing this disease.

P07 I call on Jesus because I will never take dialysis and I just say God why me?

Discrepant Cases. Participant, P01, P02, P08, P09, P10, and P11 did not mention anything relating to religion or God in their interview. All eleven participants are members of the church.

The finding was contrary to the perceptions of the other participants. Although the participants not mentioning religion was less than those who did not.

Theme 6: Living Well

All 11 participants noted that they wanted to live well in some form or fashion. Whether through diet and exercise or just living health to their full potential. P01 stated,

“I was very active, and the medication was in a low dose. It just gave me the “opportunity to become more healthy.”

P02 also stated, I changed my eating habits, I changed my body, and “I want to live”.

P03 commented, I want to live, and this disease can be managed.

P04 also commented I just eat right. I stopped drinking

P05 stated, “I feel better because I have a longer life”. My doctor caught it right on time.

P06 commented it has changed the way I eat. It has not interfered with the way I live; I just have to watch what I eat.

P07 noted I am managing my diabetes by my method. If I like it, I cannot have it. You have to be very “conscious and educated on the foods you eat.

P08 commented if something is going to happen it is bound to but I am taking every “precautionary measure to make sure I have a quality of life” and I must deal with managing my diabetes.

P09 also commented that if you keep your “blood sugar in control now, your chances of having complications such as heart trouble and blindness, those things decrease”.

P10 noted I wanted to know how to fix it, what did I need to do, what medication did I need to take.

P11 also noted I had to get out and do what I needed to do. I watch my diet and I exercise.

Discrepant Case. The finding was contrary to the perceptions of the other participants.

Theme 7: Education

All but one participant (N=10) stated that they received the education regarding diabetes management including medications, diet, and exercise. The majority of the participants were ok with medication management as long as they did not have to take a “shot”. Some of the participants did not take the information serious initially but later realized the importance of following educational information on managing diabetes.

P01 stated,

As long as I did not have to take insulin, it was ok. I would be taking a low dose pill, I had to exercise more and change my diet. I watch my mother manage and I knew I could.

P02 noted

I was started on a small dose of medication. I take one pill in the morning and one pill at night. I keep my doctor appointments. My doctor sent me to dietary counseling, and it helped me. I had the tools I needed to manage my diabetes.

P03 also noted

I had to have insulin to get my blood sugar under control in the hospital then I was changed to pills when I was discharged. I was given the information to manage my diabetes but because I also had heart disease, a lot of the information was the same. I had to make some more dietary changes. One on one is needed when education people about the disease and the education would be more effective if the wife was included.

P04 stated

I do not like taking medication I started on the pill but had to take insulin. I was not controlled due to my diet and decrease in exercising. I adjusted my own insulin and it did not work out. I did not like taking injection because I believe the insulin is toxic. Insulin is poison. I eat what I want but I am trying to do better. I know that stress can play a factor in keeping your blood sugar elevated. I now see a doctor in the private sector verses the VA doctors.

P04 also stated, "I told myself I don't have to give up nothing. I lied to the doctor and told him the insulin was making me bloated."

P05 noted I am on the pills no shots, no insulin. I am managing what I eat. I am listening to my doctor.

P06 commented

I was placed on pills initially and then went to insulin after I had a heart attack. I am trying to manage my diet and it is hard to exercise due to the results of a gunshot wound I received. The doctors at the clinic do not believe what I am saying about the foods I eat. I tell them that I am not eating fried chicken. I have been eating baked chicken and foods for a while. I am walking as much as possible, but they do not believe me. I go through the same thing every time I go to the clinic. I just let it go in one ear and out the other. They have already made up their minds about what is going on.

P08 noted

I went to the doctor because I was drinking a lot of water. They put me on pills. My doctor was good he told me how to take my medicine; he sent me to a dietitian and told me exercise. I had to stop skipping meals. I also found my own endocrinologist.

P09 also noted

I was diagnosed with diabetes through a routine checkup. My doctor called me and said he noticed that my A1c had been creeping up and he wanted to put me on metformin. I also had to lose weight and start exercising. Being in the medical field and watching my father go through it (diabetes) I had a pretty good idea of what to do. My father had a rough go it trying to sterile needles and back then you did not have a lot of resources. Sometimes the needles were dull, and we could not afford better.

P10 commented

I just wanted to know how to fix it. I was put on the pill. Grandma was controlled with medicine and she did fine, so this should be no problem. I changed my diet and started to exercise. The information I received from my doctor was “put out well”. I

understood what he was saying. I would say 90% of managing diabetes is the food and 10% exercise and water.

P11 also commented

I did not handle the diagnosis well at first because when they said I was “borderline” I went on my normal way. Then about 10 years ago due to the weight gain they said I known have “full blown” Type 2 diabetes. I was placed on the pill. I got serious lost weight and I manage my diet.

Discrepant Cases. P07 noted he did not receive the education to manage his diabetes. The education, I had none. The finding was contrary to the perceptions of the other participants.

Theme 8: Life and Death Sentence

Ten of the eleven participants expressed emotion about dealing with the diagnosis of diabetes. Some of them are now realizing the seriousness of the disease. Most of them have accepted living with the chronic illness day in and day out but some had feelings of being inadequate to manage the disease. Some of them expressed the reasons to have a healthy future. P02 stated, “this is a deadly disease and it can cause blindness, kidney problems, heart problems and amputations. This disease is serious. ‘I want to live.’”

P03 stated, “I have been giving into it because it is a losing battle for me”. Heart disease and diabetes at my azepeoles send me internet links about cures but if there was cure it would be all over the new.”

P04 noted, “I talked about diabetes like it was cancer. I started being aware of the consequences, it is manageable not a death sentence. I have a fiancée.”

P05 commented, “I feel better, I have a longer life and ‘me and mama have 2 sons and they gave us 12, that is pretty good.”

P06 noted, “I know what to keep it at; I need to keep it down. I try to follow what they say, I don’t let what they say bother me.”

P07 commented, “death went through my mind initially.”

P07 also noted that it is a disease that makes you wonder where you get it from. “My kidney was not right, and I had to see a nephrologist. It is time for me to call Jesus if I have to have dialysis. I cannot do it. It is scary.”

P08 commented, “there are a lot of things out there to help you. They want to prolong life and they do not want to see you pass away or lose limbs. I have a grandson now and I want to play football and baseball with.”

P09 also stated, “I want to get back into shape where I can keep up with my grandchildren in the swimming pool.”

P10 commented that you have to have will power.

P11 also commented, “my life is still the same and I am doing what I need to stay healthy.”

Discrepant Cases. P01 did not mention anything in his interview concerning feelings of uncertainty about managing his diabetes. The finding was contrary to the perceptions of the other participants.

Summary and Transition

I investigated the perceptions of African American men concerning the social and cultural lived experiences that determine the management of Type 2 diabetes in this

phenomenological study. The participants ages in the study ranged from 48 to 76 years of age. A total of 11 African American men answered the invitational questions and participated in interviews with open-ended questions regarding their attitudes/behaviors, personal factors, knowledge of the disease, and environmental factors that they believed influence the management of their Type 2 diabetes. In this chapter eight themes emerged from the thematic analysis; role of the Black woman, family and social cohesion, manhood, dietary changes, role of religion, living well, education, and life and death sentence. The themes were used to address the research question in the study, “what are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men?”

Chapter 5 includes a summary and interpretation of the findings, the results are be compared and contrasted to current literature, limitations of the study, recommendation for research and practice, implications for future research, implication of social change and the study’s conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this qualitative study was to examine the lived experiences of social and cultural determinants of Type 2 diabetes self-management among African American men. This qualitative phenomenological approach was used because I wanted to capture the lived experiences of the participants through one-to-one interviews. I wanted to discover common themes about the African American male's understanding about what social and cultural experiences determine the management of Type 2 diabetes in this study population. Data were collected through conducting face-to-face in-depth interviews with 11 participants living in Memphis, Tennessee. Main themes and subthemes significant to the lived experiences and views of African American men with Type 2 diabetes were identified.

Rich and insightful descriptions were developed by using a phenomenological approach (Creswell, 2009). In order to allow the participants to tell stories about their lived experiences with managing their Type 2 diabetes, I used interview questions that were open ended and required in depth responses. Probing and flexible follow up questions allowed the participants the opportunity to elaborate on their experiences. The interviews were semistructured, and this was a good technique for concerning the views, opinions, and experiences of African American men with Type 2 diabetes (Gill, Stewart, Treasure, & Chadwick, 2008).

The purposive sample consisted of 11 African American men with Type 2 diabetes. Walden (2017) and Creswell (2013) recommended that the sample size rule of

thumb for phenomenology studies be ≤ 10 . Sample size in qualitative studies depends on that needed to obtain saturation or identification of consistent patterns (Creswell, 2013; Walden 2017). All participants in the study lived in Memphis, Tennessee, and ages ranged from 48 to 76 years.

Interpretation of the Findings

In this section of the qualitative phenomenological study, I summarize the findings of the research question where I sought to examine the social and cultural lived experiences that determine the management of Type 2 diabetes among African American men. Based on prior literature, it was important to identify the experiences and factors that determine the management of diabetes Type 2 in this study population. African American patients showed a lack of understanding about Type 2 diabetes and its relation to their “health beliefs, nutritional practices, religious beliefs, and socioeconomic issues” (Gavin & Wright, cited in Kirk, 2014). The findings from this qualitative study may contribute to the body of knowledge on African American males and their lived experiences in the management of Type 2 diabetes. In the summary and interpretation of the findings, the results are compared and contrasted to the current literature.

The research question of my study was what are the social and cultural lived experiences that determine management of Type 2 diabetes among African American men? Eight themes were revealed through the analysis of the data: role of the Black woman, family and social cohesion, manhood, dietary changes, role of religion, living well, education, and life and death sentence. The role of the Black woman referred to the role that Black women play in the health care of her spouse or significant partner. This

healthcare includes diet, medication management, doctor's appointment, and support (physical and emotional).

Role of the Black Woman

Ten of the 11 participants noted the importance of having the support of a female to assist them with managing their Type 2 diabetes. The participants also agreed that due to the support of the Black women in their lives, they felt that they were better able to achieve goals and have better health outcomes. Findings by Kaiser (2013) support the roles of women in the health care management of their partner's chronic diseases. According to Kaiser, women's health is intimately connected to their roles as mothers, partners, and daughters. Many women also help manage their partners' health needs, and over one in 10 women are taking care of an aging or chronically sick relative, often a parent.

Family and Social Cohesion

Family and social cohesion refers to the support received by family and friends working together to assist the participants with managing their Type 2 diabetes. Nine of the 11 participants agreed the family and social cohesion served as resources to manage their Type 2 diabetes. The participants saw the influence of family and friends as positive on their eating habits because they support them and kept them accountable for what they ate. Miller and DiMatteo (2013) indicated that social and family support, when provided in positive interventions, could promote adherence in maintaining diabetes self-management in patients with diabetes. Miller and DiMatteo also concluded that family and social support lead to the promotion of relationships that assist the patient with

maintaining dietary and self-management compliance. Chelsa et al. (2004) concluded that the two strongest associations with disease management in African American patients is the family domain of emotional management and family beliefs, respectively, and that patient morale is related more to the family context. Chlebowy et al. (2010) concluded that African American participants who adhere to Type 2 diabetes regimens felt that self-management behaviors were influenced by support from family, peers, and health care providers. The participants felt that the health care providers assisted in increasing their knowledge, but they did not reinforce or give encouragement.

In addition, Miller and DiMatteo (2013) indicated that social and family support, when provided in positive interventions, could promote adherence in maintaining diabetes self-management in patients with diabetes. Only one of the 11 participants felt that family and social support was not needed to assist with managing his diabetes. The participant was very negative throughout the interview and still had not come to terms with his diagnosis.

Kadirvelu, Sadasivan, and Ng (2012) found that participants indicated that their diabetes peers were a major source of reinforcement for self-management behaviors. Social support and social network played a major role in self-management among diabetic patients. They also concluded that social support is a positive resource, although it also has the potential for negative effects (Kadirvelu et al., 2012). Kadirvelu et al. stated that support from health care providers and the patients' families and friends can provide

support to assist in overcoming social barriers and executing difficult self-management behavior, especially since self-management tasks such as glucose testing, insulin injection, diabetes meal planning, checking feet, and exercise often take place in social settings, and can change family and social routines. (p. 412)

Two of the participants did not believe that family and social cohesion played a part with managing diabetes. One of participants made contradictory statements in his interview. Initially, he talked about the support from his fiancée but later made the statement that he preferred not to involve his family because they would not understand anything about diabetes management. The second participant stated that the management of the disease was personal, and he did not feel anyone could help or understand what he was going through so why tell them.

Manhood

Manhood refers to the state of being a man or adult male person, male maturities, having traditional manly qualities such as masculinity, independence, and master of their own life, the qualities that make them feel like men. The majority of the participants ($n = 10$) suggested that masculinity influenced the way they managed their Type 2 diabetes. Some of the men associated diabetes as a sign of weakness that challenged their masculinity.

Namageyo-Funa et al. (2004) and Sherman (2015) concluded that masculinity influences how African American men manage Type 2 diabetes. Liburd et al. (2004) conducted an exploratory study to look at and comprehend the psychosocial and behavioral perspectives of African American men with diabetes. Many of the study

participants described diabetes as a form of “social inequality that they could not escape and it was robbing them of their identity as proud, robust, sexual, independent, and invincible” (Liburd et al., 2004, p. 224). The men in the study associated this disease with “weakness” and that it was a challenge to their masculinity (Liburd et al., 2004). Matthew et al. (2012) suggested that men are more concerned about diabetes constraining their lifestyles and affecting their provider roles. Another study confirmed that men tend to be more private about their diagnosis of diabetes and are less likely to be observant of nutrition recommendations in social settings (Matthew et al., 2012). Matthew et al. also found that men concealed their illness potentially due to the preservation of “traditional male values such as independence, autonomy, and ownership over decision making” (p. 8). Liburd et al. suggested that gender identity is a key cultural factor that influences health related behaviors. Due to this conflict, there can be a tendency toward nonadherence to medications and poor glycemic control (Liburd et al., 2007). One out of the 11 participants did not mention manhood or masculinity in relation to the management of Type 2 diabetes.

Dietary Changes

Dietary changes refer to changes that the participants made in their diets after being diagnosed with Type 2 diabetes. All the participants ($N = 11$) stated that they made major dietary changes when they were diagnosed with diabetes. All 11 participants noted that managing their diets has been a very daunting task. Although they all showed some apparent knowledge concerning food choices, they still had issues with dietary selections appropriate for diabetes management. All 11 participants agreed that fried food needed to

be limited or stopped and replaced with baked choices. Family, friends, and social groups played a huge decision in the diets of nine of the 11 participants. Lee (2018) concluded that African American diets are due to cultural influences, and there is a preference for soul food. Soul food usually involves fried foods, fatty meats, and rich gravies. African Americans correlate these foods with social interactions (Lee, 2018).

One of the participants (P07) felt that dietary changes were difficult due to the cost of the foods as well as the type of food needed to maintain health. Another participant (P10) believed that in order to manage diabetes effectively, he had to understand that 90% of managing diabetes is the food and 10% is exercise. Dixon (1997) stated that education is the key to assisting African Americans with changing their diets as well as doctor's advice regarding diet. If churches and other organizations participated in educational seminars about diabetes and healthier eating habits, it would help the community to make healthier choices (Dixon, 1997).

Although the other ten participants did not mention the cost or the access of foods needed to maintain a healthy diet, a study conducted in 2003 in which a community coalition compared the availability and cost of diabetes-healthy foods in a racial/ethnic minority neighborhood in East Harlem, with those in the neighboring, largely White and affluent Upper East Side in New York City (Horowitz et al, 2003). The study concluded that the availability of recommended foods in neighborhood food stores may influence the food choices of African American and Latino adults with diabetes. In addition, the evidence suggests that foods recommended as part of a healthy diabetic diet are in short

supply in low-income, non-White neighborhoods such as East Harlem (Horowitz et al, 2003).

In contrast to the above studies, Bhattacharya (2012) concluded that 75% of the women and 80% of the men in the study had a fear of failure at following diabetes guidelines. The participants doubted their abilities to make lifestyle changes prescribed by the guidelines they received after their diagnosis of Type 2 diabetes. The participants describe their changes as “big” (1074).

Role of Religion

Role of religion refers to religious support including church and or church members in the role of assisting African American men with managing their Type 2 diabetes. All the participants (N=11) were members of the church. Only five of the participants' statements indicated that the belief in God and going to church was intricate in management of Type 2 diabetes. Watkins et al. (2013) found that spiritual and religious beliefs and practices, and social support in diabetes self-care activities were important. They also found that spiritual and religious beliefs aided individuals in coping with stress and they provided support, confidence, and hope. Dixon (1997) also concluded that if churches and other organization participated in educational seminars about diabetes and healthier eating habits it would help the community to make healthier choices in their food selections.

Sherman (2015) concluded that diabetes self-management may be facilitated by ‘incorporating the spiritual beliefs and virtues of AA men living with the illness’ (p. 26). Spirituality also incorporates religion, which is commonly defined by African American

scholars as a system of beliefs, and rituals about a god or gods, shared within a community. The participants in the selected study stated “their faith in God as well as attending church does help them in their daily diabetes management” (Sherman, 2015, p. 27). Diabetes self-management may be promoted by integrating the spiritual beliefs and virtues of AA men living with the illness.

Living Well

Living well refers to the participants wanting to live a healthier and happy life. All 11 participants noted that they wanted to live well in some form or fashion. The reasons for wanting to live healthy and longer had to do with family, friends, and self-love. Many participants wanted to achieve this goal whether through diet, exercise or just living healthy to their full potential. Many of the participants changed their diets, exercised more and wanted to do the things needed to live a quality life. Many of the participants made lifestyle changes in their behavior such as stopping drinking alcohol and controlling their blood sugars. Reimer et al (2001) states that patients do not seek help unless the condition affects social and personal life. Rovner et al. (2013) concluded that people who are future-oriented are more likely to engage in health promoting behaviors, whereas people who were present-oriented were not.

Ravenenell et al. (2006) concluded that the African American male definition of health was vaster than the traditional definition of health, “absence of disease” (p. 544). The African American men in the study define being healthy as a physical, mental, emotional, economical and spiritual state of well-being. The participants also define health as being able to perform social roles. Those social roles included having a job

providing for their families. The men in the study mentioned the importance of positive influences such as “supportive social network and feeling valued by loved ones” (Ravenenell, 2006, p. 544).

Education and Life

Education refers to the educational tools, information, dietary and medication received by the residents in order to manage their disease. Education also refers to the participants' ability to effectively comprehend the information provided. All but one participant (N=10) stated that they received the education regarding diabetes management including medications, diet, and exercise. All 11 participants in the study verbalized understanding of the information provided by the physician and health care clinicians. The participants were familiar with the medical terminology as to the definition of diabetes, understanding complications, the importance of maintaining controlled blood glucose levels, preventative care, and dietary needs. Many of the participants talked about following physician and dietitian instructions and changing the way they looked at and managed their diabetes. In order for patients to be able to manage their disease they must be able to understand the information provided. The American Association of Diabetes Education (2015) states that diabetes education must be culturally appropriate, and values, beliefs, customs and language must be understood in order for education to be effective. Effective education can lead to better management of Type 2 diabetes. Better management can lead to healthier lives.

In contrast, Kirk et al. (2014) stated that multiple studies that were conducted showed that “some health care outcomes disparities are due to ineffective patient-

provider communication” (p. 22). Gavin and Wright (2007) as reported by Kirk et al (2014) state that African American patients showed “a lack of understanding about Type 2 diabetes and its relation to their “health beliefs, nutritional practices, religious beliefs, and socioeconomics issues” (p. 24). The study also concluded that poor patient education regarding the management of diabetes can lead to poor treatment adherence and patient’s health care outcomes. The findings in this study disconfirmed prior research studies that African American patients lack the ability to understand about Type 2 diabetes and how it relates to “health beliefs, nutritional practices, religious beliefs, and socioeconomics issues” (Kirk et al , 2004).

Life and Death Sentence

Life and death sentence refer to how the participants saw the management of diabetes as a life or death sentence or outcome. Most of the participants have accepted living with the chronic illness of diabetes day in and day out. One of the participants discussed the feelings of being inadequate to manage the disease. Some of them are now realizing the seriousness of the disease and have expressed the reasons to have a healthy future and life. Ten of the eleven participants expressed emotion about dealing with the diagnosis of diabetes in relation to life and death. The participants in the study discussed how they shifted their focus from just treatment of the disease to managing the disease and preventing complications. One of the participants felt very inadequate when it came to manage his diabetes. In a study conducted by Liburd et al. (2004) many of the study participants described diabetes as a form of “social inequality that they could not escape

and it was robbing them of their identity as proud, robust, sexual, independent, and invincible” (p. 224).

Summary of Interpretation of Findings

All of the participants acknowledge the importance of managing Type 2 diabetes to prevent complications and live a longer healthier life. Ten out of the eleven participants believed that the role of the female, family and social support played a major role in the effective management of their chronic disease. These findings are consistent with several studies. Kasier (2013) found that the support of women in the lives of their partners helped them to manage their diabetes more effectively. Miller and DiMatteo (2013) indicated that social and family support provided interventions that could lead to adherence to diabetes regime. Manhood also played a role in how African American men manage their Type 2 diabetes. Several studies in the literature support this finding. Many of the participants discussed the role of manhood (masculinity) in the management of their Type 2 diabetes. They felt the disease prevented them from feeling that they were in control of their lives. This finding is consistent with a study conducted by Namageyo-Funa, Jack and Gregg (2004) and Sherman (2015) where masculinity influences how African American men manage Type 2 diabetes. Liburd et al. (2004) study concluded that the African American men with diabetes felt the disease left them with an identity crisis. In addition, Matthew, Gucciardi, De Melo and Barata (2012) concluded that the men with Type 2 diabetes perceived the disease as a barrier that prevented them from their role as a provider for their homes and themselves.

Dietary adherence played a major role in the management of Type 2 diabetes in the study population. All of the participants (N=11) discussed making major dietary changes in order to manage their Type 2 diabetes. Some of the participants were able to stay on task and other still struggled with day-to-day dietary management. Many of the participants discussed the importance of the support they obtained from family and friends in their battle to consume foods appropriate for their diet and disease management. All of the participants in the study acknowledge that they did receive some education from their physician or dietary consultant regarding diet management as it relates to diabetes. Dixon (1997) confirmed the importance of education as well as physician guidance in the role of assisting African Americans with altering their diets in an effort to in manage their Type 2 diabetes. One study disconfirmed the previous study because it concluded that even when African Americans are provided with the educational knowledge of diet management many of them feel inadequate when it comes to following the dietary guidelines (Bhattacharya, 2012).

Watkins et al (2013) study results concluded that spiritual and religious beliefs and practices and social support in diabetes self-care activities were important. Many of the participants believed that religion played a major role in their ability to manage their diabetes through emotional support and dependence on God for strength. Other studies confirmed the role of religion in the management of diabetes. Dixon (1997) also concluded that churches as well as other community organizations could assist African Americans with managing their type 2 diabetes by offering educational seminars that teach diabetes management including encouraging healthier eating habits. Sherman

(2015) findings concluded that diabetes self-management that included spiritual beliefs does help the African American male with managing their diabetes. Many of the participants stressed the importance of living well and the importance of wanting to live a longer healthier life for themselves or others. Reimer et al. (2001) findings states that patients seek help when their personal and social life is affected. Rovner et al. (2013) findings also confirmed that when people have a future they are more likely to engage in activities that promote healthier living.

All of the participants acknowledge that education regarding medication, diet, and exercise was needed to manage their disease. Evidence indicates that in order for patients to manage their diabetes they must be able to understand what diabetes is and the importance of management. The American Association of Diabetes Education's (2015) findings state that diabetes education must be culturally appropriate, and values, beliefs, customs, and language must be understood in order for education to be effective. In contrast to these findings, Kirk et al. (2014) suggest that ineffective-provider communication leads to poor health outcomes. Gavin and Wright (2007) concluded that African Americans had a lack of understanding about Type 2 diabetes and its management. Many of the participants saw the chronic diseases as a life or death sentence. Many of the participants were able to accept their diagnosis and others had a difficult time with accepting and managing the disease. Liburd et al. (2004) confirm that many of the participants felt that diabetes was making them feel inadequate.

Extending Knowledge

Ten (10) of the eleven (11) participants stated that having the support of a female to assist them with managing their Type 2 diabetes helped them with achieving goals and better health outcomes. This information could be used to learn more about integrating female family members in programs to assist male partners with managing their diabetes. This finding is aligned with a study conducted by Kaiser (2013) where women helped to manage the health needs of their partners. Family and social support was also mentioned by ten of the eleven participants as key factors that lead to the adherence to diabetes regimen due to positive interventions from family and social support groups. This data is in alignment with a study conducted by Miller and DiMatteo (2013) which indicated the positive effects of family and social support. This information could be used to learn more about the effects of providing family and social education classes to family and friends when a person is diagnosed with diabetes.

The majority of the participants in the study indicated that manhood (masculinity) influenced the way they managed their Type 2 diabetes. A number of the men in the study described diabetes as a weak spot that threatens their manliness and role of a provider. Namageyo-Funa, Jack and Gregg (2004) and Sherman (2015) found that masculinity influences how African American men manage Type 2 diabetes. In the study conducted by Liburd et al. (2004), it was concluded that many of the participants in the study described diabetes as a form of “social inequality.” The information gathered could be used to assist educators with developing programs to assist African American males

with dealing with feelings of inadequacy and inferiority when confronting chronic diseases such as diabetes.

All participants acknowledge that they all made dietary changes when they were diagnosed with diabetes. All eleven participants discussed the problem with dietary selections appropriate for diabetes management. Fried foods were one of the main topics of discussion and many participants struggled with fried versus baked foods. In a study conducted by Lee (2018) it was found that African Americans diets included soul foods involving fried foods, fatty meats, and rich gravies. Dixon (1997) study concluded that education was to key to assisting African Americans with managing and changing their diets. The study also concluded that the involvement of churches and other community organizations in the management of diabetes for African American community could lead to healthier eating habits in this population. The study conducted by Bhattacharya (2012) concluded that a large number of women and men in the study feared failing due to inability to follow diabetes guidelines. The information gathered pertaining to dietary management in people with diabetes could be used to develop achievable goals and guidelines for patients.

All the participants in the study attended church. Some of the participants' in the study indicated that the belief in God and going to church was a major positive factor in the management of Type 2 diabetes. In a study conducted by Watkins et al (2013), it was concluded that spiritual and religious beliefs along with social support were important. Spiritual and religious beliefs assisted the participants with coping with stress and providing the participants with confidence, and hope. Also, the study conducted by

Sherman, (2015) indicated that attending church and having faith in God was a help with managing their diabetes. This information can assist stakeholders like churches, community health centers, and health departments develop and improve faith-based programs to assist with managing diabetes.

All of the participants acknowledge that education regarding medication, diet and exercise was needed to manage their disease. In order to control the disease, patients must understand the disease and the importance of management. In order for diabetes education to be effective, it must be culturally appropriate (American Association of Diabetes Education, 2015). Poor health care outcomes can be attributed to ineffective-provider communication (Kirk et al. 2014). In a study conducted by Gavin and Wright (2007) as reported by Kirk et al (2014) it was concluded that African Americans had a lack of understanding about type 2 diabetes and its management. Many of the participants saw the diseases as a life or death sentence and some had a difficult time accepting the diagnosis of diabetes. Feelings of inadequacy were a problem for many of the participants in the study (Liburd et al 2004). Knowledge could be extended by further study on lack of knowledge concerning what diabetes is, effects of the disease on the body, diet management, treatment modalities, and support groups. Participants and family must receive culturally appropriate education about the disease. Participants and their families' must be empowered to manage the disease.

Themes in this study supported the use of the social cognitive theory regarding understanding what social and cultural experiences determine the management of Type 2 diabetes in African American Males. The participants in the study provided insight as to

why they had certain behaviors when it came to manage their diabetes. The participants discussed why some of the acquired behaviors are maintained whether through passed down traditional reasons are acquired through trying to manage the disease. The participants discussed how their environment, the influence of others and their own behavior effected how they managed their Type 2 diabetes. Some of the participants in the study discussed their physical environment as well as the role of social support in managing their Type 2 diabetes. The social cognitive theory was a good fit for the study because it allowed the participants to explore their perception about their environment, the expectations of the behavior, and the behaviors they learned through observation. The participants also discussed their individual self-control in managing their type 2 diabetes (Bandura, 2004). In the study, the participants discussed the management of their diabetes and the positive and negative reinforcement of their behavior that they received from their support systems. Based on the feedback from self, family, physicians and support systems many of the participants continued or discontinued the behavior in regard to disease management (Bandura, 2004).

Applying the Theoretical Framework to the Results

The findings from this study supported the framework of the social cognitive theory. The social cognitive theory provided an explanation of the participants' perceptions about what they believed to be the social and cultural lived experiences that determine how they managed their Type 2 diabetes. The theory assumes that their environment, others, and their own behavior affect a person's behavior pattern (Bandura, 2004). The concepts of the social cognitive theory include the physical environment and

social support in that environment. The theory explores the individual's perception of the environment, the expectations of the behavior, behaviors learned through observation, and assumptions about the individual's self-control (Bandura, 2004). In the social cognitive theory, the choice to adhere to guidelines and treatment modalities to manage their type 2 diabetes was based on observational learning, modeling, and the influence of self-efficacy on the formation of behavior. In other words, personal factors, which include the interaction between the person and their behavior, are influenced by their thoughts and actions. The interaction between the environment and their behavior involves the person's behavior determining their environment, which in turns affects their behavior. The interaction between the person and the environment involves beliefs and cognitive competencies developed and modified by social influences. The social cognitive theory was used as the theoretical framework for interpreting the results of this study. Each construct of the social cognitive model was applied to this study and compared to the publish literature.

Personal Factors

The participants in the study provided insight as to why they had certain behaviors when it came to management of their diabetes. All of the participants reported that their personal behavior influenced their thoughts and actions regarding how to manage their Type 2 diabetes. They all discussed their reasons for adhering or not adhering to their diabetes regime. Many of the participants discussed dietary management as an issue in the management of their Type 2 diabetes. Although, dietary management was an issue they all reported that they wanted to live, and they were willing to do what

was needed to live a longer and healthy life. The findings in the study is consistent with the World Health Organization (2012) individuals with sense of self-efficacy, are able to change their behavior even when faced with obstacles (p.8).

Behaviors

All the participants in the study reported the importance of having positive reinforcement in their lives to assist them with being motivated to take care of themselves. Positive and negative reinforcement of behavior causes the behavior by the individual to continue or be discontinued based on the responses received from that behavior (Bandura, 2004). These findings agreed with Miller and DiMatteo (2013) who found that social and family support, when provided in positive interventions, could promote adherence in maintaining diabetes self-management in patients with diabetes. In addition, Chlebowy et al. (2010) conducted a study that concluded that African American adherence to type 2 diabetes participants felt that self-management behaviors were influenced by support from family, peers, and health care providers. The support systems provided cues to action, direct assistance, reinforcement, and knowledge (Chlebowy et al., 2010).

Environment

The majority of the participants in the study discussed the role of their environment in the management of their Type 2 diabetes. Participants in the study discussed how encouragement they received from support systems and the environment gave them the positive reinforcement they needed to manage their disease. Physical environment, others and social support in that environment can and does affect the

individual's behavior. Environment and behavior involve a person's behavior determining the aspects of their environment and in turn, that environment modifies their behavior. My findings from this study are consistent with Kadirvelu et al. (2012). Social support and social network play a major role in self-management among diabetic patients and social support is a positive resource. The study also stated that support from health care providers, the patients' families and friends can provide "support to assist in overcoming social barriers and executing difficult self-management behavior (Kadirvelu, 2012, p.412).

Limitations of the Study

My own bias as a researcher, culture specific and response bias were limitations in the study. Participants could be biased in their response if they were not comfortable with disclosing information they believed to be private. The participants having different beliefs and means of thoughts could influence their responses. Participants may have been anxious speaking with a woman about their feelings. Some of the participants may have had feelings of mistrust. Participants may not have responded appropriately to questions due to cultural sensitivity.

I recruited an expert panel of two professors from different universities to review and provide feedback on the interview guide that I developed. The expert panel members' feedback regarding the amount of questions asked and wording of the semi-structured questions. The panel provided feedback on how to use probing questions. The expert panel members' expertise as researchers assisted me with developing and implementing

an interview guide that provided open-ended questions that allowed the participants to elaborate on their feelings.

Participants may have given inaccurate answers during data collection due to the fear of being judged. Answering questions based on what they thought I wanted to hear rather than what was actually true. The researcher may find it complicated to assist participants with feeling comfortable enough to disclose their true feelings. Reporting bias could also occur if the audio recordings were not transcribed as recorded. To improve the accuracy of transcriptions, I listened to each audio over 3-4 times while typing. After transcribing the audios, I listened again with the transcribed data in hand to ensure I transcribed what I heard. I also took field notes to record body language and facial expressions.

The way I designed the questions in the interview guide may have led to certain types of responses. I may have unintentionally designed questions that lead to supporting my conclusion. Participants may have responded differently to a male researcher. The sample was drawn from three African American churches in Memphis, Tennessee. Surveying African American men from churches may have been a barrier. Therefore, the findings are not representative of a national sample of African American men. Voices of those African American men that did not participate in the study or any study, are voices that will not be heard.

Recommendations

The phenomenological study contributes to the advancements in the field of public health, education and disparities by understanding the lived experiences of African

American men living with Type 2 diabetes. The themes that emerged in this study focused on share experiences African American men faced managing their Type 2 diabetes. Dietary factors appeared to be the most common problem. All participants in the study indicated that they had made major changes to their diets but still did not adhere to the guidelines set forth to manage their Type 2 diabetes. The participants who had support from a black female appeared to follow dietary guidelines better than those who attempted to manage their diets alone.

One participant, who managed his diet alone, expressed a great deal of frustration about what to eat and what not to eat, even after attending dietary management classes. Based on the findings, it would be helpful if more intense training on diet management were given to patients, family and or community support when they are first diagnosed with Type 2 diabetes including quarterly dietary classes with follow up and updates. It would also be helpful if community resource centers and religious leaders played a role in creating awareness to the public and or community about Type 2 diabetes and the management of this disease.

The second barrier that the participants faced was the role of masculinity in the management of Type 2 diabetes. The majority of the participants suggested in the study that their masculinity influenced the way they managed their Type 2 diabetes. Feelings of not wanting to appear weak or inadequate were a main concern. Many of the participants saw the disease as a life or death sentence. Based on the findings, it would be helpful if part of the patient's education on diabetes management could include behavioral counseling.

Implications

Implications for Social Change

The study was conducted to gain an understanding of the lived experiences of African American men living with Type 2 diabetes. Masculinity should also be explored to see how it affects health care disparities in African American men. African American men tend to be more private about their diagnosis of diabetes and are less likely to be observant of nutrition recommendations in social settings (Mathew, et al, 2012). One social change implication may be to work with public health stakeholders, physicians, community organizations, and religious leaders to plan outreach awareness programs that include family, friends and community members. These programs can provide information to help support and increase the self-esteem of black males living with diabetes. The policy makers can use these results to assist state and federal governments with petitioning insurance carriers to include behavioral counseling as a part of diabetes management.

Education about the benefits of patients with diabetes adhering to appropriate diet control in the management of diabetes should include family, friends, community support, organizations, businesses, and religious churches. Increased availability of this information is necessary to improve health outcomes. Cultural beliefs and negative opinions about the disease should also be addressed. Health care providers must provide effective teaching upon diagnoses including addressing cultural beliefs.

Implications for Future Studies

All participants acknowledged the problems with the dietary management portion of managing their diabetes Type 2. Further study is needed to involve African American men in diabetes management studies including dietary management. Further studies are needed on the role of peer and community support in the management of diabetes in the African American community. This may help to identify ways in which peers and community can help motivate and improve the self-esteem of African American males dealing with Type 2 diabetes. Study is also needed to find creative ways to provide dietary teaching including cooking classes for African American males with Type 2 diabetes.

A majority of the participants agreed that issues around masculinity played a negative role in the management of their Type 2 diabetes especially when it came to dietary adherence. More studies should be done to look at the role of masculinity and its relationship to disease management in African American males. Research studies should also focus on the psychological aspect of managing Type 2 diabetes in the African American male population.

Many of the participants in the study waited until the tape recording was off to reveal some of their true feelings about their lived experiences. For example, a participant stated after the recorder was turned off that he felt that he was treated differently because he attended a clinic and not a private doctor. There should be studies on the perception of healthcare received by primary care physician verses a physician seen in a clinic setting.

Implications for Public Health Practice

There are several implications for the practice of public health. First, in order to have changes in the health care outcomes of African American men it is imperative that strategies be developed and implemented to increase this population's participation in health care research. Strategies must include ways to address trust issues, benefits of participation and cooperation. Research studies have shown the importance of positive support from family and friends when battling chronic diseases. Future diabetes management interventions should include educating family, friends, and significant support systems.

Conclusion

In this study, I examined the perceptions of African American men about their lived experiences in managing their Type 2 diabetes. This study provided insight into factors influencing the adherence and non-adherence to diabetes management. African American men in the study have identified dietary concerns and role of masculinity as factors that have led to poor adherence to the management of their Type 2 diabetes. Family, friends, doctor relationships, community and religious support have been factors that have led to some compliance. The results of the study are of great benefit to health care professionals, policy makers, public health stakeholders and community resources. These organizations together can work to improve programs, develop and implement policies to assist African American Males with improving health care outcomes. Compliance can be promoted through positive, powerful influences from physicians, communities, health care centers, national men's organizations, family, friends and

churches. African American men with Type 2 diabetes have a daunting task of managing Type 2 diabetes. In order to assist this population with managing this challenging and deadly disease it will take a village. Societal and cultural factors do affect the management of Type 2 diabetes in African American men.

References

- Alarcon, R.D. (2009). Culture, cultural factors and psychiatric diagnosis: review and projections. *World Psychiatry*, 8, 131-139. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755270/pdf/wpa030131.pdf>
- Allen, S.G. (2018). *Study: Black Much Less Likely to Take Part in Health Research Studies*. Retrieved from <https://diverseeducation.com/article/114115/>
- American Association of Diabetes Educators (2015). Cultural Consideration in Diabetes Education, AADE Practice Synopsis. Retrieved from <https://www.diabeteseducator.org/docs/default-source/default-document-library/cultural-considerations-in-diabetes-management.pdf?sfvrsn=0>
- American Diabetes Association (2010). Diagnosis and Classification of Diabetes Mellitus. *Diabetes Care*, 33(1), S62-S68. doi:10.2337/dc10-S062
- American Diabetes Association. (2016). Standards of medical care in diabetes—2016: summary of revisions. *Diabetes Care*, 39(Supplement 1), S4-S5.
- American Diabetes Association (ADA), (2013). *The cost of diabetes*. Retrieved from <http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html?referrer=https://www.google.com/>
- American Diabetes Association (2013). *Treatment and Care for African Americans*. Retrieved from <http://www.diabetes.org/living-with-diabetes/treatment-and-care/high-risk-populations/treatment-african-americans.html?referrer=https://www.google.com/>

- Baker, E.A., Schootman, M., Barnidge, E., & Kelly, C. (2006). *The Role of Race and Poverty in Access to Foods That Enable Individuals to Adhere to Dietary Guidelines*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1636719/>
- Bandura, A. (2004). Health Promotion by Social Cognitive Means. *Health Education and Behavior, 31*(2), 143-164. Doi:10.1177/1090198104263660.
- Belle, G. (2009). Can the African-American diet be made healthier without giving up culture. Retrieved from York Community College: <https://www.york.cuny.edu/academics/writing-program/the-york-scholar-1, 5>.
- Black, S. (2002). *Diabetes, diversity, and disparity: What do we do with this evidence?* Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447113/pdf/0920543.pdf>
- Boyle, J. P., Honeycutt, A. A., Narayan, K. V., Hoerger, T. J., Geiss, L. S., Chen, H., & Thompson, T. J. (2001). Projection of diabetes burden through 2050: impact of changing demography and disease prevalence in the US. *Diabetes Care, 24*(11), 1936-1940.
- Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.
- Caballero, A.E. (2007). *Cultural Competency in Diabetes Mellitus Care: An Urgent Need*. Retrieved from https://www.joslin.org/docs/INSULIN_2007_80_caballero_4-11.pdf

- Campos, C. (2006). *Narrowing the Cultural Divide in Diabetes Mellitus Care: A Caucus on Improving Cultural Competency to Better Serve Hispanic/Latino Populations*. Retrieved from <http://tipher.com/downloads/Narrowing%20the%20Cultural%20Divide%20in%20Diabetes.pdf>
- Centers for Disease Control and Prevention (2016). *Diabetes*. Retrieved from <https://www.cdc.gov/media/presskits/aahd/diabetes.pdf>
- Centers for Disease Control and Prevention (2011). *Diabetes Fact Sheet*. Retrieved from <http://www.cdc.gov/diabetes/pubs/factsheet11.htm>
- Centers for Disease Control and Prevention (2015). *Diabetes Public Health Resource*. Retrieved from <http://www.cdc.gov/diabetes/statistics/prev/national/fig2004.htm>
- Center for Disease Control (2017). *National Diabetes Statistics Report, 2017*. Retrieved from <https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>
- Centers for Disease Control and Prevention. (2015). Rates of diagnosed diabetes per 100 civilian, non-institutionalized population, by age, United States, 1980–2014. *Diabetes Public Health Resource*.
- Chelsa, C.A., Fisher, L., Mullan, J.T., Skaff, M.M., Gardiner, P., Chun, K., & Kanter, R. (2004). Family and disease management in African-American patients with type 2 diabetes. *Diabetes Care*, 12, 2850-2855. Retrieved from <http://dx.doi.org/10.2337/diacare.27.12.2850>

- Chow, E.A., Foster, H., Gonzalez, V., & Melver, L. (2012). *The disparate impact of diabetes on racial/ethnic minority populations*. Retrieved from <http://clinical.diabetesjournals.org/content/30/3/130.extract>
- Choy, L. T. (2014). The strengths and weaknesses of research methodology: Comparison and complimentary between qualitative and quantitative approaches. *IOSR Journal of Humanities and Social Science*, 19(4), 99-104.
- Colaizzi, P. (1978). Psychological research as a phenomenologist views it. In: Valle, R.S. & King, M. (1978). *Existential Phenomenological Alternatives for Psychology*. Open University Press: New York.
- Coleman, L., Kelly, J.,(2004). Black Men and Diabetes: Preventing It, Managing It. Retrieved from <https://www.webmd.com/diabetes/features/black-men-diabetes-preventing-managing#1>
- Compliance. (n.d.). Retrieved April 9, 2017, from <https://www.merriam-webster.com/dictionary/compliance>
- Creswell, J. W. (2007). *Educational Research: Planning, Conducting, and evaluating Quantitative and Qualitative Research*. Prentice Hall.
- Creswell, J.W. (2009). *Research design: Quantitative, qualitative, and mixed methods approach*. Thousand Oaks, CA: Sage.
- Creswell, J.W. (2013). *Qualitative inquiry & Research design: Choosing among five approaches*. Thousand Oaks, CA: Sage.
- Culture. Retrieved from [https://www. Merriam-webster.com/dictionary/culture](https://www.Merriam-webster.com/dictionary/culture)
- Cultural factors. Retrieved from encyclopedia.com

- Delamater, A.M. (2006). *Improving patient adherence*. Retrieved from <http://clinical.diabetesjournals.org/content/24/2/71.full.pdf+html>
- Dictionary.com (2018). Ethnicity. Retrieved from <https://www.dictionary.com/browse/ethnicity>
- Dixon, B. M. (1997). African-American food and nutrition: From survival to choice. *Ethnic News Watch*.
- Edmonds, W. A., & Kennedy, T. D. (2012). *An applied reference guide to research designs: Quantitative, qualitative, and mixed methods*. Thousand Oaks, CA: Sage.
- Farlex Partner Medical Dictionary (2012). Definition of Adherence. Retrieved from <http://medical-dictionary.thefreedictionary.com/adherence>
- George, S., Duran, N., & Norris, K. (2014). A systematic review of barriers and facilitators to minority research participation among African Americans, Latinos, Asian Americans, and Pacific Islanders. *American journal of public health, 104*(2), e16-e31.
- Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Method of data collection in qualitative research: interviews and focus groups. Retrieved from <https://www.nature.com/articles/bdj.2008.192>
- Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2008). *Health behavior and health education: Theory, research, and practice* (4th ed.). San Francisco, CA: Jossey-Bass.
- Grzywacz, J.G., Arcury, T.C., Ip, E.H., Nguyen, H.T., Saldana, S., Reynolds, T., Bell, R.A., Kirk, J.K., & Quandt, S.A. (2012). Culture “in Diabetes- Related Beliefs

among Low-and High – Education African American, American Indian, and White Older Adults, Retrieved from [https://www. Ncbi.nlm.nih.gov/pubmed/?term=Reynolds%20T%5Bauthor%5D&cauthor=true&cauthor uid=23140078](https://www.Ncbi.nlm.nih.gov/pubmed/?term=Reynolds%20T%5Bauthor%5D&cauthor=true&cauthor%20uid=23140078)

Heydari, A., Dashtgard, A., & Moghadam, Z.E. (2014). The effect of Bandura’s social cognitive theory implementation on addiction quitting of clients referred to addiction quitting clinic. *Iran Journal of Nursing Midwifery Research, 19(1)*, 19-23. Retrieved from <http://www. Ncbi.nlm.nih.gov/pmc/articles/PMC3917180/>

Hoepfl, M.C. (1997). Choosing Qualitative Research: A Primer for Technology Education Researchers. Retrieved from <http://scholar.lib.vt.edu/ejournals/JTE/v9n1/hoepfl.html>

Hslung, P.C. (2010). The use of negative cases and unexpected findings. Retrieved from <https://www.utscc.utoronto.ca/~pchsiung/LAL/interviewing/complexity/negative>

Hurt, T. R., Seawell, A. H., & O’Connor, M. C. (2015). Developing effective diabetes programming for Black men. *Global qualitative nursing research, 2*, 2333393615610576.

Jack Jr, L., Gross, T., & Troutman, A. (2010). Exploring masculinity and the social context: Research and practice implications for Black men living with diabetes. *Diabetes in Black America: Public health and clinical solutions to a national crisis*, 130-145.

James, D. (2004). Factors influencing food choices, dietary intake, and nutrition-related attitudes among African Americans: application of a culturally sensitive model. *Ethnicity and Health, 9(4)*, 349-367.

- Jang, Y., & Yoo, H. (2012). Self-management programs based on the social cognitive theory for Koreans with chronic disease: a systematic review. *Contemporary nurse*, 40(2), 147-159.
- Kadirvelu, A., Sadasivan, S. & Ng, S.H. (2012). Social support in type II diabetes care: A case of too little, too late. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3514066/pdf/dmso-5-407.pdf>
- Kaiser Family Foundation (2013). Chapter 7: Women and Family Health. National Health Survey. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey-chapter-7.pdf>
- Kirk, J.K., Hilderbrandt, C., Davis, S., Crandall, S.J., Siciliano, & A.B., Marion, G.S. (2014). Perceptions of Culturally Competent Diabetes Management in a Primary Care Practice. *Journal of Cultural Diversity*, 21(1), 22-28
- Koenig, H.G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. International Scholarly Research Network. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3671693/pdf/ISR.N.PSYCHIATRY2012-278730.pdf>
- Lee, L. (2018). Nutrition and the African American Diet. Retrieved from <https://www.clintonnc.com/features/lifestyle/27515/nutrition-and-the-african-american-diet>

- Lemacks, J. Wells, B., Ilich, J.Z., & Ralston, P. (2013). Interventions for improving nutrition and physical activity behaviors in adult African American populations: A systematic review, January 2000 through December 2011. Retrieved from http://www.cdc.gov/pcd/issues/2013/pdf/12_0256.pdf
- Liburd, L.C., Namageyo-Funa, A., & Jack, L. (2007). Understanding “Masculinity” and the Challenges of Managing Type 2- Diabetes among African –American Men. *Journal of the National Medical Association, 99*(5), 550-2, 554-8.
- Liburd, L.C., Namageyo-Funa, A., Jack, L., & Gregg, E. (2004). Views within and beyond: Illness narratives of American Men with Type 2 Diabetes. *Diabetes Spectrum, 17*, 4219-4224. doi:10.2337/diaspect.17.4.219.
- Lynch, E.B., Liebman, R., Ventrelle, J., Avery, E.F., & Richardson, D. (2014). A Self-Management Intervention for African Americans with Comorbid Diabetes and Hypertension: A Pilot Randomized Controlled Trial. *Preventing Chronic Disease, 11*, 130349. doi:http://dx.doi.org/10.5888/pcd11.130349.
- Manhood-* define as the state or time of being a man or adult male person; male maturity. Traditional manly qualities. Retrieved from <https://www.dictionary.com/browse/manhood>
- Mathew, R., Gucciardi, E., De Melo, M., & Barata, P. (2012). Self-management experiences among men and women with type 2 diabetes mellitus: A qualitative analysis. Retrieved from <http://bmcfampract.biomedcentral.com/articles/10.1186/1471-2296-13-122>

Merriam –Webster Dictionary (2016). Definition of African American. Retrieved from

<http://www.merriam-webster.com/dictionary/African%E2%80%93American>

Merriam-Webster (2016). Definition of Culture. Retrieved from

<http://www.merriam-webster.com/dictionary/culture>

Miller, T.A., & DiMatteo, M.R. (2013). Importance of Family/Social Support and Impact

on Adherence to Diabetic Therapy. *Diabetes, Metabolic Syndrome and Obesity:*

Targets and Therapy, 6, 421-426. Doi:10.2147/DMSO.S36368. Retrieved from

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3825688/>

Mosby's Medical Dictionary, 8th edition (2009). Definition of Self-Care Management.

Retrieved from <http://medical-dictionary.thefreedictionary.com/self-care>

National Diabetes Statistics Report (2017). Estimates of Diabetes and its Burden in the

United States. Retrieved from

<https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf>

Nursing Research (2012). Instruments in nursing research. Retrieved from

http://nursingplanet.com/Nursing_Research/e-book/instruments.html

Pan, A., Lucas, M., Sun, Q., van Dam, R.M., Franco, O.H., Manson, J.E., Willett, W.C.,

Ascherio, A., & Hu, F.B. (2010). Bidirectional Association between Depression

and Type 2 Diabetes Mellitus in Women. Retrieved from

<http://www.medscape.com/medline/abstract/21098346>

- Peek, M.E., Cargill, A., & Huang, E.S. (2007). Diabetes Health Disparities: A Systematic Review of Health Care Intervention. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2367214/pdf/nihms-44293.pdf>
- Peersman, G. (2010). Overview: Data Collection and Analysis Methods in Impact Evaluation. Retrieved from https://www.unicef-irc.org/publications/pdf/brief_10_data_collection_analysis_eng.pdf
- Powers, M.A., Bardsley, J., Cypress, M., Duker, P., Funnell, M.M., Fischl, A.H., Maryniuk, M.D., Siminerio, L., & Vivian, E. (2015). Diabetes Self-Management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. *Diabetes Care*, 38, 1372-1382. doi:10.2337/dc15-0730
- QSR International; 2018. NVivo 12 [software program]. Version 12.
- Raingruber, B. (2013). Health Promotion Theories. Retrieved from http://samples.jbpub.com/9781449697211/28123_CH03_Pass2.pdf
- Regoniel, P. (2013). How to reduce researcher bias in social research. Retrieved from <http://simplyeducate.me/2013/08/12/how-to-reduce-researcher-bias-in-social-research/>
- Reimer, T.T., Choi, E., Kelley, Skemp, K., & Enslin, J.C. (2001). Cultural Barriers to Care: Inverting the Problem. *Diabetes Spectrum*, 14(1), 13-22. Retrieved from <http://dx.doi.org/10.2337/diaspect.14.1.13>

- Ricci-Cabello, I., Ruiz-Pérez, I., Nevot-Cordero, A., Rodríguez-Barranco, M., Sordo, L., & Gonçalves, D. C. (2013). Health care interventions to improve the quality of diabetes care in African Americans: a systematic review and meta-analysis. *Diabetes Care*, *36*(3), 760-768.
- Robbins, J. M., Zhang, H., Kasi, S.V. (2001). Socioeconomic status and type 2 diabetes in African American and Non-Hispanic White Women and Men: Evidence from the third national health and nutrition examination survey. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446485/pdf/11189829.pdf>
- Rovner, B.W., Casten, R.J., Harris, L.F. (2013). Sociocultural influences on diabetes self-management behaviors in older African Americans. *Diabetes Spectrum*, *26*(1), 29-33. doi:10.2337/diaspect.26.1.29. Retrieved from <http://spectrum.diabetesjournals.org/content/diaspect/26/1/29.full.pdf>
- Ryan, P. (2009). Integrated Theory of Health Behavior Change: Background and Intervention Development. *Clinical Nurse Specialist*, *23*(3), 161-172. doi:10.1097/NUR.0b013e3181a42373.
- Schillinger, D., Grumbach, K., Piette, J., Wang, F., Osmond, D., Daher, C., Palacios, J., Sullivan, G.D., & Bindman, A.B. (2002). Association of health Literacy with Diabetes Outcomes. Retrieved from <https://pbrn.ahrq.gov/tools-and-resources/pbrn-literature/association-health-literacy-diabetes-outcomes>
- Sell, K., Amella, E., Mueller, M., Andrews, J., & Wachs, J. (2016). Use of Social Cognitive Theory to Assess Salient Clinical Research in Chronic Disease Self-

Management for Older Adults: An Integrative Review. *Open Journal of Nursing*, 6, 213-228, retrieved from <http://dx.doi.org/10.4236/ojn2016.63022>.

Sherman, L. (2013). The Self-Care Management Experiences of African American Men Living with Type 2 Diabetes. Retrieved from <http://oaktrust.library.tamu.edu/bitstream/handle/1969.1/151155/SHERMAN-DISSERTATION-2013.pdf?sequence=1>

Sherman, L.D., & McKyer, J. (2015). Where are they? The inclusion of African American men in empirical studies of type 2 diabetes self-management. *Journal of Social Health Diabetes*, 3, 102-114. doi:10.4103/2321-0656.152820

Signorello, L.B., Schlundt, D.G., Cohen, S.S., Steinwandel, M.D., McLaughlin, J.K., Hargreaves, M.K., & Blot, W.J. (2007). Comparing Diabetes Prevalence Between African Americans and Whites of Similar Socioeconomic Status. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2089102/pdf/0972260.pdf>

Stanford University (2012). Using Nvivo for Qualitative Data Analysis. Retrieved from http://web.stanford.edu/group/ssds/cgi-bin/drupal/files/Guides/UsingNVivo9_0.pdf

Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. Retrieved from <http://utsc.utoronto.ca/%7Ekmacd/IDSC10/Readings/Readings/text%20analysis/theses.pdf>

- Sutton, J., & Austin, Z. (2015). Qualitative Research: Data Collection, Analysis, and Management. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4485510/>
- Trochim, W.K. (2006). Research Knowledge Base, Qualitative Validity. Retrieved from <http://www.socialresearchmethods.net/kb/qualval.php>
- Twombly, J. G., Long, q., Zhu, M., Wilson, P.W.F., Narayan-Venkat, K.M., Fraser, L.A., Webber, B.C., & Phillips, L.S. (2010). Diabetes Care in Black and White Veterans in the Southeastern U.S. *Diabetes Care*, 33(5), 958-963.
doi:10.2337/dc09-1556
- Walden University (2011). Doctoral Guide Book. Retrieved from http://catalog.waldenu.edu/mime/media/7/987/Doctoral+Study+Guide_final_cover+date.pdf
- Walden University (2017). Qualitative Research: Sampling & Sample Size Considerations. Retrieved from imy.laureate.net/FacultyDocumentation/quality_res_smpl...
- Walden University (2012). Visions, Missions and Goals. Retrieved from <http://catalog.waldenu.edu/content.php?catoid=61&navoid=9236>
- Watkins, Y., Quinn, L.T., Ruggiero, L., Quinn, M.T., & Choi, Y. (2013). Spiritual and Religious Beliefs and Practices, and Social Support's Relationship to Diabetes Self-Care Activities in African Americans. *Diabetes Educator*, 39(2), 231-239.
doi:10.1177/0145721713475843

- White. Retrieved October 19, 2017 from [https://Merriam - webster.com/dictionary/Caucasoid](https://Merriam-webster.com/dictionary/Caucasoid)
- White person. (n.d.) *WordNet 3.0, Farlex clipart collection.* (2003-2008). Retrieved November 12, 2016 from <http://www.thefreedictionary.com/White+person>
- Willi, C., Bodenmann, P., Ghali, W. A., Faris, P.D., & Cornuz, J. (2007). Active Smoking and the Risk of Type 2 Diabetes. Retrieved from <http://www.medscape.com/medline/abstract/18073361>
- World Health Organization (2012). Health education: Theoretical concepts, effective strategies and core competencies. Retrieved from http://applications.emro.who.int/dsaf/EMRPUB_2012_EN_1362.pdf
- World Health Organization (2016). Diabetes. Retrieved from http://www.who.int/topics/diabetes_mellitus/en/
- World Health Organization (2017). How to investigate the use of medicines by consumers. Retrieved from <http://apps.who.int/medicinedocs/en/d/Js6169e/>
- Zeh, P., Sandhu, H., Cannaby, A., & Sturt, A. (2013). Cultural Barriers Impeding Ethnic Groups from Accessing Effective Diabetes Care Services: A systematic Review of Observational Studies. Retrieved from <http://diversityhealthcare.imedpub.com/cultural-barriers-impeding-ethnic-minority-groups-from-accessing-effective>

Appendix A: Expert Panel for Qualitative Instrumentation

Instructions: Please review the attached Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” and respond to the following questions regarding the construction, validity and potential reliability for the Qualitative research.

Section I. VALIDITY EVALUATION

A test, survey, questionnaire, evaluation or assessment instrument is valid to the extent that the instrument measures the construct(s) that the instrument purports to measure.

1. Instrument Construction:

1.(a). Are the instructions for completing the instrument clear?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

1.(b). Is the application and results of the Qualitative Instrumentation of research topic *Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men* adequately reflected in this instrument?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

1.(c). What items would you add? The focus of your questions is on people. Do you see a connection between people and resources the men would need to manage their diabetes?

1.(d). What items would you delete?

2. Content Validity:

Will the scores yielded by Qualitative Instrumentation of research topic *Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men* adequately represent the content or conceptual domain of the construct being measured? In other words, does the instrument have adequate and appropriate items that constitute a representative sample of the complete domain of items used to generalize the construct being measured? Please see the attached table of specifications [instrument blueprint] that reflect which items and how many items within the instrument are designed to measure each type of content domain.

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

3. Construct Validity:

Qualitative Instrumentation research topic “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” is designed to measure

Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men. Please see constructs definition: ????

Insert constructs definition here: ???

3.(a) Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” represent concepts or constructs it should represent and does not represent concepts it should not represent? In other words, does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” adequately represent the constructs it purports to represent?

Yes. It would be helpful to know your definitions of social and cultural.

No (if no, please explain)

Yes, provided the following actions are taken:

3.(b) Is the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” inclusive of the important dimensions or facets of the constructs it purports to measure.

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

3 (c) Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” avoid excess reliable variance, ensuring no items are easier or harder for some respondents in a manner relevant to the interpreted construct?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

4. Face Validity

Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” look valid? Does it appear to represent a measure of the construct it purports to measure?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

5. Item Bias

Does the wording or placement of an item avoid affecting someone’s response? (This includes the avoidance of double-barreled items, words or phrases, which raise emotional red flags, ambiguous wording, gender bias, racial/ethnic bias, and the manipulative placement of an item or wording of an item)

Yes

No (if no, please explain) The ‘yes-no’ questions could be reworded to more open-ended questions. For example, “How do you feel about the instructions that health care professionals have given you to manage your diabetes? (after participant responds, you could ask, “Were the instructions

specific enough to help you?" (depending on response, ask participant to explain their yes or no response).

Yes, provided the following actions are taken:

6. Consequential Validity

Does the Qualitative Instrumentation of "*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*" instrument embody desirable values and have potentially positive consequences for the discipline or field it reflects?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

Section II. RELIABILITY EVALUATION

A test, survey, questionnaire, evaluation or assessment instrument is reliable to the extent that whatever construct(s) the instrument measures, it measures the construct(s) consistently.

A. Internal Consistency

Are the items that make up the Qualitative Instrumentation of "*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*" internally consistent with each component and/or the constructs being examined, assessed, evaluated or measured?

Yes Overall, yes. Having a clear definition of the constructs would be helpful.

No (if no, please explain)

Yes, provided the following actions are taken:

B. Potential for Reliability (Potential for Consistent Responses)

Understanding that research participants completing this instrument will vary in their understanding and experience with the "*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*" and thus vary in their responses, is there anything about this instrument that would lead you to believe that this instrument would not consistently measure "*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men.*"

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

Please provide any additional comments, suggestions for improvement, and/or any other thoughts regarding the construction, how the survey to be easier to complete, validity and/or reliability of the Qualitative Instrumentation of (research topic).

Panel Member

Printed or typed Name: [REDACTED] Title: Professor

Department: College of Nursing Organization Location: [REDACTED]

Signature: [REDACTED] Date: 10/28/17

Expert Panel for Qualitative Instrumentation-Second Reviewer

Instructions: Please review the attached Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” and respond to the following questions regarding the construction, validity and potential reliability for the Qualitative research topic.

Section I. VALIDITY EVALUATION

A test, survey, questionnaire, evaluation or assessment instrument is valid to the extent that the instrument measures the construct(s) that the instrument purports to measure.

1. Instrument Construction:

1.(a). Are the instructions for completing the instrument clear?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

1.(b). Is the application and results of the Qualitative Instrumentation of research topic: “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” adequately reflected in this instrument?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

1.(c). What items would you add?

1.(d). What items would you delete?

2. Content Validity:

Will the scores yielded by Qualitative Instrumentation of research topic “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” adequately represent the content or conceptual domain of the construct being measured? In other words, does the instrument have adequate and appropriate items that constitute a representative sample of the complete domain of items used to generalize the construct being measured? Please see the attached table of specifications [instrument blueprint] that reflect which items and how many items within the instrument are designed to measure each type of content domain.

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

3. Construct Validity:

Qualitative Instrumentation research topic “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” is designed to measure construct validity? Please see constructs definition:

Insert constructs definition here:

3.(a) Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” represent concepts or constructs it should represent and does not represent concepts it should not represent? In other words, does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” adequately represent the constructs it purports to represent?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

3.(b) Is the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” inclusive of the important dimensions or facets of the constructs it purports to measure.

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

3.(c) Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” avoid excess reliable variance, ensuring no items are easier or harder for some respondents in a manner relevant to the interpreted construct?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

4. Face Validity

Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” look valid? Does it appear to represent a measure of the construct it purports to measure?

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

5. Item Bias

Does the wording or placement of an item avoid affecting someone’s response? (This includes the avoidance of double-barreled items, words or phrases, which raise emotional red flags, ambiguous wording, gender bias, racial/ethnic bias, and the manipulative placement of an item or wording of an item)

Yes

No (if no, please explain)

Yes, provided the following actions are taken:

6. Consequential Validity

Does the Qualitative Instrumentation of “*Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men*” instrument embody

desirable values and have potentially positive consequences for the discipline or field it reflects?

- Yes
 No (if no, please explain)
 Yes, provided the following actions are taken:

Section II. RELIABILITY EVALUATION

A test, survey, questionnaire, evaluation or assessment instrument is reliable to the extent that whatever construct(s) the instrument measures, it measures the construct(s) consistently.

A. Internal Consistency

Are the items that make up the Qualitative Instrumentation of *“Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men”* internally consistent with each component and/or the constructs being examined, assessed, evaluated or measured?

- Yes
 No (if no, please explain)
 Yes, provided the following actions are taken:

B. Potential for Reliability (Potential for Consistent Responses)

Understanding that research participants completing this instrument will vary in their understanding and experience with the *“Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men”* and thus vary in their responses, is there anything about this instrument that would lead you to believe that this instrument would not consistently measure *“Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men.”*

- Yes
 No (if no, please explain)
 Yes, provided the following actions are taken:

Please provide any additional comments, suggestions for improvement, and/or any other thoughts regarding the construction, how the survey to be easier to complete, validity and/or reliability of the Qualitative Instrumentation of *“Social and Cultural Factors Influencing the Management of Type 2 Diabetes Among African American Men.”*

Panel Member

Printed or typed Name: [REDACTED]

Title: PhD, MS, RN

Department:

Organization Location:

Signature: [REDACTED] Date: 10-29-17

Appendix B: Interview Protocol and Interview Guide

Interview Protocol and Data Collection Tool

Time of Interview:

Date of Interview:

Location of Interview

Interviewer Name: Lavetta Lopez

Interviewee ID:

Introduction of Researcher:

Explanation of the Project:

Invitational Questions

- 1 Hello and welcome, thank you for coming. Your participation is greatly appreciated. The interview will take approximately 60-90 minutes.
- 2 Do you have any questions regarding why the research is being conducted?
- 3 Do you have any questions about how the data will be kept?
- 4 Do you have any questions on how the data will be used?
- 5 Are you comfortable? If so, then we will begin. Thank you.

Interview Guide

Personal Factors

1. What do you know about your diagnosis?
2. How do you handle this disease?
3. Do you feel supported by family members?
4. Do you feel supported by friends?
5. Is it helpful to share your diabetes information with others?

Behaviors

6. When did you know that you first had diabetes? What treatments were you given or offered?
7. How do you manage your diabetes?
8. How has been diagnosed with diabetes change your life?

Environmental Factors

9. Before you were diagnosed with diabetes, what types of meals did you eat? A) Give me an example of what you ate today?
10. After your diagnosis, how did that change?

Probes

- a. Were provided with the education, skills and or tools to manage your diabetes?
- b. Should diabetics do self-management without guidelines?
- c. What have you found helps you with your diabetes?
- d. Do you believe that support from family, caregivers, friends, and church members is important when dealing with diabetes management?
- e. If so, does that family member or caregiver with diabetes eat differently from you and other family members?

Thank you for assisting me in my research. If you have any questions after this interview, please call (XXX) XXX-XXXX for assistance.

Appendix C: Letter Requesting Church Facility Use

October 30, 2017

Dear Sirs.

My name is Lavetta Lopez. I am a PhD Public Health student with a specialization in Community Health at Walden University. I would like to request your permission to interview participants in my study at your facility. The titled of my topic is “Cultural Factors and the Management of Type 2 Diabetes Among African American Men”. I would also like to ask you if it is necessary to receive permission from any owners, parent company board or any Institutional Review Board (IRB) within your organization. I am currently waiting for approval on my proposal from the University Research Reviewer (URR). Once the proposal has been approved, I must do my oral presentation and pass. Once I have successfully passed my oral presentation I can then collect the data for my study. A rapid response to this letter will be greatly appreciated. Thank you for your time.

If you have any questions, please feel free to contact me at XXXXXXXXXXXXX or by cell phone at XXXXXXXXXXXX.

Respectfully,

Lavetta Lopez