NARRATIVES OF BLACK OLDER WOMEN COMMUNICATING WITH

HEALTHCARE PROFESSIONALS

by

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DEDICATION

It is good to give thanks to the LORD,
And to sing praises to Your name, O Most High;
[2] To declare Your lovingkindness in the morning,
And Your faithfulness every night,
[3] On an instrument of ten strings,
On the lute,
And on the harp,
With harmonious sound.
[4] For You, LORD, have made me glad through Your work;
I will triumph in the works of Your hands.

[5] O LORD, how great are Your works!
Your thoughts are very deep.

Psalms 92:1-5

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ABSTRACT

Utilizing Black feminist thought and women ways of knowing as a framework, this phenomenological qualitative research examined the lived experiences of seven Black older women, ages 67 to 87, communicating with healthcare professionals. The research questions that guided the study were: (1) what are the experiences of the study participants navigating interactions with healthcare professionals? (2) how does communication and transfer of information occur between Black older women and their healthcare professionals? (3) what communication strategies do Black older women prefer to use while interacting with healthcare professionals? and (4) what is the role of culture when examining rapport and communication between Black older women and healthcare professionals?

Conversational interviews were the main data collection source and Colaizzi's (1978) method served as the data analysis process for the study. Dissertation findings suggest that aging, culture gaps, establishing trust and personal connections, as well as the ability to voice their opinions, had an impact on the communication process between the participating Black older women and their healthcare professionals. Thus, this dissertation documents Black older women's communication preferences, their perceptions, frustrations, and advice while interacting with healthcare professionals. It also discusses learning in older adulthood and the necessary condition for such learning to happen.

CHAPTER I

INTRODUCTION

Inspired by my grandmother, in which, our family affectionately refers to as "Granny", my concern for the somewhat forgotten generation (older population) has been heightened. As Granny is getting older, her encounters with healthcare professionals has increased. One evening we had a conversation about one of her doctor's appointments. She expressed frustration because she did not feel comfortable telling the doctor about her physical ailments because she always felt rushed, and the doctor often discounted her feelings by making comments such as: "you are just getting older and you should expect to feel that way. Go ahead and take this prescription and we will see you back in two weeks..." Granny left that appointment feeling that the initial reason for the visit was not addressed. Due to this occurrence, Granny decided to find another doctor. This incident is the inspiration and origin of my study. The driving thought was, I wonder how many other older women are having similar experiences during their healthcare interactions.

Later, I completed a pilot study with a 72-year-old retired professor whose experience was quite different. This pilot study was part of a research class and it allowed me to test my interviewing skills and interview questions. In this pilot study, opposite to what my granny had experienced, Dr. H (pseudonym) felt confident and able to communicate well with her healthcare professionals. Based on the dynamics of her relationship with the healthcare professional, she expressed the importance of trust. Dr. H was confident in sharing her needs, concerns, thoughts, and feelings with her healthcare professionals. She could not reflect on any times of perceived discrimination or misconduct; however, she did mention incidents where certain assumptions were made

by the healthcare professional such as her ailments were due to her age only. During the interview, she explained that she hoped her healthcare professional to be "someone who doesn't make automatic assumptions when I walk through the door. Some doctors treat patients based on assumptions rather than what is going on with the individual. Doctors can talk about symptoms; however, I am concerned with what is causing those symptoms." Studies have shown that healthcare professionals hold conscious and unconscious negative stereotypes of minority patients, tending to view them as less educated and less likely to be adherent than their European American counterparts (van Ryn & Burke, 2000).

Although assumptions are subjective and reflective of one's point of view, they can be influenced by stereotypes. Stereotypes develop based on cultural beliefs, values, and behaviors. Therefore, my study took a shift when I was able to dismiss my own biases and expectations based on my Granny's "one-time" experience (one isolated incident) and since then has been resolved. I assumed my grandmother was being discriminated against by her doctor. I had just put her doctor in a box and I was the one using stereotypes. Therefore, the present study focuses on documenting the experiences of Black older women, their communication challenges and strategies, and their relationships with healthcare professionals.

Statement of the Problem

The process of communicating, reviewing, interpreting and managing one's medical information can be troublesome at times. These processes are important and critical for all adults and more so for the older generation who may need to visit their doctors or healthcare professionals more often. Everyone should feel comfortable

communicating with their health professionals. Finding a main doctor whom one can feel comfortable talking to is the first step in good communication (Institute & Aging, 2017). The utilization of specialized words and medical jargon that physicians use can be intimidating and somewhat discouraging to someone going through the aging process.

Generational communication gaps still exist between healthcare professionals and their elderly patients, especially concerning interpersonal communication (Gunderson, Tomkowiak, Menachemi, & Brooks, 2005; Leung, LoGiudice, Schwarz, & Brand, 2009). In more recent studies this gap does not seem to be closing, as physicians in training hold similar preconceived philosophies before they even begin their careers as practicing physicians. These findings continue to add to the declining quality of healthcare afforded to elderly patients (Higashi, Tillack, Steinman, Harper, & Johnston, 2012). The literature reports that Black elderly women are the greatest consumers of health caring services and are the most vulnerable (Riekse & Holstege, 1996). With this documented information, things should look a little different for the Black older woman when it comes to encounters with her healthcare professionals. It is crucial that Black older women have a "voice" in their healthcare participation.

Culture is a major component of influence of the Black woman because it is dynamic and adaptive to include strong family values, norms, and practices (Kreuter, 2004). It is a common practice to identify and focus on only one component of a situation encountered, however, Black feminists are shaped both by cultural differences and "intersecting oppressions". This concept refers to the way mainstream institutions have denied access to Black women, in other words, the culture they are raised with and the experiences they have in life (Collins, 2000). Cultural differences identified by

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Collins (1990) are: The concepts used in thinking and acting, group validation of an individual's interpretation of concepts, the thought models used in gaining knowledge, and the standards used to evaluate individual thought and behavior. Intersecting systems of oppressions are race, class, and gender in which Black feminist thought fosters a fundamental paradigm shift of embracing the oppressions. By embracing the oppressions, Black feminist thought reconceptualizes the social relations of domination and resistance (Collins, 1990).

Inadequate health literacy and the cognitive and sensory changes associated with the aging compound in elderly Black women are major concerns (Speros, 2009). Cognitive decline can negatively impact the communication processes between elderly Black women and healthcare professionals. There are age-associated changes that affect the brain in the context of general research to lifespan development. Prominent changes in cognition are difficulties in attention and memory (Bialystok & Craik, 2006). Some of the speculated causes of change are linked to age. For instance, the longer we live the more anxieties and diseases will impact the brain and systems that support brain function (Bialystok & Craik, 2006).

Another concern is the number of questions patients ask as well as symptoms they disclose. Patients' recall and understanding of complex medical information given and even the amount of time spent for this information exchange can be overwhelming (Weisman, 1987). However, research that focuses specifically on Black elderly women is limited (LaVeist et al., 2000). This sparked my interest to document the narratives, perceptions, and lived experiences of this population with their healthcare advisors. This

documentation can also include common preferences and practices of healthcare professionals during routine encounters with Black older women.

I proposed to study the narratives of Black older women regarding their encounters with their healthcare professionals. There is a gap in literature exposing the need to identify culturally relevant strategies that healthcare professionals can adopt and utilize to better serve Black older women. Identifying such strategies could reduce and eliminate possible communication disconnects between these two groups. As to promote change, enhance the quality of life, longevity, and personal satisfaction, it is crucial Black older women' voices are heard.

Research Questions

Communication is fundamental to human existence. There is a link between quality of communication and quality of life (Stewart, 1995). There have been references made about bridging the communication gaps between the elderly population and healthcare professionals to promote meaningful interpersonal communication (Venter, 2016). These references can be as brief as understanding that there are different ways or forms of communication that cause conflict between these two stakeholders. There are many potential areas of research and areas of exploration in this field. Documenting experiences of the people receiving the healthcare services and identifying effective strategies of communication between patients, Black older women in this case, and healthcare professionals is a starting point that can lead to the consideration of other teaching and learning opportunities.

These following are the primary research questions guiding the study:

1. What are the experiences of the study participants navigating their interactions with healthcare professionals?

2. How does communication and transfer of information occur between Black older women and their healthcare professionals?

3. What communication strategies do Black older women prefer to use while interacting with healthcare professionals?

4. What is the role of culture when examining rapport and communication between Black older women and healthcare professionals?

Purpose of the Study

This study documents the lived experiences of Black older women regarding the encounters with their healthcare professionals they frequent most (see Appendix A for definition of relevant terms). A goal of the study was to identify communication challenges and strategies that Black older women encounter in their interactions with healthcare professionals. This study explores communication strategies useful for both groups. Another goal was to be a patient advocate for this population and document what Black older women are going through as they navigate the healthcare system. Study findings have potential to contribute to the literature in the field of communication with older populations, specifically as it pertains to Black older women.

Significance of the Study

In addition to contributing to the body of research on the narratives of Black older women and the communication interactions with their healthcare professionals, this study has potential to benefit both stakeholders. The healthcare professionals, in their work

practice, can positively influence outcomes of this relationship as well as the participation and quality of life of Black older women in their season of aging. Documenting the perspective of Black older women affected by poor communication and lack of compassion will add to the body of literature in the field of adult education and healthcare. Healthcare professionals will benefit from study findings by gaining insight into how to better serve this population of patients. In addition, study findings have potential to indirectly benefit other Black older women in similar situations.

Researcher's Perspective

Growing up the oldest of three girls, one of my responsibilities in the home was taking care of my sisters. I enjoyed this role as caregiver and aspired to be a nurse when I grew up. After high school, going to college, and getting so far into the nursing curriculum, I realized that drawing blood and collecting patients' specimens was not pleasurable for me. I do have a passion for working with people, however, not the clinical side of patient care. With that passion and administrative background, I have been serving in the field of Health Information Management (HIM) formerly known as medical records, as an instructor for many years. I consider my career a ministry of giving back to young adults. I am called by God to minister to my students through motivation, empowerment, and encouragement to success as they journey through their next levels of life. I often think of myself as a life coach, and enjoy mentoring all students, however, I feel a true calling for working with and encouraging women.

My professional background in HIM informed my research because of the knowledge and experience I have gained from the perspective of a healthcare

professional. I understand the appropriate culture and best practices that should be implemented in the healthcare environment.

It is my assumption, that there is a communication disconnect between Black older women and their healthcare professionals. If concerns of communication such as obscure medical jargon, cultural issues, and Black women's ways of knowing are elucidated, quality of life for the Black older woman can be enhanced by informing all study participants. Study findings have potential to benefit patients and their families as well as the healthcare professionals.

Theoretical Orientation

Black feminist thought is defined by Collins (2000) as a way to comprehend and capture themes from the origins of Black women's experiences, and from their ways of knowing, and positioning these understandings in the world. Black feminist thought is utilized to create and validate knowledge in ways that are different from the mainstream American educational system (Collins, 2008). Collins emphasizes the "interlocking" nature of the wide variety of statuses for example, race, class, gender, nationality, and sexual orientation that makes up our standpoint. This researcher explained: "I feel it is radical to be dealing with race, sex, class, and gender identity all at one time. I think that is radical because it has never been done before" (Collins, 1990, p. 2). In other words, Black feminist thought reconceptualizes the social relations of domination and resistance. Collins (1990) also discussed culture as shaped by both cultural differences and "intersecting oppressions"- which refers to the way that mainstream institutions have denied access to Black women, in other words, the culture they are raised with and the experiences they have in life. Cultural differences identified by Collins (1990) are: The

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concepts used in thinking and acting, group validation of an individual's interpretation of concepts, the thought models used in gaining knowledge, and the standards used to evaluate individual thought and behavior.

Collins stresses that where there are sites of domination, there are also potential sites of resistance. The Black feminist thought conceptual perspective involves gathering data through phenomenological interviewing and explores the meaning of the "lived experience," in this case the lived experience of Black older women. This concept supports the use of a qualitative research methodology because it is collaborative, transformative, and empowering.

Collins (2000) argued that Black feminism creates and validates knowledge in ways that are very different from the American educational mainstream system, which has been dominated by elite White men. Although this knowledge and methodology may correspond to these elites' lived experience, it has little relevance from the standpoint of oppressed people. Collins' goal was to trace out ways that Black feminists have produced and recorded knowledge. Black feminist thought demonstrates Black women's emerging power as agents of knowledge. According to Collins, "Knowledge is a vitally important part of the social relations of domination and resistance" (p. 1). This researcher also speaks about cultural differences such as the concepts used in thinking and acting, group validation of an individual's interpretation of concepts, the thought models used in gaining knowledge, and the standards used to evaluate individual thought and behavior (Collins, 1990).

In addition, Collins (2000) addressed Black feminist thought that originated from six themes coupled with low socioeconomic status (SES) and limited resources. These

themes can be associated with how Black women communicate and possibly why they respond in certain ways to certain situations. The themes were identified as:

1. The dialectical relationship among Black women. This relationship occurs between Black women as a group. Within groups, Black women can share and construct wisdom about their social and cultural experiences.

2. U.S. Black women's standpoint. This dialectical relationship amidst the intersectionality of oppression creates a position from a Black woman's standpoint. Standpoint refers to group knowledge, and recurring patterns of different treatment that accompany intersecting oppressions. Black women exist in two worlds, one of black struggle against male superiority and one where she struggles against white supremacy.

3. Connecting the practice of Black feminism and Black feminist thought. The third feature is the relationship between action and thought. On the individual level, Black women's actions and lived experiences lead to resistance against oppression. The premise is that Black women's historical experiences may stimulate activism.

4. Dialogical practices and Black women intellectuals. Acknowledging the existence of a Black woman's standpoint is necessary in the academy by investigating Black women standpoints as a catalyst for change within and outside of the university setting.

5. The role of Black women intellectuals in Black feminist thought. The role of Black women intellectuals is central to Black feminist thought because it is important as a critical social theory. There must be Black women

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intellectuals who produce knowledge and promote social change in
society,

6. The dynamic nature of social movements and role of social justice. Black
feminist thought is concerned with social justice projects, which are
designed to be educational, political, and empowering not only of Black
women but of other groups seeking justice.

Other authors have theorized about Black feminist thought and Collin's work;
such is the case of Alinia (2015). Alinia presented a review of Collins' concept of
intersectionality, the relationship between oppression and resistance, and the politics of
empowerment. Alinia (2015) explained that, developed through an interaction with
Black women's everyday struggles, Black feminist thought is important for its
contribution to critical social theories and methodologies as well as for providing
important knowledge for the use of social justice movements. Alinia (2015) noted that
Black feminist thought reveals how domination is organized and operated in various
domains of power. For example, it illustrates the path of struggle and empowerment of
Black women, while at the same time highlighting the challenges and difficulties they
have faced in combating intersecting oppressions. In Collin's words: "In all their lives in
America…Black women have felt between loyalties that bind them to race on one hand,
and sex on the other. Choosing one or the other, of course, means taking sides against the
self, yet they have almost always chosen race over the other" (Collins 2009, p.132). This
quote speaks to the experience shared around the globe by many other subordinate
groups, especially women who face intersecting oppressions. Women's call for their

rights has been regarded as threatening and harmful to the unity of the Black community in the common struggle.

Likewise, another author examined the ways in which Black feminism functioned as a critical social theory. Gist (2016) exposed ways in which Black and Brown women are marginalized through institutionalized structures and practices. Drawing heavily from the work of Collins, this article defined and explained Black feminist critical pedagogy and argued that it is a critical knowledge project that generates knowledge and creates perspectives that allows evaluation of how Black women are situated as social agents in society. This critical consciousness of the patterns of inequality facilitates a process in which new social narratives of justice can be written to eliminate these practices. For example, a young Black girl from a working-class background in the United States reads the social world as a competitive arena where society's winners and losers are determined based on the quality of an individual's effort. She reasons that if her actions mirror hard working winners, then she will be academically successful. Her perspective of achievement is individuals can achieve their dreams through dedication and hard work. Now suppose she works hard but does not achieve her dream, i.e. college acceptance at an elite university. How might she understand this outcome? In this article, Gist offered a thought proving scenario and provided the reader an opportunity to view life through the lens of Black feminism from an analytical framework for interpreting the social world.

The Black Feminist Thought philosophical orientation of learning highlights the role of cultural differences and intersecting oppressions. The literature provided specific examples of application of the learning perspective that helps readers of the social world

understand how Black women can be marginalized through institutional structures and practices. The literature also supported a critical awareness of these patterns of inequality that can encourage new social narratives of justice in efforts to diminish these unjust practices. It would be interesting to see what strategies are discovered to eliminate such practices, how these strategies are used in the arena of the academia at an elite university as well as in the healthcare industry, and finally, the student and patients' perspective of the benefits.

Dissertation Roadmap

This is a traditional dissertation, in other words, it is divided in five chapters: Introduction, Review of literature, Methods and study design, Study findings, and Conclusions. The first chapter provides the reader with the context and motivation to conduct the study, the statement of the problem, research questions and purpose of the study, significance, researcher's perspective, and theoretical orientation. Chapter II discusses relevant literature organized under the following themes: learning in older adulthood, Black women and knowledge, Black women and healthcare, communication issues, and communication strategies in healthcare. Next, Chapter III outlines the study design and details for study implementation. It is divided into eight big sections: researcher's roles, narrative inquiry, case study, setting and participants, data collection, data analysis, trustworthiness, ethical considerations. Chapter IV presents the study findings starting with the participants' profiles and reports on their communication preferences, as well as their positive perceptions, frustrations, and advice to healthcare professionals. This chapter also analyzes the conditions needed for learning to take place in older adulthood based on the data collected from study participants. Learning in

adulthood is discussed through the following themes: learning throughout life and the four pillars of learning, affective learning, learning through established trust, learning with support groups, and learning with technology. Finally, Chapter 5 presents the study highlights, study contributions, recommendations for practice, ideas for future research, and closing thoughts.

CHAPTER II

LITERATURE REVIEW

This qualitative study documents the narratives of Black older women as they describe their interactions with healthcare professional during routine clinical visits, as well as the communication strategies they utilize during these encounters. The chapter provides a review of literature as divided into five sections. The sections address topics discussed in the study, specifically, learning in older adulthood, Black women and knowledge, Black women and healthcare, communication issues, and communication strategies in healthcare.

Learning in Older Adulthood

Continued participation in learning should be a main goal as people age. Older adults have a wealth of knowledge that they can contribute to community wellbeing. When involved in further learning (e.g., skills in technology), older adults have the opportunity to acquire personal strategies for the development of different areas of their life.

Still, older adults are often neglected as candidates of learning. To this regard, Purdie and Boulton-Lewis (2003) investigated the learning needs of adults over 70 years of age. Using the results of their study, they designed and administered a learning needs, barriers, and efficacy questionnaire to 160 adults. These researchers found that the most important needs were associated with transportation, health, and safety and the strongest barriers were those associated with physical disabilities (Purdie & Boulton-Lewis p. 129).

Another aspect that has been explored in the literature relates to the wealth of knowledge that older adults possess and the contributions they can make to the

community. To this effect, Biggs, Carstensen, and Hogan (2012) presented a social capital perspective as they considered how learning in older adulthood contributes to community wellbeing. The "social capital" of older adults is "accrued knowledge and experience, understanding of the ways things interact with each other, and an ability to place single events in their wider perspective" (Biggs et al., p. 38). In other words, due to their wisdom, older adults can see the bigger picture and share their accumulated knowledge and experience with others in the community to provide support or help find solutions to community issues.

To continue to make the argument, Price (1991) explained that by providing education opportunities and learning support to older adults they can acquire new skills such as self-reflection. In an article on the expectations of the midlife women learners, Price (1991) found that midlife and older learners set extremely high goals for themselves and require affirmative feedback from their instructors. Most classroom settings and instructions provide various opportunities to evaluate knowledge and offer feedback. For example, one of the learners from Price's (1991) study reported, "I have learned more about myself this term than at any other time in my life" (p. 57). This new-found self-awareness is the catalyst for developing personal growth inducing strategies, which inevitably lead to self-improvement and doing things differently. Though this information provided was specific to learners in the classroom setting, this study is relevant in the healthcare industry to better understand the needs of older adult learners as patients when they clearly articulate their expectations. Health professionals should be aware and flexible to adhere to these requests as to promote efficient dialogue with patients.

In this day and age where technology is often our primary means of communication, it is important that this flexibility of health professionals in dialogue with older adult learners not be limited to merely face-to-face conversation. Chatham (2014) addressed and offered learning and teaching techniques to encourage the elderly population to engage in patient portals online. The author suggested: 1) Not assuming that elderly patients are not technologically proficient, 2) Convincing seniors of the benefits of patient portals, 3) Identifying the appropriate people to educate these patients. Chatham goes on to say that poor implementation of these strategies is the problem when considering the lack of technological engagement amongst older people. It is important that professionals emphasize the features that are likely to help the elderly to be more successful in adaptation (Chatham, 2014). Health professionals should be more open to the ideas elderly people have about resolving certain apprehensions. Treating them based on pre-conceived thoughts or stereotypes must become a thing of the past. When eliminating these assumptions and thoroughly explaining the benefits of healthcare interactions, there is a greater possibility of adherence to medical recommendations and outcomes. Implementing these techniques regarding older adults and technology serve to benefit the patient from a medical perspective and would benefit different areas of their lives.

Likewise, Field (2009) reported that technological changes have the potential to transform learning, and promote new types of social networking, therefore, contributing to resilience and well-being. Equally, there are risks of a sharp digital divide, where some groups - particularly older adults - are unable to adapt and apply new technologies. According to Speros (2009), older adults tend to process information at a slower pace and

use less working memory which may indicate that their ability to process multiple bits of information at a given moment is challenged. New technology can be very intimidating, which makes it easy to empathize with the frustrations of an older learner. This digital divide may inhibit access to new learning opportunities (including information and guidance) supported by information and communications technology. Therefore, learning and support should be targeted to enable success of the older adult. Targeted support behaviors include: helping the learner gain an understanding of the varying nature of new technologies and engaging the learner in social networking, for example, making sure all older adults can use Facebook (Field, 2009, p. 33).

Yet another strategy is explored to assist this population in adapting; this strategy directs attention away from technology and emphasizes a more active approach to learning. Withnall's (2011) study on the concept of longlife learning, found that older people expressed ideas about the importance of learning for broadening horizons, social interactions, and maintaining an active and inquiring mind. Withnall's work supported the idea of various learning forms contributing not only to social inclusiveness but an individual's desires for personal development and creativity as they grow older. This article confirms the importance of the aforementioned learning strategies. Incorporating older adult friendly technology and fostering environments for self-reflection is important because learning has a greater effect on the adult learner than just increasing their knowledge (Price, 1991). Learning coexists and cultivates other advantageous outcomes such as increased well-being, resiliency, and spontaneity (Biggs, Carstensen, & Hogan, 2012; Field, 2009).

Black Women and Knowledge

Belenky, Clinchy, Goldberger, and Tarule's (1986) work describes five knowledge perspectives through which women view themselves and their relationship to knowledge. These perspectives are empirically derived from studying five stages of knowing: Silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge.

Silence

This refers to total dependence on whims of external authority. Women are afraid of voicing their opinion and expect that they would be punished by an authority figure. In this stage, women constantly question their decisions and are unable to voice their own opinion. Women view themselves as mindless, voiceless, and without freedom to express their thoughts. Such behavior is usually developed when women have suffered mental, physical, or sexual abuse and do not feel they belong.

Received knowledge

 This is where women see themselves as capable of receiving and reproducing knowledge from external authorities, but do not see themselves as being able to construct or create knowledge. For example, taking heed to the advice of a person of higher status versus lower status even though the information is the same.

Subjective knowledge

From this perspective, truth and knowledge are conceived by as personal, private, and intuitive. For example, in this level of knowledge, women realize they have their own voice and right to express their thoughts and opinions. Women understand they do not

have to agree with the authorities on everything. They realize the truth, but never expresses it due to fear of spoiling their associations with others.

Procedural knowledge

This procedural knowledge is present when women are invested in learning, methods for obtaining and communicating knowledge. There are two types of procedural knowledge, separate knowing, distinguished by evaluation and objectivity in judging others point of view and connected knowing distinguished by acceptance and appreciation of another's' point of view. The notion of 'ways of looking' is central to the procedural knowledge position. Knowledge is a process. For instance, a separatist can speak in favor of the requested view without projecting their own feelings into the situation, whereas, a connected knower knows other's situations, empathizes with them, and helps them in making the right decision.

Constructed knowledge

This approach views all knowledge as contextual. Women experience themselves as creators of knowledge and place value on both subjective and objective strategies for knowing. Such women understand that it is one's responsibility to speak, express, listen, share ideas, analyze, and ask questions. They understand that they can speak and listen to themselves and others at the same time. They want a better quality of life for themselves and others.

These five ways of knowing color the lenses with which Black women view and interpret their life experiences. This theory suggests that the aforesaid ways of processing knowledge are not exclusive to each Black woman, as most of them tend to follow this model closely. Consequently, there are elements of a Black woman's life that she has in

common with many other black women. Furthermore, these mutual experiences are vastly different from those of white women (Collins, 2000).

Drawing on this perspective of lived experiences, Banks-Wallace (2000) explained how women view knowledge and how they approach learning and knowing. Womanist epistemology regards the everyday experiences of African American women as critical to addressing problems related to the concepts of knowledge and truth such as being stereotyped and judged by others. This perspective is also central to understanding how women use experience to distinguish knowledge from wisdom (Collins, 2000). This experiential knowledge can also be a vehicle to interpersonal development. In an earlier publication, Collins (1990) noted that sharing experiential knowledge with others is operating under the primary assumption that this knowledge will be used to build or nurture connections between people.

In addition to knowledge being used to create networks, Cole (1970) gave special attention to explaining that the essence of blackness, too, functions in a similar way. Black America evaluates knowledge and identifies with blackness originating from consistent themes of soul and style. Cole explained that, "Soul and style are major expressions in Black subculture" (p. 52). For example, "The way Blacks get happy (possessed) in sanctified churches or the movement of a Black woman's hips when she dances, that's soul. Style is the way a Black woman speaks of going to the beauty parlor to get her "kitchen touched up" (Cole, 1970, p.53). This researcher further explained: "soul is the ability to feel oneness with all Black people. It is the knowing smile as two Black people, perfect strangers, exchange a glance in the middle of a crowded urban street" (Cole, 1970, p.54). Identifying the collaborative nature of blackness, the findings

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showed that participants in Cole's study expressed themselves better and were more

comfortable communicating in environments that were familiar to them because they felt

understood and connected. Collins (1986) added that when a group of people share a

culture, this "insider" relationship is satisfying to all involved. This study relates well

with Cole (1970) as it reiterates the weight familiarity has in forging intimacy amongst

kindred strangers.

Black Women's Culture and Healthcare

The need for cultural sensitivity in the healthcare industry is an issue that has been

made clear (Resnicow et al., 1999). Despite the ubiquity of this concern within public

health research and practice, there has been little conceptual work done defining cultural

sensitivity and how Black women are impacted. Resnicow, Baranowski, Ahluwalia, and

Braithwaite (1999) presented a model for understanding cultural sensitivity from the

perspective of Public Health. Their study described a process for applying this model to

the development of health promotion and disease prevention. The authors asserted that,

"cultural sensitivity is defined by two dimensions: Surface and deep structures. Surface

structure refers to how well interventions fit within a specific culture while deep structure

involves incorporating the cultural forces that influence the target behavior in that

proposed target population" (p. 11). For example, surface structure may involve people,

places, language, music, and clothing familiar to the target audience. When surface

structure is identified, *deep* structure requires understanding the cultural, social, and

environmental forces that influence Black women. By developing a standard where

practitioners are more aware of their active role in intentionally creating a culturally

comfortable environment, the results could include a more positive overall healthcare

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experience for Black women. Increasing cultural sensitivity in healthcare not only fosters

a positive overall experience, it also facilitates increased participation to specific

programs. For instance, Bailey and Belin (2000) conducted a focus group that informed a

culturally competent cancer education program for African-American women. The

qualitative data collected for the study highlighted the importance of three aspects: (1)

spirituality, (2) the cultural trust factor within the social groups, and (3) the intra-ethnic

preference of role models.   This research emphasizes Black women and their

apprehensions toward seeking preventative healthcare. Young women in the study said

that their mothers would be more likely to attend a program if they went with their

daughters, especially older women. This research team concluded that, "because role

models such as an elder, close friend, and/or physician from the community shared faith-

based cancer stories in church settings, they were viewed by participants as having

similar cultural values and thus were trusted and deemed truthful" (Bailey & Belin, 2000,

p. 140). When role models come from similar cultural backgrounds thus creating an

intra-ethnic preference, they are more likely to motivate African-American women to

participate in intervention programs. Bailey and Belin (2000) illustrated the

interrelationship of cultural beliefs and healthcare utilization. When identified, the

perceived cultural barriers associated with African-American women can be used

strategically to provide them with better health care services.

Similar to Bailey and Belin's evaluation of culturally alike role models, Kreuter

and McClure (2004) examined the role of culture as a factor in enhancing the

effectiveness of health communication. The authors described culture as a major

contributor of influence on Black women because it is dynamic and includes strong

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family values, norms, and practices. Kreuter and McClure (2004) agreed that, culture is also learned, shared, transmitted intergenerationally, and reflected in a group's daily social regularities. When an individual can relate with another person based on background similarities e.g. age, race, ethnicity, etc. that source of information becomes more credible. Thus, when Black women receive information from someone like them, ratings of the source is often more favorable (Kreuter and McClure, 2004).

Likewise, Kreuter and Houghton (2006) found that health information culturally appropriate for a specific group may be more effective in capturing attention, stimulating information processing, and motivating changes in healthcare behavior than information that does not integrate culture. Culture is a major consideration regarding the comprehension of health information. The implication of the study identifies the need for more research on the role of culture in health communication and increasing this recognition is an important factor in the public health sector. This recognition has the potential to contribute to the development of new and more effective strategies to help eliminate health disparities. Although the ideas presented are applicable to a wide range of population subgroups, the article draws heavily on their experiences working with urban African American adults. This study provided evidence of the effectiveness of healthcare communication when cultural tailoring was combined with behavioral tailoring. This combination of approaches led to significantly greater change in Black women's healthcare behavior.

According to Kreuter and Houghton (2006), patients' care seeking behaviors, or their willingness to invest in their health care, must be taken into consideration to successfully integrate culture. Culture has been identified by previous researchers as an

important factor associated with healthcare behaviors. More specifically, Martin, Trask, Peterson, Martin, Baldwin, and Knapp (2010) investigated the influence of culture and discrimination on care-seeking behavior of elderly African Americans. One of the emerging themes from their study identified the importance of God and spirituality on health, illness, and healing. Participants agreed on: "God made this body, and He's the only one who really know(s) how it works. The doctors have a little insight on it, but He's the only one who can do healing" (p. 322). The implications from this study suggested that some older African Americans have cultural characteristics that permeate their perception of healthcare-seeking behaviors. Moreover, enhanced knowledge of cultural nuances can be effective in facilitating community forums between older African Americans and healthcare professionals. In other words, Martin et al. (2010) aimed for their project to increase knowledge and understanding about elderly African Americans' cultural views and how these views lead to lack of healthcare utilization by this population. This understanding can assist in the future design of culturally appropriate interventions that can benefit healthcare professionals of various disciplines.

In reviewing the literature, it became evident that culture can influence and impact Black women's overall healthcare experience, but also their decision to even seek healthcare in the first place. The literature emphasized the importance of being sensitive to cultural differences. The body of literature also supports the argument that healthcare professionals should be held accountable for cultural awareness to effectively serve this population of study. Other important aspects shared by some of the authors is that culture is learned and inclusive to strong family values, beliefs, norms, practices, and spirituality. All in all, the literature explored the characteristics of culture as well as the importance of

awareness. Each author presented different aspects of the topic and sometimes

overlapping findings. Although literature confirms the essential role of culture, there is

limited information about the perspective of health professionals once cultural differences

are encountered. In other words, once awareness has been discovered, how has their

practice changed to accommodate this population?

<div align="center">**Communication Issues**</div>

A study by Black (2009) investigated the disconnect between education and

behavior by examining how those factors affect communication, satisfaction, anxiety, and

self-efficacy. This article explored current theories of communication to understand

health behavior change. The changes discussed were key constructs of measuring the

patients' perceptions of benefits as well as barriers of communication in public health.

Black (2009) reported that, "The consensus across several fields of academic literature is

that communication between physician and patients is the cornerstone of the relationship"

(p. 25). Furthermore, patient satisfaction is negatively impacted when this relationship is

hindered by non-effective dialogue. Physician-patient communication and patient

satisfaction are interdependent of one another that most patient satisfaction scales also

include measures of physician-patient communications. The research concluded by

theoretically linking communication and behavior change together. Black (2009) quoted,

"Over the years great strides have been made in understanding how to educate health

consumers" (p. 35). Most of current health communication literature focuses on

knowledge acquisition, processing of information, and subsequent behavioral changes.

All of these concerns can enhance further research because an individual's way of

communicating can vary from person to person, more specifically, being aware of how

older women receive information and then create their own stories based on how they perceived that information (Black, 2009). After this processing occurs, how the actual comprehension of information manifests through daily interactions is another key point worth analyzing further.

The way that information is perceived and, most importantly, acted upon depends chiefly on the initial presentation of the information. However, it is important to note that there are features that could potentially obstruct the reception of the message. For instance, Cuevas (2012) identified four barriers that affect the quality of the patient-provider relationship for African Americans. Those barriers are: (1) Perceived discrimination, (2) medical mistrust, (3) race discordance, and (4) poor communication. A deductive approach was used to enhance the understanding of how these barriers were interrelated and impacted relationships. Cuevas further reported, "Prior studies have shown that these barriers negatively affect patient-provider relationships, however, few have captured how patients actually speak about these barriers" (p. 3). In other words, the patient's point of view and voice are missing in this type of research. The author conveyed that perceived discrimination can unfavorably influence health outcomes. For example, when an elderly Black woman believes she received unfair treatment by a physician or healthcare professional, she is less likely to adhere to the recommended treatment plan and return for follow-up visits. In conclusion, "Poor communication can become a cause for the low use of services for ethnic minorities, particularly African Americans" (Cuevas, 2012, p. 12). Consequently, patient non-adherence and dissatisfaction become even more likely to occur.

As supported by Cuevas (2012), the conversation continues with the impact that one's presumptions have on communication. Shelton (2017) explored communication barriers and trust issues perceived by Black women when seeking preventive health services. The study captured the reflections of four participants who shared a common belief of their healthcare provider being somewhat apathetic when it came to addressing their health care needs. As a result, three of the four participants reported having poor communication and trust issues with their health care provider. Shelton's (2017) work reiterates the idea presented by Cuevas, O'Brien, and Saha (2016) that Black women lack trust in their health care providers because of the absence of support, especially when patients are seen as consumers rather than patients. Trust is a fundamental attribute of the patient-provider relationship, affecting every aspect of clinical exchanges and interventions from personal disclosure to adherence to treatment (LaVeist, Nickerson, & Bowie, 2000). These findings informed the need for further research as it is not likely that a person, more specifically, an elderly woman will engage in constructive dialogue if trust is not apparent in the interaction between herself and healthcare professionals.

Furthermore, Hansen, Hodgson, and Gitlin (2016) presented a critical review on older African Americans speaking about their healthcare encounters. The purpose of this study was to examine their perspectives of these encounters and identify ways to enhance trust. Although trust is a major factor of providing appropriate care, there are also challenges in establishing and maintaining that trust in health care (Shore, 2007). The findings presented by Hansen et al., (2016) indicated that provider behaviors leading to mistrust included assuming stereotypes, spending inadequate time listening to patients, disregarding patient preferences, and insufficiently explaining treatments. Thus, it is

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important for healthcare professionals to show empathy by treating each patient as an individual, giving them complete attention, and acknowledging their personal health preferences without any preconceived thoughts.

Health outcomes are also dramatically improved once practitioners are made aware of the preconceived notions they might be operating under. Examples of this includes passing judgments based on race, gender, and even age. Ageism is described by authors as being the unfair judging of elderly adults simply because of their advanced age (Gunerson, Tomkowiak, Menachemi, & Brooks, 2005). Lueng, LoGiudice, Schwarz, and Brand (2011) also presented an article with a background of ageism to include hospital doctors' attitudes toward older people. Physicians, both novice and experienced, reports showed that they tend to assume elderly patients all have some type of cognitive disability before speaking with them or assessing them. Lueng et al., (2011), further reported that, "Often times doctors tend to be less engaged when communicating with older patients and will only present patient results to the family and friends of an elderly patient, assuming that they will not be able to understand" (p. 308). In even worse cases, the physician will present an oversimplified version to the patient that paints an inaccurate picture of the reality of the results.

How can ageism be eradicated in public health? Studies suggest to begin by making physicians aware of subconscious prejudices they may hold. Additionally, researchers advocate that this process requires new physicians to be trained and held accountable about these prejudices. Higashi, Tillack, Steinman, Harper, and Johnston (2012) explored the attitudes of physicians-in-training toward older patients. Specifically, they examined why, despite increasing exposure to geriatrics in medical

school curricula, medical students and residents continue to have negative attitudes toward caring for older patients. Efforts to educate medical students about appropriate geriatric care tend to reproduce the uncertainties surrounding aging. They also contribute to the tendency of students to develop demoralizing attitudes about older patients, labeling them "frustrating" or "boring". When displaying this type of behavior to the patient, communication disconnects can occur and/or persist further if the older patient feels like they are being a bother to the professional. This far the literature supports that everyone should feel comfortable communicating with their health professionals.

The authors in this section support the needed discussion of older patients communicating better with their healthcare professionals as well as bringing awareness to healthcare professionals of the factors that may inhibit such communication. The themes that remain consistent amongst authors were the perceptions and expectations between patients and healthcare providers. One aspect the authors agreed upon was that the patient-provider relationship is an important factor affecting quality care. Another author investigated the gap between education and behavior changes of patients and how healthcare providers can change the way they conduct their conversations to eliminate barriers. This understanding also brings awareness to the impact on patient satisfaction (i.e., likelihood of adhering to medical instructions and returning for follow up appointments). Finally, each author offered supporting evidence that quality communication from healthcare providers is connected to and reflects the patients' overall satisfaction of their medical care experience.

Communication Strategies in Healthcare

As Wiebe (1997) stated, unclear communication can cause an entire medical encounter to fall apart, therefore, healthcare professionals should be aware of this aspect of their practice. This researcher supports the idea presented by Halter (1999) explaining how the range of life experiences and cultural backgrounds can influence older patients' perception of illness, willingness to adhere to medical regimens and ability to communicate effectively with health care professionals. Elderly adults have accumulated lifelong illnesses and disabilities that can lead to loss of hearing, vision, and motor function. These functional faculties certainly influence communication with healthcare professionals. Halter (1999) also noted that, "Communication can be hindered by the normal aging process, which may involve sensory loss and decline in memory" (p. 74). This study was relevant because it made apparent awareness from healthcare providers of the broad range of physiological differences among older individuals. The suggestion was for providers to practice deliberately using prior patient experiences to address common problems among future older patients.

Using previous patient-cases as a precedent for future interactions is a beneficial tool in various regards. One is able to learn from both their mistakes and successes, which proves to be an essential tool especially when learning to communicate effectively. For example, Robinson, White, and Houchins (2006) provided suggestions to healthcare professionals to improve communication with older patients. They recognize that the communication process in general is complex and can be further complicated with age. Robinson and colleagues (2006) proposed: "Basic strategies of communication such as sitting face to face and maintaining eye contact, are crucial when dealing with elderly

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patients who may have trouble hearing or concentrating" (p. 74). These researchers also explained that the ability of healthcare professionals to "plug in" and connect with their patients' physically and emotionally is of great importance. Once the connection ensues the effective communication process begins. Other strategies suggested by Robinson et al. (2006) are to allow extra time, speak slowly and clearly, stick to one topic at a time, and simplify your medical instructions. This same study also noted the most common complaint patients have about their doctors is that they do not listen.

Understanding different types and forms of communication can serve as a strategy for enhancing communication. According to Deep, Salleh, and Othman (2017), communication is the act of sharing information, giving and receiving messages, and the transfer of information from one person to another. The authors suggested that, "Training of employees (e.g. sharpening their skills and traits) and good leadership could reduce, manage, and eventually resolve the communication conflicts" (p. 1194). The authors focused on the overall role of culture in triggering communication conflicts. Therefore, when there are cultural differences, there also comes cross-cultural misunderstandings (Deep et al., 2017). This information is relevant because if healthcare professionals are not aware of these cultural differences and behaviors, it can affect their means of communicating effectively. In other words, the strategies used to communicate with one elderly Black woman may not necessarily work for communicating with all Black women. Hence, replicating that awareness of the influence of culture can serve as a strategy for effective communication.

Communicating effectively goes beyond merely the words that are said; professionals must be aware of the message they communicate without using words.

Klein (2005) explained that body language, facial expressions, eye contact, posture, hand gestures, and tone of voice often provided additional clues that influence communication. This study aimed to increase awareness of communicating with various patients and presented strategies for more effective communication. With the goal of quality care in mind, healthcare professionals are urged to listen to their patients because they have much to say (Klein, 2005). Klein goes on to emphasize, "Proper responses require engaged listening without interruption" (p. 15). Providing reassuring noises such as "uh-huh" and head-nodding as well as hand gestures can reinforce the message. According to Klein (2005) taking the time to reflect on basic communication skills and how healthcare professionals communicate with patients can lead to increased provider self-awareness and satisfaction in their professional practice.

Klein's (2005) view of the healthcare professionals' role in communication with this population is supported by other researchers. For example, non-verbal and verbal communication with Black and White patients was a study done by Elliott, Alexander, Mescher, Mohan, and Burnato (2016) illustrating significant differences between these two groups. Findings of this research reported that physicians were using fewer positive rapport-building non-verbal cues with Black patients. Consequently, this behavior impacted trust in physicians and medication adherence. These authors observed and documented different non-verbal communication behaviors, such as open body position, eye contact, proximity, and touch as important to establishing positive patient-doctor rapport. Notably, Elliott et al. (2016) argued that when this positive rapport does not happen it is more likely that the patient will not return for follow-up visits.

To summarize this chapter of the literature review, there is a consensus that exploring strategies of communication could impact, improve, and enhance different components of the relationship between healthcare professional and patient. The literature confirmed that communication can be complex and multifaceted for healthcare professionals. Additionally, the process of communicating, reviewing, interpreting, and managing one's medical information can be troublesome at times. Therefore, effective communication is critical for all adults, more so for the elderly who may need to visit their doctors more often.

Some authors (Deep, Salleh, & Othman, 2017; Robinson, White, & Houchins, 2006) are specific about the strategies for the elderly population and offer tips such as sitting face to face, maintaining eye contact and speaking slowly. The literature also provided specific recommendations for healthcare professionals on how to improve their communication with older patients. Those suggestions are learning to listen and pay attention to body language of their patients (Klein, 2005). They also discussed the importance of awareness about different types of communication; for example, non-verbal versus verbal communication and the influence each has on the continued care of their patients. Each author gave compelling arguments with a common overlapping theme of the enhancement of communication skills that could be achieved by implementing certain strategies for the elderly population.

In closing this chapter, it is important to highlight that almost no literature was found on the experiences of Black older women communicating with healthcare professionals. This is the gap that the present dissertation addresses.

The following chapter presents the methods and study design for this research. It further explains the conceptual framework, setting and participant selection, data collection and analysis, and ethical considerations to conduct the study.

CHAPTER III

METHODS AND STUDY DESIGN

This study describes the experiences of Black older women regarding the encounters with their healthcare professionals. The focus was twofold: Document the communication challenges they face and identify the communication strategies they utilize when interacting with healthcare professionals. Therefore, the study explored communication strategies useful for both groups' healthcare professionals and patients. This chapter outlines the study design and details for study implementation. The following pages discuss the researcher's roles, narrative inquiry, case study, setting and participants, data collection, data analysis, trustworthiness, ethical considerations and expectations.

Positionality

In qualitative studies, the researcher is considered an instrument of data collection and analysis, the filter of the information (Denzin & Lincoln, 2003; Merriam 2009). This means the data are mediated through this human instrument who makes decisions, analyzes, and reflects. For this purpose and to achieve credibility, the qualitative data should be able to describe relevant aspects of the self, including biases and assumptions, expectations, and experiences to qualify his or her ability to conduct the research (Greenbank, 2003). Characteristics of a good qualitative researcher include asking probing questions to get to deeper levels of the conversation, becoming a good listener and observer (Merriam, 2009; Patton, 2015). The goal of an effective qualitative researcher is to build a picture using ideas and theories from various data sources (Merriam, 2009).

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In qualitative studies, the researcher seeks facts and causes of human behavior and wants to learn about possible variables, so differences can be identified (Roberts, 2014). As a researcher, my goal was to serve as a patient advocate to a fairly "forgotten and/or overlooked" generation, namely Black women ages 65 and older. A patient advocate is defined as an individual who pleads for and preserves a patient's rights to health care (Mosby's Medical Dictionary, 2009). My professional practice, foundation of learning in health information management (more particularly, medical terminology), and experience with collaborating with providers is an area of expertise that I bring with me to the implementation of this study.

Everyone is entitled to have a "voice" in his or her healthcare regiment, therefore, my goal was to build rapport with the study participants to gain knowledge about their lived experiences and communication exchanges with their healthcare professionals. Because I have a personal and professional investment in this study, I was aware of and monitored my verbal interactions and feedback to the participants when interacting with them. I also monitored my thoughts and interpretations to be truly open to "hearing" the different perspectives and realities of the study participants. I kept my biases in check to convey the participants' points of views and stories, not mine.

Being a good listener and observer was important as to capture non-verbal gestures, absence of data, data redundancy, and unexpected findings that may explain the experiences of the study participants and unveil answers to the research questions. The goal was to identify and explore communication strategies to benefit Black older women like my granny. I realized that I had to keep an open mind and keep reflecting so stakeholders could benefit from this research, therefore, personal biases had to be

minimized when possible. The healthcare professionals could benefit as to increase their knowledge of their patients' communication strategies which will lead to better plans of care and better quality of life for the patients.

Conceptual Framework

The conceptual framework for this study brings together elements from different theories and approaches to adult learning. These are: Black feminist thought, women's way of knowing, learning in older adulthood, and culture. To this effect, Maxwell (2005) defines the framework as, the system of concepts, assumptions, expectations, beliefs, and theories that support and informs your research. Figure 3.1 illustrates the conceptual framework supporting the assigned analysis for the study. The healthcare professionals are the roots, depicting responsibility for driving the growth and enhancement of the patient physician relationship. The trunk of the tree illustrates hands supporting the Black older woman as an anchor to the roots. The leaves of the tree represent the four major components of the study that symbolize knowledge, wisdom, and growth. The center and main focus of the study is Black older Women. Figure 3.1 serves as a visual presentation of the conceptual framework of the study.

Figure 3.1 Study Conceptual Framework

Black feminist thought

Collins (2000) explains that Black feminist thought (BFT) is a tool to comprehend

Black women's experiences and their ways of knowing to position these understandings

in the world. BFT emphasizes intersectionality and the struggles of Black women for

racial and gender equality. This dual struggle suggests that the experiences of Black

women do not compare with any other demographic and affect them in ways that other

groups of people must be cognizant of when working with them. BFT is utilized to

create and validate knowledge in ways that are different (i.e. culture) from the

mainstream American educational system (Collins, 2008).

Women's ways of knowing

The work of Belenky et al. (1986) describes five knowledge perspectives explaining women's views of themselves and how they relate to knowledge. These ways of knowing color the lens with which Black women view and interpret their life experiences. These five perspectives are silence, received knowledge, subjective knowledge, procedural knowledge, and constructed knowledge. In s*ilence,* women communicate a sense of voicelessness and appeared to be disconnected from knowledge. In the second perspective*, received knowledge,* women look up to author figures to validate knowledge. In this perspective women feel confused and lack confidence. In the third perspective, *subjective knowledge*, women trust their conscience and experience rather than external sources or experts. In *procedural knowledge*, women acknowledge that multiple sources of knowledge exist, and innate knowledge can be deceptive. In the final perspective, *constructed knowledge,* women view knowledge as contextual, they see themselves as capable of constructing knowledge, and place value on subjective and objective knowing.

Learning in older adulthood

Speros (2009), says that older adults tend to process information at a slower pace and use less working memory which may indicate that their ability to process multiple bits of information at a given moment is challenged. As individuals age, certain cognitive functions become increasingly more difficult, such as eyesight and hearing abilities.

Culture

Culture is a major contributor of influence because it is dynamic and includes family values, norms, and practices (Kreuter & McClure, 2004). One's culture is intertwined intrinsically within these values which makes each group unique. Culture contributions to shape people's thinking, ideologies, and behavior.

Phenomenology

In qualitative research, phenomenology captures the essential meanings of an individual experience, the social construction of group reality, and the language and structure of communication (Schwandt, 2001). Phenomenology focuses on exploring how human beings make sense of experience and transform experiences into consciousness, through both individual and shared meaning (Patton, 2002). As a research method, phenomenology seeks to document what people experience and how they interpret the world. This research method requires experiencing the phenomenon as directly as possible. This leads to the importance of participant observation and in-depth interviewing to capture the lived experience of an individual. According to Van Manen (1990), the nature of an experience is adequately described when the language used for such description illustrates in great detail the quality and significance of the experience. Phenomenology deals with the shared knowledge of the individuals that have experienced the same phenomenon (Creswell, 2008). Furthermore, Patton (2002) describes experiencing a phenomenon as how people perceive it, describe it, feel about it, judge it, remember it, make sense of it, and talk about it with others (p. 104). Thus, the present dissertation captures the narratives of Black older women regarding the communication process and learning experiences they have come across while interacting

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with healthcare professionals. This phenomenological study explores and paints a picture including rich details of these encounters.

Narrative

According to Jonassen and Hernandez-Serrano (2002, p. 66) stories are the oldest and most natural form of sense making. Stories are the way we make sense of our experiences, how we communicate with others, and how we understand the world around us. Narrative research uses various methodological approaches to analyze the stories shared by the study participants (Riesman, 2007). Since the early 1990's, stories have moved center stage as a source of understanding the meaning of human experiences (Merriam, 2009). "Narrative is understood as a spoken or written text giving an account of an event/action or series of events/actions, chronologically connected" (Czarniawska, 2004, p. 17). In this dissertation, the terms narrative and story were used interchangeably to refer to the anecdotes and descriptions provided by the study participants and not necessarily in a chronological manner. Creswell (2013) asserts that, narrative stories tell of individual *experiences*, and they may shed light on the *identities* of individuals and how they see themselves. Therefore, the study documents communication strategies that Black older women utilizes to communicate with their healthcare professionals.

The key to narrative inquiry is the use of stories as data, and more specifically, first-person accounts of experiences told in story form having a beginning, middle, and end (Merriam, 2009). At the heart of narrative analysis is "the ways humans experience the world" (Connelly & Clandinin, 1990, p. 2). Narrative analysis extends the idea of text to include in-depth interview transcripts, life history narratives, historical memoirs, and creative nonfiction (Merriam, 2009; Patton, 2002). A good narrative illustrates the

uniqueness and complexities of the storyteller in a way where the reader can reflect upon themselves and the situation (Riessman, 2008).

For this dissertation I collected and documented stories of Black older women relevant to their routine appointments with healthcare professionals they visited most frequently. I used these narratives to inform, educate, and inspire this population of women as well as their healthcare professionals. Also, I would like to promote awareness of the Black older woman's perspective offering evidence that more can be done to satisfy and surpass her communication needs and the services she receives.

Study Setting and Participants

The study was conducted in Central Texas where the community demographics are 98% urban and 2% rural (U.S. Census Bureau, 2010). The information describing demographics where study participants were selected comes from the (2010) U.S. Census. Of the 12,660 households, 19.2% had children under the age of 18 living with them, 27.9% were married couples living together, 10.1% had a female householder with no husband present, and 57.5% were not families. About 31.0% of all households were made up of individuals, and 5.7% had someone living alone who was 65 years of age or older. The racial makeup of the city was 72.55% White, 5.53% African American, 0.65% Native American, 1.23% Asian, 0.11% Pacific Islander, 17.03% from other races, and 2.90% from two or more races. Hispanics or Latinos of any race were 36.50% of the population. For every 100 females, there were 96.8 males. For every 100 females age 18 and over, there were 95.4 males. The per capita income for the city was $13,468. About 13.8% of families and 28.5% of the population were below the poverty line, including 22.1% of those under age 18 and 15.1% of those age 65 or over (San Marcos, Texas,

n.d.). The study focus on the rural population percentage including those who live in a location considered as a low-income area, who are over the age of 65, and possibly on government assistance (i.e., those who rely solely on social security as their primary insurance provider).

According to Patton (2002), qualitative purposeful sampling typically focuses on relatively small samples, even single cases (N=1) (p. 46). For this study I recruited seven participants. They met the following criteria: Black woman ages 68 or older, a recipient of government assistance healthcare and/or rely solely on social security and were willing and able to participate in the study. To recruit participants for the study, two strategies were helpful: referrals and snowball sampling. This method is when the interviewee gave the researcher the name of another potential candidate to interview. By asking a few people who else to talk with, the snowball gets bigger and bigger as to accumulate new information-rich cases (Patton, 2002).

Data Collection

Interviewing is a good technique to use because this method captures information that cannot be directly observed such as feelings, past behaviors, or a person's interpretation of the world (Patton, 2002). Interviewing serves the purpose of entering other people's perspective and mind set, to gather their stories (Patton, 2002). Depending on the type of interview, i.e. ethnographic, phenomenological there are several components/ benefits of interviewing. Information of a person's culture as well as lived experiences can be considered in the interviewing process. Narratives of personal events that possibly could have led to guided actions and social interactions may emerge from this technique of data collection (Merriam, 2009).

Individual Interviews

The word interview has origins associated with the French *entre voir*, meaning "to be in the sight of" and referring to a meeting of people face to face. It also has Latin origins with the prefix "inter" meaning among and between and "view" referring to seeing, looking or inspection (Skinner, 2013). Face to face interviews can take advantage of social cues such as voice tones and body language. Through body language, the interviewee can also offer additional information that can be added to the verbal response of the participant (Opdenakker, 2006). An interview is useful in obtaining a special kind of information in which the researcher wants to find out what is "in and on someone else's mind" (Patton, 2002, p. 341). It is also necessary to interview when we are interested in past events that are impossible to replicate as well as to enter into the other person's perspective. Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit (Patton, 2002). Interviewing is useful when we cannot directly observe feelings, behavior, or how participants interpret the world around them (Merriam, 2009).

I conducted 45-minute to an hour individual interviews with the study participants and a brief 30-minute follow-up when needed. I used a set of questions (see Appendixes B and C) that served as a guide to direct the conversations with the study participants. The interviews took place in the participant's home and were audio recorded. The focus was on the participants' narratives and perspectives of their encounters with healthcare professionals. According to Patton, 2002, an interview guide is prepared to ensure that the same basic lines of inquiry are pursued with each person interviewed. However, I conducted the interviews as an informal dialogue that allowed the participants to feel

comfortable when sharing their stories in which I could also ask other questions as

needed. The second interview, when needed, was a brief follow-up to focus on clarifying

responses, asking further questions on topics I missed during the first interview, and

included any additional information the participants wanted to add.

Field Notes

Field notes include a description of facts, the observer's perceptions and

reactions, and the analytical reflection of what is happening in the study (Merriam, 2009;

Patton, 2002). This method of data collection allows the researcher to return to an

observation later during data analysis. Field notes assisted me in collecting data in the

most efficient manner, therefore, not relying on my memory. As noted by Patton (2002),

"do not trust future recall. At the moment one is writing it is very tempting, because the

situation is still fresh, to believe that the details of a particular situation can be recalled

later" (p. 302). Similarly, Merriam (2009) explained, even if the researcher has been able

to take detailed notes during an observation, it is imperative that full notes in a narrative

format be written, typed, or dictated soon after the observation was made. The author

explains it takes great self-discipline to sit down and describe something just observed.

For the present study, to keep a detailed history of the research process as it unfolds, the

author suggests keeping the following checklist in mind when typing the field notes:

- Describe what happened: describe the event, experience, situation, or new
  knowledge;
- Notice participants' emotions and reactions
- Assess what was good/useful and what to do again

- Ask was there anything that needs to change for the next interview. Is there anything I have missed? What other questions I need to ask the participants?

- Make a note about any practical action steps that flow from the interview

- Provide context for reflecting on the individual interviews

- Provide a reference point for what happened during the interview

- Keep in mind the stages of the reflective process (e.g., experience, reflection, action, and repeat the cycle). Through this process, the researcher writes about what happened, establishes what was learned, and considers what to take away from that learning

- Make a note of ideas to remember or follow up;

- List questions to explore, discuss, or find out more about.

Data Analysis

Different researchers approach data analysis from different points of view. For example, there is an ongoing discussion about when data analysis starts and when it ends. To effect, Merriam (2009) explains that data analysis is an ongoing process; the idea is that the researcher approaches data collection and analysis using a reflective perspective and conducts analysis from the beginning to the end of the research study implementation. For this dissertation, I utilized Colaizzi's (1978) phenomenological method for data analysis that suggests seven steps.

Step 1: Making sense of the protocol. An important feature of phenomenology is for the researcher to immerse herself in the data collected. Here, the protocol refers to the transcript's product of the conversational interviews with the Black older women

participating in the study. Therefore, this step requires reading the transcript several times to acquire an overall sense of them to initiate the analysis process.

Step 2: Extracting significant statements. From each transcript, I extracted key stories that speak directly to the lived experience of the Black older woman during medical encounters. These may include the participants' experiences communicating with healthcare professionals, communication challenges during routine appointments, cultural issues, and learning in older adulthood. Significant statements are direct quotations that relate an experienced they lived related to the focus of the study.

Step 3: Formulating meanings. In this step, I carefully determined the meaning of the stories conveyed by the participants. Colaizzi (1978) points out that this step involves a creative insight from the researcher to "leap from what his subjects say to what they mean" (p. 59). The focus of this step was to make sense of the stories without compromising the original meaning or intention from the participants.

Step 4: Organizing formulated meanings into clusters of themes. This step implies grouping or sorting the meaningful stories that were already identified in the previous two steps with the purpose of organizing them under categories and clusters of themes. During this step, I also identified commonalities in the stories and new categories of themes may emerge.

Step 5: Exhaustively describing the investigated topic. This step involves the process of integrating all the results to provide a unified narrative that addresses the research questions formulated for the study. In this case, I used meaningful stories provided by the participants to create a narrative account of the Black older women's experiences communicating with healthcare professionals.

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Step 6: Stating the fundamental structure of the phenomenon. Here, the results were integrated into an in-depth description of the phenomenon and provides the readers with the core understanding. According to Colaizzi (1978) "an effort is made to formulate the exhaustive description of the investigated phenomenon in as unequivocal statement of identification of its fundamental structure" (p. 61). I provided rich detail and meaningful narratives that convey the participants' voices.

Step 7: Returning to the participants. This is where the researcher integrates the results into a comprehensive description of the topic and returns to the data provided by the participants to confirm the results.

Trustworthiness

To build and maintain trustworthiness Lincoln and Guba (1985) propose constructivist inquiry that suggests the implementation of four elements: *credibility, transferability, dependability, and confirmability.* In combination, the authors view these criteria as addressing trustworthiness as a parallel to *rigor* (pp.76-77). As they explain, multiple and constructed realities cannot be studied in pieces but only holistically since interrelated pieces influence all other pieces. The pieces themselves are influenced by the nature of the immediate context.

Credible research advocates an unbiased distortion of data to serve the researcher's vested interests and prejudices (Patton, 2006). Since a qualitative researcher's perspective is naturally biased due to her close association with the data, it is noted by Patton (2006) that the investigator must adopt a stance of neutrality. This simply means the investigator does not set out to prove her perspective or manipulate the

data to arrive at predisposed truths (Patton, 2015, p. 51).   The researcher's credibility depends on his or her training, experience, track record, and presentation of self.

Transferability confirms that findings have applicability in other contexts. Transferability is a direct function of the similarity between the two contexts and how they work in other locations, i.e. workplace to home (Lincoln and Guba, 1985). To ensure that practitioners and other researchers get a complete understanding of how the study was implemented, ample details were provided regarding the data collection process. According to Lincoln et al. (1985), the investigator needs to provide "sufficient thick descriptive data" to make transferability possible (p. 298). The researcher has a responsibility to provide a detailed description of the study's context to enable readers to compare the "fit" with their situations (Merriam, 2009).

Dependability is described by Lincoln and Guba (1985) as the ability to show that the findings are consistent. That is, rather than demanding that outsiders get the same results, a researcher wishes outsiders to concur that, given the data collected, the results make sense and are consistent with what the data are making evident. If the findings of a study are consistent with the data presented, the study can be considered dependable (Merriam, 2009).

Confirmability serves this study as to document the procedures for checking and rechecking the data throughout the entire research. Necessary steps were taken to ensure the study findings were supported by the data collected and the results depicts the participants' reality, versus personal predispositions and beliefs as researcher (Lincoln & Guba, 1985). The data from the participants were portrayed through direct quotations.

The study documents verbatim quotes from the participants with a purpose of bringing life to their stories as they articulate their experiences with healthcare professionals.

Ethical Considerations

I used the "Ethical Compliance Checklist" from the APA (2010, p. 20) that provides guidance of ethical issues and concerns that could arise before the study began, during data collection, data analysis, the interpretation of data, and when publishing and disseminating the research. The study also utilizes the ethical considerations outlined by the Institutional Review Board (IRB). Specifically, all participants completed and signed a consent form (Appendix C). Specific details of the consent form were discussed with each participant to encourage questions. The principal investigator ensured that their privacy and the confidentiality of the information they provided would be a priority. All data (interviews, recordings, notes, documents, and transcriptions) collected is stored in a password-protected platform only accessible to the researcher and dissertation chair.

As the researcher, it is my responsibility to take the necessary steps to protect participants as they share their personal stories. Talking about communication challenges alone could be difficult, furthermore, embarrassing and seen as shameful when discussing personal healthcare. Pseudonyms were assigned to each participant and specific details were omitted when documenting the stories such as names of clinics and specific healthcare professionals.

CHAPTER IV

STUDY FINDINGS

This chapter provides the profiles of the seven Black women, ages 67 to 87, participating in the study. The focus is to illuminate the experiences of these women when communicating with their healthcare professionals and present their perceptions during these encounters. I researched first names for African-American females and assigned each participant her own pseudonym reminding me of their personality traits. Therefore, Betsy, Rose, Lucy, Ethel, Kandace, Lilly-Mae, and Sallie are pseudonyms utilized for the study participants. Table 4.1 serves as a quick reference to illustrate their age, origin of birth, occupations, and role in their families at the time of this study. The participants appear in chronological order of their age. Following the table are narratives introducing the study participants, written in first person to give them voice. The narratives are structured to present two parts. First, the narratives describe the participants' personal characteristics, including fond memories of growing up as well as their demographics and birth place. The second portion of the narratives identify the essence of the participants' perceptions and interactions with healthcare professionals that provide a glimpse of their journey as older patients. This section also aims to help the reader make meaning of the narratives in relation to the study. After introducing the seven participants there is a brief discussion highlighting the historical context and similarities of their stories.

Table 4.1

Profiles of the Study Participants

Pseudonym	Age	Origin of Birth	Occupation	Roles in the family
Betsy	87	McDavid, Florida	Retired registered nurse	Wife, mother, grandmother, great grandmother
Ms. Rose	83	San Marcos, Texas	Childcare provider	Wife, mother, grandmother
Lucy	80	San Marcos, Texas	Retired cook	Mother, grandmother
Ethel	80	San Marcos, Texas	Secretary in the school system	Mother, grandmother
Kandace	73	Brooklyn, New York	Educator/ Long-term substitute teacher	Mother, grandmother, a pastor's wife
Lilly	68	Century, Florida	Retired teacher	Mother, wife, grandmother
Sallie	67	Chicago	Realtor	Mother, sister

All narratives in the dissertation illustrate the study participants' words. Their stories were collected throughout interviews and appear here as cohesive narratives.

Betsy The Boss Lady

Betta bring me my glasses so I can have them if I need to read anything. I was born in McDavid, Florida in 1931. My daddy was a railroad man and my mother did seasonal work. I had twelve siblings and we all grew up with the White people as well as Blacks. It was a privilege for us to do that because the White people had a lot of money, nice cars, and a lot of gardens with tools and toys we did not have. As an adult, I traveled all over the world. I have been to the Holy Land five different times. I have been married for sixty something years to a fairly decent gentleman. I have enjoyed my life. The Lord blessed me with four children, a host of grandchildren, and one great-great

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grandchild. I think I am privileged to still be here. I have been around a long

time and have seen a lot of things. I have helped a lot of people along the way.

When I go to doctor's appointments now, I let him know right

away who I am and what I have done as a nurse. I let them know right

away, I was not born yesterday. I know I have had a lot of experience,

however, I just need the doctors to slow down so I can understand what

they are saying.

Betsy, 87, is a well-respected matriarch of her family who demands attention when she walks into a room. She did not mind people knowing she was in charge. She began the interview with a command, "go get my glasses..." henceforth, where her pseudonym Betsy the boss lady came from. Before retiring, she was a registered nurse for 28 years. At the time of the interview, Betsy serves in the roles of wife, mother, grandmother, and great grandmother (even great, great grandmother).

Ms. Rose

I was born on a farm between New Braunfels and San Marcos. I could

remember when I was about ten years old, my oldest brother would be

shooting marbles and would somehow always get me in trouble. After

several occasions of getting caught in mischief with my brother, I asked

my mom for my own space. She gave me a box for a garden. I bought my

little seeds, so I would always have beets. I love beets, and would always

have beets, greens, and onions because I also loved onions. My mother

also had a sewing machine in which I learned to love sewing. Gardening and

sewing became my hobbies that I loved to keep myself busy and out of trouble.

My doctor prescribed medicines and did not tell me the side effects
or what feelings to expect. I had to figure it out on my own. While on
vacation, I got really sick due to side effects of a new prescribed
medication. Being in another state, I was terrified of not being able to
recover and make it back home to see my doctor. If only my doctor would
have made me aware of the side effects, this could have eliminated a
stressful period during a time that was supposed to be relaxing and
enjoyable. If I knew the side effects, maybe the doctor could have
tweaked my dosage or something before leaving. Maybe
miscommunication was the problem here? I learned that I must be aware
when I change medications how it will make me feel or act. Since then, my
daughter goes to all my appointments with me because she can ask better
questions when I forget things.

Ms. Rose, 83, is a very soft-spoken woman with a calm demeanor and presence. She lives in San Marcos with her daughter, husband, and grandchildren. After her high school graduation, she got a job taking care of children and cooking and worked in this capacity for about 58 years. At the time of the interview, Ms. Rose was retired and enjoys spending time with her family and friends.

Feisty Lucy

I have been in San Marcos all my life. We had a Black school here
where all the Black students went and when it was later integrated in 1955 or
56, we had to go to another school. It was kind of hard on the Black kids because
we did not want to go to the school with the white kids and they did not really

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want us there either. It was tough back in the day. But thanks be to God, we

overcame it all, you know. My parents were both hard workers and my mother

lived until she was 85.

When I got sick and could not return to work, I had two major surgeries

with long recovery periods. My typical appointment consisted of people with some

type of handicap, and most of them my age and older. The patients came in with

their walkers and canes just like me. I must say, the healthcare workers were all

very patient with me, however, the waiting time before seeing the actual doctor is

too long. They tell you to be there at 10:00 and do not call you back until 11:00

or later. Then you had to wait in the back even longer. This was very frustrating.

Lucy, 80, is an out-spoken Black woman who does not mind sharing what

is on her mind. She is full of personality, feisty, adored, and well-respected by

those closest to her. She is also the matriarch of her family. Before retiring, she

worked in food services with the same company for 25 years. At the time of the

interview, she enjoys volunteering at the local food bank. So also, relishes

reminiscing and laughing out loud with her sister who visits her often.

Ethel

For a time in my life, I use to clean houses. I cleaned homes during

the time my kids were growing up. When they became school age, I got a   job at

the school they attended. I remember the principal walking into the

office and saying, "Mrs. Ethel, stay calm and put on your parent hat."

I knew one of my children was in trouble when he said that. My six

children knew and understood the consequences of poor behavior. I do

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understand that some Black women and men are reluctant to say certain things to

people of other nationalities and healthcare professionals should be aware of

that. I can remember being frustrated about the timeliness at my appointments.

When the patient is there on time for their appointment, the doctors

should be ready to see them, at that time they scheduled, especially an

elderly patient. Older people cannot just sit there for hours. On several

occasions, I have sat in the waiting room for at least an hour before going

back to see the doctor. I could understand if the patient is a little younger,

they would probably be ok waiting a little longer, however, not the elderly.

Some of them just cannot physically sit for long periods of time.

Ethel, 80, was born and raised in the San Marcos area. She is a stern mother of

six children who understood the wrath that would be upon them if they got into trouble.

She is well respected in the community and has a reputation of not being afraid to speak

up when necessary. For several years she worked as a secretary for counselors in a

secondary school and later became the school nurse's assistant. At the time of the

interview, Ethel is retired and enjoys her naps. She also takes care of her four dachshund

grand dogs. On a warm day, she enjoys sitting on the porch watching the kids play at the

community park across the street from her house.

Kandace The Church Lady

My mother passed away when I was four years old, therefore, my brother

and I were raised by my grandmother and later moved into foster care. I really

enjoyed reading and did a lot of it when I was alone or with my brother. He has

passed on now, but we did everything together and really enjoyed going to

church. We taught Sunday school and even started a youth program. Then

my brother got separated from me in foster care when I was about six years

old. I miss him.

After I moved to Texas with my husband in pursuit of my

bachelor's degree, I suffered a heart attack. During the recovery period

in the hospital, I realized that I asked a lot of questions about the medicine

prescribed to me because I do not like taking medicine. The doctors

seemed to get frustrated with me when I asked so many questions. Their

responses and non-verbal gestures made me feel intimidated. Often, I felt

embarrassed and frustrated with myself because I still did not know what

they were talking about even after asking so many questions. I just wanted

to be able to be functional and not over medicated. I would like the

doctors to take more time and talk with me.

Kandace, 73, was born in Brooklyn, New York and raised in Harlem. As an adult she worked in a bank for 15 years. She started her bachelor's degree in New York and later moved to Texas with her husband where she completed her degree. She later obtained a master's degree from a university in Florida. Kandace is married and together she and her husband have six children. At the time of the interview, she serves as a minister and church administrator where her husband is the pastor. In a part-time capacity, she is also a substitute teacher at a local middle school.

Lilly-Mae The Teacher

I am the oldest of four children, born to hardworking Black parents. We are a pretty close nit family. I consider myself healthy and like to stay busy with physical activity such as swimming, walking, and occasional travel.

In my season of aging, I realize that my relationships with my healthcare professionals have evolved from the time when I was younger to now. They seem more interested and concerned about the level of my physical activity. I consider myself a life-long learner and enjoy researching ailments I have experienced so that I am more informed by the time I return to my next doctor's appointment. However, I often overload my doctor with the information I have researched. Sometimes I get frustrated when I am asked about my overall health without any feedback or advice from the healthcare professional. They are supposed to be the expert and I want them to share their thoughts and professional guidance about my specific condition. I want them to offer more holistic alternatives instead of rushing straight to medications. I would also like healthcare professionals to provide better documentation of benefits and risks of certain medications. This type of documentation will also help me assist my elderly parents when they are prescribed medications without sufficient explanations. My parents are typically very compliant patients (well Dad anyway), however, I would like to know the "why" in order to help them understand better since they have limited cognitive abilities at their age.

Lilly-Mae, 68, grew up in Houston, Texas. She has four children and several grandchildren. She earned a bachelor's degree in home economics and later earned a

master's degree in the same field of study. Before retiring, she served as a middle school teacher for 26 years and is currently active in her church ministry. At the time of the interview, Lilly-Mae serves in the roles of wife, mother, grandmother, and friend. She enjoys volunteering at her church, feeding the ducks in the neighborhood pond, and working on arts and craft projects at the community college. On a very part-time base (once or twice a week), she also serves as a substitute teacher at a local middle school.

Sallie The Realtor

> *Overall wellness is important to me regarding my mind, body, and soul. I just moved here from Chicago where I sold houses and properties. However, because the state of Texas has different real-estate laws, I am in the process of taking classes for my Texas certification. As previously mentioned, wellness is important to me because I have a true passion to share with others that a healthy lifestyle stymied my aging. I do not look my age, which is partly genetics and I do not take that for granted. I would like to get involved with others, particularly Black women to show them how to manage their wellness with aging. Taking care of myself is a priority, so I do not go to the doctor very often. I have not gone to a doctor for any lengthy period, however, my mother had a different experience. Mom has passed away now. She was 88 years old when she died due to a chronic illness.*

> *Particularly in her later years, she had to go to see the doctor more often. During this time, I could remember her doctor of several years becoming either jaded and insensitive, or maybe he was saddened because her health had declined so rapidly. I remember having to address him*

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about the way he spoke to my mom because she revered him so much

that she hung onto his every word. It was frustrating because she was a

very competent and compliant patient, but he would give so many

instructions with not much compassion toward her age and illness.

Sallie, 67, was born in Chicago. She was a realtor in Chicago and has recently moved to Texas to be closer to her sisters. At the time of the interview, Sallie was in the process of earning her Texas real-estate certification. She has since earned her Texas certification and is currently working as a full-time realtor. She also remains very active at her local gym. She is a mother of one adult daughter and enjoys social activities with close friends she has befriended since moving the San Marcos.

The section above introduced the participants and provided an understanding of how they are connected to the study. The next section offers a reflection of the role of Black feminist thought in understanding the study participants' narratives. Finally, a brief review of the historical events occurring during certain periods of the study participants' lives. Although going beyond the scope of the study, these events are worth mentioning. The acknowledgement of these events as part of the participants' reality is important because of its possible impact on their upbringings, ways of thinking, and development as adults. For example, some of the natural anxiety and unwillingness to feel free with people of authority or higher professional status may result from a specific past occurrence. Additionally, the following section makes a connection to the role of culture and how it influences the participant's behavior. According to Merriam (2009), culture refers to beliefs, values, and attitudes that structure the behavior patterns of a

specific group of people. In this case, the Black older women participating in the study emphasized the importance of hospitality, deciphering non-verbal ques, and relationships.

Collins (2000) made it clear, "Black women neither have identical experiences nor interpret experiences in a similar fashion" (p. 27). The lived experience of each study participant is testament to their own personal truth. The study participants learned to live their lives in spite of challenges during their healthcare encounters. According to Black feminist thought, Black women's tendency to be oppressed led to them behaving and thinking defensively. For instance, one of the participants indicated that upon arriving at the appointment she was sure to make the doctor aware of her nursing background and that she was "not born yesterday". In this case, based on previous negative experiences, she anticipated the doctor's behavior to avoid further mistreatment and negligence.

Within the notion of Black feminist thought traits such as race, class, gender, and sexuality intersect and heighten systems of power. Because Black women have distinctive histories, influenced by these systems of power, they have created unique worldviews for self-definition. According to Collins (1990) African American women share the common experience of being Black women in a society that devalues women of African descent. This concept manifested themselves among the dissertation participant profiles. Most of them were strong matriarchs in their families; they were known for being "stern" or having a reputation of not being afraid to speak up. However, for some of them, their power and voices were crushed in a space where the participants felt virtually powerless.

Four of the study participants were born in the 1930's and experienced events like The Great Depression, World War II, and The Civil Rights Movement. These were times

of great turmoil for the African American community. For a long time, African Americans were subjected to discrimination regarding education, employment, housing, and voting (Neufeldt & McGee, 1990). The nationwide disagreement of race matters grew more and more intense as the years went on. Based on their age, the assumption is that by the 1960's, all of the study participants had experienced and endured segregation and discrimination. Specifically, in 1960, sit-ins started across the nation at establishments where service was being refused to Black customers. Racially incited riots plagued the East of the United States where four of the study participants were born. These incidents left many dead, injured, arrested, and homeless. Additionally, in the 1950s and 1960s the Civil Rights Movement organized efforts of African Americans and their allies to end de jure segregation in the South, where three of the study participants were born (Civil Right Act, 1964). These examples demonstrate the significance of history in each of the participants' lives. Similarly, cultural values add context to the study participants narratives.

As a Black woman myself, there is a cultural connection I have with my participants that is essential to this study. There was an immediate sense of trust and relational bond created with them. During the interviews the participants just wanted someone to talk to and share their stories. As a culture we love to tell stories because they have been a means to preserve and perpetuate our history long before written record became available to us. Even more so, the older generation enjoys sharing history and how things have changed. Aided by the fact that I was able to connect with them on this level, the interview process was much smoother. The participants wanted to make sure I was comfortable, as if to prepare me for a special journey we were embarking on

together. "Come on in this house and have a glass of water. You had lunch yet?" said one of the participants. Black people are keen on hospitality and always offer guests food and water when they come over to visit. This is more evidence that social interactions are affected by cultural beliefs.

When relating this concept to non-verbal communication between patients and physicians, race and culture equally have a significant impact on the encounter (Elliott et al., 2016). When entering a room, it is customary for Black people to address one another with a hug or a least the proper greeting, (i.e. good morning or afternoon) before beginning a conversation. This gesture indicates acknowledgment of an individual and symbolizes respect. Lucy expressed feelings of frustration when one of her healthcare professionals just walked in the room and began talking without acknowledging her, "a handshake is fine. You do not have to hug me or nothing, just respect me." She said, "after that experience I had to fire him, and I never went back."

Many Black people have experienced being immersed in a space where they were not welcome. However, this negative attitude is not always perpetrated with words, but often by the use of microaggressions and nonverbal communication. These microaggressions are defined as ubiquitous slights, including patronizing behaviors, stereotyping, ignoring persons, and other insults (Sue et al., 2007). Due to such experiences, Black culture emphasizes how vital it is to be aware of such signals, because a lack of awareness could cost you your life (e.g. signs and symptoms of pain).   Non-verbal communication with patients consists of actions such as eye contact, open body position, and touch. For example, Kandace reported, "I appreciated when the doctor made eye contact with me and greeted me with a smile." Most of the participants in this study

preferred face-to-face communication because this type of communication non-verbally articulated genuine care. Kandace further explained that, "we know what we are talking about when it comes to the way our bodies are feeling, so act like you are listening". While she was sharing this interaction, the scowl on her face communicated disappointment, feelings of dismissal, and disrespect.

The Black older women participating in the study valued the significance of relationships. It was important to cherish the moments shared with loved ones. Lucy mentioned, "I enjoy and cherish time spent sitting around the dinner table with family laughing and reminiscing about old times. These shared moments are used to encourage and motivate each other when going through tough times." Most of the study participants reported bringing a family member with them to their appointments. Family members at appointments would advocate for them and take offense when they were mistreated.

Participants' Experiences Communicating with Healthcare Professionals

The goal of this section is to explore the participants' stories about their communication preferences at routine doctor's appointments. The following excerpts are essential parts of data gathered during the interviews. According to Wiebe (1997), unclear communication can cause an entire medical encounter to fall apart. Particularly, non-verbal as well as verbal communication is considered as an important aspect of the study participants' encounters. Non-verbal communication is linked to rapport, facial expressions, warmth, supportiveness, agreement, and interest. Unfortunately, this lapse in communication has resulted in the study participants feeling forgotten, not only as individuals, but as an entire generation. This sentiment was further verbalized in statements describing being left out, dismissed, and neglected. During the interviews,

they simply wanted to share their stories and be listened to. All the study participants were happy about sharing special memories as well as challenges they face as Black older women.

After reporting the participants' narratives on their communication preferences, three themes emerged: Positive perceptions, frustrations, and advice to healthcare professionals. Next those three themes will be presented in greater depth.

Positive Perceptions

As a whole, the group perceived being polite and respectful when spoken to, as indicators of positive engagement. Additionally, proper greetings, handshakes, eye contact, and acknowledging their presence also served as encouraging signs. When these verbal and non-verbal connections were established, the study participants expressed positive feedback about their interactions with healthcare professionals.

On thirty-four occasions, the participants used specific language to confirm the existence of their positive perceptions. Some of the cited language included the importance of a pleasant demeanor and attentive listening. Face to face communication as well as the use of phones calls instead of e-mail messages were also documented as contributors to positive perceptions. When asked to describe their experiences during routine doctors' visits about their communication preferences, participants did not mention the medical competence and expertise, instead they mentioned how polite and patient the doctor was. Lillie-Mae, who previously worked as an educator verbalized appreciation to a warm approach of the healthcare professional and the fact that she felt respected by the doctor. Table 4.2 illustrates the study participants verbatim positive feedback and communication preferences gathered in the interview.

Table 4.2

Study Participants' positive perceptions.

Positive Perceptions	**Pleasant and Listens:** *What I like about him is that he is very thorough, I feel like everything is good. He reminds me that I am doing well. He is very positive.* (Lilly-Mae) *She supports my efforts and says, I wish more people your age would do what you do.* (Sallie) *Yeah, she's very friendly, and I like that.* (Feisty Lucy)
	Face to face communication: *I prefer face-to-face because if I do not understand something, he will sit in front of me and explain things word for word.* (Kandace)
	Phone calls versus E-mail communication: *There's this assumption that everybody is comfortable with technology, but I still relish a phone conversation.* (Sallie)

Lilly-Mae

> *What I like about him, that he is very thorough. I feel like, "oh everything is, you are really doing well". He is very positive. In his office there are three healthcare professionals that work together with him, so if he is not available the other two physician assistants are able to fill in the gap for him. I appreciate this because there is a good continuum of care. Oh, they also speak to me very respectfully and kind. They are concerned about my well-being.*

Sallie

My doctor was really good. She supported my efforts. She always

encouraged me by saying, "I wish more people your age would do what

you do." I appreciated her saying things like that because it encouraged

me to continue taking care of myself. She is the person who sparked my

interest in being a wellness coach. This would be an opportunity for me to

share my experience with other women. I would tell others, "You

can age well. Embrace the season because it is just old age. You

will have aches and pains, as they are symptoms that come with aging.

Everyone ages differently and more quickly in some cases."

Feisty Lucy

Yes, she is really good and explains things well to me. This is what I need

because sometimes I would not tell the doctors everything in fear of what they

would tell me. My little old doctor is was very friendly and I liked going to see

her. Especially when I had gone through tough medical situations or procedures

and then they threw more information at me. This information could be

discouraging coming from someone who was not as friendly. With this particular

doctor, I would go into my appointment and she would shake my hand and appear

to be happy to see me. She would even shake my daughter's hand or whoever was

there with me. I liked that. She was very friendly.

Kandace

My doctors are in San Antonio, so I sometimes must rely on phone

communication. However, I always prefer face to face dialogue,

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especially when I have a lot of questions. Being older, I have experienced

a lot over the years. I realized that I have to ask the doctors or nurses to

speak louder because I do not hear them well sometimes. Some of my

doctors have the tendency to mumble words and they do not realize their

voice dropped and it is easy to say, "Oh, that is because she's old…" I

appreciate when the healthcare professionals make eye contact with a

smile and have a pleasant voice. I prefer them to take time and talk to me.

Do not keep walking out the door while you are speaking because I cannot

hear you well with your back toward me. I came to this appointment to

meet you, so respect my time and give me your total attention.

Sallie

Sometimes when dealing with younger professionals, they assume you

know what communication methods to expect. Tell me exactly what to expect,

since I am not technologically savvy. Do not assume that I would automatically

use a computer to follow-up with you after our appointments. Do not tell me not

to worry or be intimidated. Just show and tell me exactly what form of

communication to expect. CALL MEEE and do not email me. I still relish a

phone conversation.

The interviews concluded the importance of the participants' positive

perceptions of their healthcare providers. Participants looked for various cues

(e.g., eye contact, a smile, facial expressions, hand gestures, encouragement, and

overall friendliness that indicate sincerity) which fueled and shaped the

participants view of how their general encounter was. This particular aspect falls

under constructed knowledge, during which our participants placed emphasis on

both subjective and objective strategies for knowing (Belenky, Clinchy,

Goldberger, & Tarule 1986). Here participants understand that they can acquire

knowledge by listening to their healthcare professionals but also by listening to

themselves. How they intuitively felt about their situation was valid because it

had bearing on the participants inclination to schedule a follow appointment and

even to how closely they would adhere to the doctor's orders. Black feminist

thought supports the idea that Black women possess a unique standpoint or a unique

perspective and that they share these perceptions as a group. Some of these

commonalities became evident through the narratives presented in this dissertation.

Frustrations

The collected data revealed thirty-nine cases in which study participants

articulated their frustrations. Some common frustrations mentioned by the study

participants included a general lack of consideration of their time and perspective. More

specifically, the study participants voiced that their time was disregarded when they were

forced to wait long periods of times prior to actually meeting with the doctor. Then

finally, upon meeting with the healthcare professional, they were not given adequate time

to address their concerns. Study participants expressed concerns of not being respected,

feeling ignored, and overlooked. In this regard, Belenky et al. (1986) explained the

development of self, voice, and mind in relation to silence and the struggle to be heard, to

fit in, and feel respected. When ignored by healthcare professionals as mentioned by the

study participants, this behavior of silence is activated. In this stage of knowing, Black

women view themselves as mindless, voiceless, and without freedom to express their

thoughts. For example, Ms. Rose said, "the doctors already know their responses without asking or consulting with me and without listening to me, so why should I say anything? They do not listen to me." Without conversing, listening to others, and drawing out their own voice, people fail to develop a sense that they can talk and think things through (Vygotsky, 1978). In addition, Betsy commented, "they do not give old people the attention they deserve. It is like they forgot about us". Communication is the sharing of information; the giving and receiving of messages; the transfer of information from one or more people to one or more other people (Savery & Duffy, 1995).   Table 4.3 represents the study participants' expressed frustrations they experienced during routine doctors' visits. In coding the data, three subthemes emerged: long wait times, not enough time per visit, and not listening.

Table 4.3

Study Participants frustrations

Frustrations	**Long wait times:** *They say be there for 9:00, and it will be 11:00 before they see you. That's what frustrates me.* (Ms. Rose) *Sometimes the wait can be a little long, a little lengthy and I'm sitting and sitting.* (Lillie-Mae)
	Not enough time per visit: *I really do not think they take enough time with old people and give them the attention they need and deserve. I really don't.* (Betsy The Boss Lady)
	Not Listening: *I think they dismiss you when you say you're in pain and they think you're just being hysterical. We know what we're talking about, so act like you're listening.* (Kandace) *And he just kept talking and never addressed my question. Why they keep telling me this stuff that I already know?* (Feisty Lucy) *I felt like I was rushed. So, I let her know that this was not fun for me. Sorry I missed it, but I need you to be more patient.* (Sallie)

Ms. Rose

I think if healthcare professionals would be on time, that would make a big

difference. The time I went to my husband's appointment, we waited a

while in the waiting room, but he had to stay in the back for so long that

he thought they forgot about him. I do not want to just sit there. It is

unacceptable when the lady tells us to be there for 9:00 and we are not

seen until 11:00. That is what frustrates me. When the person who makes

the schedule tell me a certain time, then they need to be on time also,

instead of having me sitting there waiting.

Betsy The Boss Lady

Doctors really do not take their time because they are in such a hurry. I

really do not think they take enough time with old people and give them

the attention they need and deserve. Society in general seems to be in a

rush. Everybody is in a rush. Everything is a rush. When the healthcare

folks do not take time with me and rush me, I forget a lot of things I

wanted to say and remember them when you get home. Oh well, too late

now. I want them to use patience. Give us old people a chance. We do

not think fast and are very slow, old, and forgetful. So, remember that, we

are slow, old, and forgetful. Not only in body and motion, but in our

thinking facilities. Be patient with us because we are old people who are

forgetful.

Kandace

I think what frustrates me most at doctor's appointments is when I feel

intimidated by them rattling off words and names. I have to ask, "what does that

mean and what is going on with me". I do not know if they think we should

already know it or not, however, I often tell the doctor that I feel a little

uncomfortable and overwhelmed with the medical terminology and jargon. I

asked many questions and still do not understand, and when I do not understand,

I typically will not do what they are asking me to do. I needed to speak with my

doctor about a new prescription, but I felt like he just dismissed me when I

brought up the subject. It is frustrating when I tell the doctor how I feel and that I

am in pain and he ignores me. I think some doctors dismiss older people and they

think you are just being hysterical. I want doctors to know, "We know what we

are talking about, so act like you are listening". This has happened to me over

the years and it is annoying and unfair to me as an older patient. They must

respect us as women, culturally, and as we get older. We know what we are

talking about, especially when it comes to our own bodies. I am not just going on

a rant. Listen to me!

Feisty Lucy

At one of my appointments, the doctor had an attitude when I finally got to

the back to see him. I did not like that. My daughter-in-law was with me

and he directed all the questions to her. I am telling you the truth, I was

mad because he did not seem to be kind to me. It was like, he never even

looked up at me. And when I did ask a question, he just kept talking to her

and never acknowledged me or my question. Girl, I fired him and never

went back. That was a hard thing for me because I was angry and hurt. I

am sitting there, and you are depending on somebody to tell you what is

wrong with you and he did not even look at me.

Sallie

There are so many steps. The person who gave me the information was

either a nurse or a nurse's aide, something like that, and very fast. I do not

know if that was because I do not look my age. I would guess it might have

something to do with that, because only older people typically will not pay

attention. But she appeared to be frustrated with me. I felt like I was

rushed, and I let her know, "This is not fun for me as the patient getting

this procedure. Sorry if I missed it but I need you to slow down and be

more patient". She lightened up a little bit and we got through the

appointment successfully.

Long wait times to see the doctor, not enough time with the doctor, negative

feelings eroding their confidence, feeling dismissed, ignored, and disrespected are all

common frustrations with the study participants. Experiencing such frustrations

established within the participants that they are being ignored and their voice is being

silenced. In certain situations, silent women have little awareness of their intellectual

capabilities and live as voiceless, therefore, when ignored it could appear as a normal act

of life Belenky et al. (1986).

The authors state that one component of silencing women is when situations cause

the woman to feel that control of their life resides completely with external authority

figures. Collins (2000) found the need for a Black feminist epistemology to address

"other ways of knowing" as a way to challenge the status quo since, historically, White

males have determined what is valid as knowledge, and what the world should consider

to be true. This hegemonic ideology has vanquished the voices of all women, as well as

the unique experiences of Black women (Collins, 2000; Hooks, 1989). This specific

element is felt by the study participants when they arrive to their appointment and have

no control over whether they must wait an hour prior to seeing their healthcare

professional. This crippling control by outside authority (i.e., doctors) is further

confirmed by participants not having an adequate amount of time with their doctor. Participants also cited their insufficient meeting time often lead to healthcare professionals treating them dismissively, consequently perpetuating more negative feelings. Some of these negative feelings include being dismissed, ignored, and disrespected. Study participants claimed that the aforementioned frustrations lead to their confidence being diminished considerably. Studies indicate that confidence and previous favorable experiences of speaking up can enhance such behavior (Lyndon, Sexton, Simpson, Rosenstein, Lee, & Wachter, 2012). However, due to the participants' disintegrated confidence by their healthcare professionals, they are less likely to speak up, and unfortunately are further silenced during their healthcare encounters.

Advice to Healthcare Professionals

Forty-four times study participants offered advice on how to increase the aforementioned positive perceptions, and alternatively, diminish the noted frustrations. For example, being polite, kind, and visibly engaged during conversations was suggested by study participants. Furthermore, participants conveyed the need for healthcare professionals to thoroughly explain medical instructions. According to participants, medical information ranging from diet to medication usage could be communicated better. Older adults process information at a slower pace and use less working memory which may indicate the challenge of their ability to process multiple bits of information at a given period of time (Speros, 2009).

Table 4.4 displays the study participants' final theme: advice offered to healthcare professionals when communicating with Black older women.

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Table 4.4

Advice to Healthcare professionals

Advice to Healthcare Professionals	**Be more polite:** *Greet me in a friendly mood. You do not have to hug me or nothing, just respect me.* *(Feisty Lucy)* *Be more personable, however, not meaning that you're above them.* *(Lilly-Mae)*
	Responsive, Listen, and take time to explain: *I like when they talk slowly so I can understand. Be sure to repeat because most old people do not hear well.* (Betsy The Boss Lady) *If you give me instructions about medications, ask me to repeat if back to you to display that I understand.* (Lilly-Mae) *I would like them to speak to me and call me by my first name because that would be more personable.* (Kandace)

Feisty Lucy

> *Speak to me in terms that I understand. They should understand that as*
>
> *older people we are different from their younger patients, but as humans*
>
> *we are the same. You know what I mean? Yeah. So, because I am Black,*
>
> *do not come in addressing me by saying, "What's up?", and all that*
>
> *because I am Black. Treat me just like you would anybody else, regardless*
>
> *of my age or color. Greet me in a friendly mood. A handshake is fine.*
>
> *You do not have to hug me or nothing, just respect me. That is very*

important to me. I am a proud Black woman, so respect me like that. As I

said before, do not forget we are Black women who are also human

beings.

Betsy The Boss Lady

They should be sure to repeat themselves because most old people do not

hear well. If you repeat it again, motion your hand or something, then

they will pick it up quicker. I like when they speak slowly so I can

understand them. We had a specialist who came to the nursing home

where I go and told us that your hearing goes down after 65. That was

helpful to me in a lot of ways because I am losing mine. It is all downhill

after that. Hearing and understanding Black people is the main problem.

They do not take time to listen. When an older patient thinks that someone

is not listening to them it is easy for them not to listen or respond. Then

we become noncompliant patients when it comes to medical instructions.

Doctors do not take time to explain to old people why they are doing

certain things. I find that to be a problem. Take time to explain the

situation because more people would comply when you tell them why. I

think they really should learn more how to communicate better with their

older patients.

Lilly-Mae

Yes, I would like them to repeat what you just said. For instance, when

dealing with my aging parents, the healthcare professionals need to

ensure that their patients understand those instructions. The same with

me, if they give me instructions about a specific medication, they should

have me repeat those instructions back to them and display that I

understand. Another piece of advice is to just be personable. I realize that

they have personal lives too and are human beings, however, as their

patients, we are priority. Healthcare professionals have a series of

patients that come in and out of their offices with all sort of conditions

that need to be addressed. Yes, they have families too, but they should be

more personable. I understand that asking each patient to repeat things

could be very time consuming, however, this is important to older people.

I think doctor's visits would be much better when the patient is able to talk

and the healthcare professional listens. I'm not talking just to hear myself,

but I need them to listen to me.

Kandace

I would like them to speak to me and call me by my first name because that

would be more personable. Most of the time they will just start talking

and do not acknowledge me. I mean, especially if I have not seen them in

a while. For example, my heart doctor, it will be six or seven months

since I have seen him, so he may have forgotten the specifics about me.

However, I still would hope he would at least read my chart, and say,

"Okay Ms. Kandace, I see you have done this or that". Doctors should be

a little more personable.

All study participants concluded that there are opportunities for

healthcare professionals to improve their interactions with older Black

women. Specifically, participants desired their healthcare professionals to be less passive

and more patient. The interviews also confirmed that the participants wanted their

healthcare professionals to make an effort to establish a personal connection with them.

Each of these aspects that the participants desire to see addressed arise from the need of

their subjective knowledge to be satisfied. Subjective knowledge is derived solely from

within each individual person. In this study, the participants determine what is true based

primarily and intuitively on their personal experience. Most of the participants referred to

the doctor as their own healthcare professional, symbolizing a sense of belonging and a

close connection. Eye contact, facial expressions, body language, and hand gestures send

underlying messages that indicate sincerity. The study participants felt more engaged

and important when asked about personal details such as family events, social activities,

and hobbies. Using warm words and a friendly tone of voice is very much valued by the

study participants. When participants have positive experiences to draw upon, it increases

their subjective knowledge and, overall, creates a more positive experience.

Learning in Older Adulthood

There are many factors that contribute to the ability to learn as older adults. This

section highlights how the Black older women in the study experienced learning. It

addresses the following themes: learning throughout life and the four pillars of learning,

affective learning, learning through established trust, learning with support groups, and

learning with technology.

A Black woman's standpoint and those of other oppressed groups is not only

embedded in a context, but exists in a situation characterized by domination. Because

Black women's ideas have been suppressed, this suppression has stimulated African-American women to create knowledge that empowers people to resist domination Collins (1990).

Learning is a personal process that is shaped by the context of adult life and the society in which one lives (Merriam, 2004). The number of older adults is increasing at an all-time high. The proportion of people age sixty and over is growing faster than any other age group (United Nations, 2010). Due to this trend, learning has become an important pathway to improve older adults' quality of life. Similar to the idea that communication does not occur just because someone spoke to you or you heard something, learning does not occur simply because you were taught or told some information.

The gender model of feminist pedagogy advocates a connected approach to education. This approach affirms women's experiences, voices, and ways of knowing. The nature of truth and reality and the origins of knowledge shape the way we see the world and ourselves as participants in it (Belenky et al., 1986). The goal of connected education is to help women develop their own authentic voices and see themselves as independent thinkers and constructors of knowledge (Belenky et al., 1986). For example, study participants demonstrated this theory and were able to learn based on their experiences, their truths, and the way they interpreted those experiences. They also developed wisdom regarding their health and often had a feel for how certain things affect their bodies based on those prior experiences. "We know what we are talking about", claimed Kandace concerning how she is often dismissed for knowing what to expect from certain medications.

Learning Throughout Life and the Four Pillars of Learning

As people age, learning transpires in different ways. For learning to continue happening, certain conditions must be provided by healthcare professionals. With the seven study participants in mind, there are essential conditions that must be present for learning to occur with Black older women. Healthcare professionals should be aware of the importance of the relational connection with Black older women (e.g., acknowledgment and a hug that represented relational behavior). It is vital to create environments of continuous learning by implementing strategies of engagement and motivation. Older adults may engage in learning throughout their lives in a variety of venues and formats.

The narratives shared by the Black older women participating in the study made evident that learning in older adulthood is possible. In situations that are more patient-centered the concerns are focused on who the patient is; in this case, they are older, come from different backgrounds, and have certain communication preferences. With all these components accounted for, learning can happen when patients learn about their own conditions and actively participate in their healthcare process.

The concept of learning throughout life is also possible through four pillars of learning and are described as the foundations of education (Unesco, 1996, pp. 22-24). According to Unesco (1996), the first pillar is *learning to live together* which creates an understanding of others and their history, traditions, and spiritual values. The study participants offered different pieces of advice to get to know them better and improve their interactions. The second learning pillar that lays the foundation for learning throughout life, is *learning to know*. This learning pillar highlights the combination of

sufficiently broad education with the possibility of in-depth work on a selected number of topics. As reported in the narratives provided by the study participants, this pillar was not nurtured by healthcare professionals to assist patients to do new learning. *Learning to do* is the third pillar of learning that involves the acquisition of a competence that enable people to deal with a variety of situations (e.g. working in teams and problem solving). For example, Betsy realized she felt comfortable learning with support groups. The final pillar of learning is *learning to be*. This concept is relevant in the 21st century as to emphasize that everyone must exercise independence and judgement combined with a stronger sense of personal responsibility for the attainment of common goals (Unesco, 1996, p.23). The healthcare professionals failed to promote self-knowledge (e.g., talents, memory, reason, power, and communication) in the study participants. All seven study participants reported frustrations and advice for improving healthcare professionals' ability to help them achieve self-knowledge (*learning to be*).

Learning as an older adult requires consideration of the physical changes, decline in cognitive skills, and learning preferences. As Betsy stated, "we are old and do not think as fast as younger people." The narratives provided by the study participants illustrated that as people age, their ability to learn is altered due to physical deterioration as well as a decline in cognitive skills (e.g., memory, problem solving, reading, and paying attention). Similarly, based on prior experiences with health care providers, study participants also made decisions about returning to receive a service or how to interact with health care providers. For example, Lucy did not return to a follow-up visit when she felt disrespected or mistreated at a previous appointment.

Affective Learning

Affective learning refers to behaviors involved in expressing feelings in attitudes, appreciations, and values (Mosby's Medical Dictionary, 2009). In this case, study participants explained that creating a personal and emotional connection with their health care professionals was extremely important for them. Displaying affection was connected to showing respect and care. Study participants explained how they expected health care professionals to interact with them by looking at them in the eye, offering a hug or handshake, inviting them in the office and to sit down, and calling them on the phone. In other words, affection display was interpreted as caring and validation.

Learning from one's emotions, requires bringing these emotions into one's awareness (Boucouvalas & Lawrence, 2010). Emotions such as anger, sadness, joy, and confusion affect people's ability and desire to learn. For instance, Lucy reported that she felt hurt when the healthcare professional ignored her and spoke directly to her daughter who accompanied her at that appointment. Therefore, she "fired him." Often healthcare professionals are driven by literary knowledge and underestimate older adults' intrinsic ability to evaluate themselves and how they feel. Due to the fact that their assessment of how they feel may not be derived from research, it is often undervalued.

Learning Through Established Trust

Research has shown that establishing trust positively affects communication and instruction when working with older adults (Brooks, Ballinger, Nutbeam & Adams, 2017). For older adults to participate fully in learning, trust between healthcare professionals and patients must be established. Cuevas (2012) explained medical mistrust as a barrier for establishing good patient-provider relationships. This author

explains that 'medical mistrust' as a concept encompasses a range of terms (e.g. cultural mistrust and medical distrust) that are found in studies pertaining African Americans in the healthcare system. According to Cuevas (2012), "African Americans who hold mistrust tend to have more negative views and expectations of their health providers..." Trust is a crucial component of the patient-provider interactions and affects every aspect of the clinical exchange (LaVeist, Nickerson, & Bowie, 2000). Kandace was able to rely on a different source and trusted person to explain her medication to her. While this was not the physician who had prescribed the medication, he was the one who took the time to sit with her and be thorough offering details. Kandace learned it was in her best interest to focus her attention on someone who proved to be attentive to her needs.

Through trial and error, older adults have developed wisdom. In one case, Rose's doctor prescribed a new medication and she experienced negative side effects that her doctor had not communicated or made her aware of. After that experience of poor communication and disconnect, Rose learned it was important for her to have someone dependable and who she trusted to accompany her to appointments. From that point on, Rose brought her daughter to intercede on her behalf when necessary. When the learner is able to reflect back on life experiences, existing knowledge, and motivations, they are then able to provide advice to healthcare professionals. Only when one has processed information and is able to connect their knowledge with the actual experience, can they give said advice.

Learning with Support Groups

Lieberman and Borman (1991) reported that active participation in support groups positively affected the health status of the group members. They found that better

outcomes were demonstrated on depression, anxiety, and coping with aging for those who participated in support groups than for those not in a support group. Study participant, Betsy, recounted when a speaker came to her community center and talked about various aspects of getting older. When discussing the negative effects of aging, Betsy was more apt to learning and internalizing the information while amongst her peers. She felt safe and reassured knowing that she was not the only one dealing with certain physical ailments and changes. This is an example of how learning occurs in older adulthood and the study participant used the tools she had, to learn about her condition and stage of aging. "Learners co-create and share knowledge, framing adult learning as a social endeavor" (Hansman & Mott, 2010, p. 18). In some contexts, learners may be motivated by different purposes, yet they are joined together for mutual collaboration. Quality of life for older adults is better when they are immersed in environments that cultivate community and encourage them to embrace the phase of life they are in.

Learning with Technology

Patient portals are becoming more and more prevalent in the healthcare setting. Often to schedule an appointment, reorder prescriptions, or view lab results patients have to use an online patient portal. Many older adults (but not all) experience issues with accessing the internet or their patient portal yet portals are still widely pushed by providers and their clinics.

Being able to use modern, everyday technology is important to the autonomy of older adults (Sleger & van Boxtel, 2013). Due to the fact that older adults grew up in a very different technological age than younger generations, typically they start with a non-positive view of technology (Chatham, 2014). Consequently, they are reluctant to

embrace it because they think it is difficult and think, "oh that's not for me". In a study

conducted by Hernandez (2016) the most significant barrier was believing themselves to

be too old to learn technology. Age related barriers and society alienation also play a role

in preventing older adults in adopting the change in technology (Bernard, 2013). As

people grow older, they tend to feel isolated and intimidated by technology. Sadly, a lack

of confidence remains an obstacle for older adults to learn and use the internet.

The study participants' opinions were split into two groups, those interested in

technology and those who were not. Even though technology is not welcomed by all, in

an era where technology is a major source of communication, the study participants,

Kandace, Lilly, Ethel, and Sallie all openly embraced this opportunity of learning and

were willing to use technology to learn about their health condition and improve their

life. Kandace took it upon herself to research the medication and its side effects. She

reported, "If I do not understand why it is beneficial, I do not take any medication. I get

on my computer and do my own research." Most of the time, Kandace was a very

compliant patient, however, after reading about the new medication prescribed by her

doctor she felt the medication was unnecessary. She would not take it until she was

confident that she had explored all the information such as side effects.   Similarly, Lilly

was interested in staying current with the latest technology (i.e. laptop and tablet) and

researching her own medical conditions. Lilly would research her diagnosis and report

an abundance of information back to her healthcare professional at the next appointment.

Ethel also embraced technology by using her smart phone and email communication for

setting doctor's appointments and reminders of when to take her medicines. When asked

about her preference of communication, she actually frowned upon the idea of using a

traditional land line versus her mobile phone. She gave the impression that she relied on her smart phone as a major source of communication. In the same way, Sallie, the realtor, understood the importance of technology when conducting her on-line business, however, she preferred face-to-face communication when required to interact with healthcare professionals. In summary, study participants of various were more open to the use of technology and devices. This finding is congruent with existent literature (Wang et al., 2011) stating that older adults interested in learning and in keeping current were more likely to use technology for communication purposes.

In contrast, Lucy, Betsy, and Rose did not show interest in using technology as related to their healthcare routine or for communication purposes with healthcare professionals. This group of women were more reluctant to use technology. Similarly, a study by Hernandez (2016) reported that older adults with no previous technological experience are easily confused by technology; they often do not have a computer, mobile devices, or Internet connection. This was reflected in the older study participants; Lucy, Betsy, and Rose were reluctant to handle smart phones, did not have internet at home, did not know how to use the patient portals, and also lacked interest in learning about technology. Family members would frequently assist them with this aspect of their healthcare routines.

To sum up, this chapter recounted the powerful and motivating experiences of seven Black older women and their journeys communicating with the healthcare professionals they visited most frequently. The Black older women in this study shared positive perceptions about their encounters, common frustrations, and offered advice to healthcare professionals about their communication preferences. Each of the seven

participants in this study had unique and intriguing stories to impart. Additionally, the

intent of this study was to illuminate their lived experiences as Black older women

finding their voice as they navigate through the healthcare system. The project provided a

venue for the study participants to chronicle their experiences and voice their perception,

frustrations, and advice interacting with healthcare professionals.

CHAPTER V

CONCLUSIONS

This qualitative case study explored the narratives of Black older women communicating with their healthcare professionals. Seven women ages 67 and older volunteered as participants in the project: Betsy, Rose, Lucy, Ethel, Kandace, Lilly, and Sallie, (all pseudonyms). The goal of the study was to inform current and future healthcare professionals of communication strategies and best practices when serving Black older women.

The dissertation journey began with a concern about my Granny, 87-years-old, speaking about a routine doctor's appointment. She left that appointment feeling frustrated because she did not feel confident in sharing those ailments with her healthcare professional. The incident happened a year ago when Granny was still able to participate and fully answer interview questions, however, now at 88, as time has passed her condition has progressed. She experiences signs and symptoms of dementia and is working through the beginning stages of Alzheimer's. However, despite her reality she is in very good spirits. She enjoys sharing her life stories with loved ones, bossing granddaddy around, and playing old hymnals on the piano. Her positive outlook despite her reality is mostly due to the strong support she has from her family and community.

There is hope for Black older women when critical stakeholders (i.e., healthcare professionals) play an active role in empowering them to invest in their healthcare. Hearing Granny's story and those similar to hers has heightened my respect for this forgotten generation. It has also served as a personal catalyst to learn more about how to improve the quality of life for this population. Enjoying a better quality of life is possible

when older women are confident, empowered, and feel genuinely cared for. Educators are responsible for preparing healthcare professionals. The benefits of learning from the information presented in this dissertation goes beyond healthcare professionals and extends to family members. Even if it means one more year having Granny with us and enjoying her company, it is worth it. This research is useful to Black older women and healthcare professionals as a whole in this chapter. The next section presents the study highlights, study contributions, recommendations for practice, future research, and closing thoughts.

Study Highlights

A major highlight from this dissertation relates to the study participants' desire to be heard: "I am still here, do not count me out." All seven women had stories they were proud of and wanted to share. Once they felt confident in having voice, they were willing to hear more about their healthcare conditions and participate in improving their health and following medical instructions. In the process of recruiting study participants, they resulted in being much older than the anticipated research plan of 65, thus, ranging from 67 to 87 years of age. By exploring the narratives of older Black women, the study addressed the needs of these women as connected to their interactions with healthcare professionals.

Another study highlight is the identification of core values for educators to teach and instill in future healthcare professionals that can impact change. When students are taught core values in the classroom this can significantly make a difference in the professional healthcare field. The core values that emerged from this study that are

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deemed essential are empathy, compassion, personal connections, and communication with older patients.

Empathy involves understanding the patient's feelings and involves a level of self-awareness that allows an individual to accurately demonstrate this understanding to the patient (Ulrich & Glendon, 2005). It is the ability to recognize and consider the feelings and special circumstances that a person is going through and simultaneously be able to identify with that person's feeling as if they were their own (Trad, 2012). Students should be taught that empathy builds trust. For example, when the study participants perceived a sense of empathy from me, they seemed to open up more in our dialogue. They felt comfortable sharing their stories. A study reported by Leo et.al, (2009) indicated that healthcare professionals lack of empathy was a major source of disappointment in the healthcare field.

Compassionate communication begins with an awareness of your own well-being because when we focus on our well-being we create a space for the well-being of others around us. We create a space for authentic listening and speaking. To be compassionate, the communication should touch the heart. When you place your hand on your heart; this is the center of compassionate communication. Notice your state of well-being. Imagine your whole being is entirely cared for. Compassionate communication includes awareness, speaking with clarity, and listening with openness and attention (Moscowitz,2018).

In relation to cultivating personal connections, healthcare professionals should be encouraged to be personable. Taking a few moments before the visit to ask some friendly questions about the patient establishes rapport. Good rapport and positive feelings all

play a role in how the study participants perceived their overall experience. Their

perception helped decipher what they determined as truth and even contributed to their

inclination to follow the given instructions. Using friendly conversation ensures

clinicians are not rushing though their time with the patient and are able to build that

doctor-patient that Black older women desire. There is not a one-size-fit all mentality.

This relationship should be authentic and customized for each patient. Healthcare

professionals should be trained and equipped to cater to those individual needs.

Lastly, communication with older patients requires being intentional and keeping

in mind who they are, in terms of age, gender, ethnicity, and cognitive ability.

Maintaining eye contact is crucial when dealing with older patients who may be

experiencing hearing loss. Speaking clearly and at the appropriate volume are useful

strategies that can impact the communication exchange process. In addition, the amount

of information given at a particular time can affect how much is comprehended and

committed to memory.

On a separate note, healthcare professionals and educators need to be aware of the

combined characteristics that make patients unique i.e. age, race, culture, gender, and

history (Collins, Bilge 2016; Crenshaw, 1991). It is important to keep in mind the social

and political aspects influencing each individual's story.

The study participants' stories also disrupted the status quo by bringing light to

the stereotypes and misconceptions that some healthcare professionals hold. For

example, the concept of blanket diagnoses stating that everything happening to the

patient is due to being old became evident in the study. It was common to the study

participants to hear, "You are feeling this way because you are old. This is normal,

because you are old..." Black feminist thought emphasis on the ongoing interplay and struggle between oppression and activism. Such thought views the world as a dynamic place where the goal is not merely to survive or to fit in or to cope; but rather, it becomes a place where we feel ownership and accountability (Collins, 1990). Study participants spoke about knowing their bodies and how they react to a new medication or experiencing new symptoms. This self-knowledge was neglected by their healthcare professionals at times.

As a concluding highlight, there were congruencies between the participants' stories and the literature on the acceptance/rejection of technology as a need to stay current. This idea was addressed in detail in the previous chapter.

Study Contribution

There is a gap in the literature surrounding the experiences of Black older women interacting with healthcare professionals. Specifically, there is a scarcity of research on the stories of Black older women sharing their feelings and thoughts about these encounters. The majority of research is focused on the healthcare professionals generically working with patients of color. This research was unique in its own accord because it focused on the narratives of Black older women and considered their lived experiences and perceptions of healthcare professionals. The goal of the study was to document their stories and serve as an advocate for this population and their needs in connection to their interactions with healthcare professionals.

This dissertation also addressed a gap in the curriculum for healthcare professionals training students to better serve Black older women. The curriculum needs to include training the students on how to connect and initiate authentic conversations.

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This type of training can occur in the internship or clinical rotation phase of the curriculum. Students learning to communicate effectively with all types of patients will be prepared to enter the field upon graduation.

In closing, study findings add to the body of literature on the intersectionality theory. Intersectionality is centered on examining the dynamics of difference and sameness and has played a significant role in the consideration of gender, race, and other axes of power in a large portion of academic disciplines and political discussions (Cho, Crenshaw, & McCall, 2013). This study contributes to understanding the overlap in the experiences of Black older women that includes healthcare, age, race, culture, gender, and history. Intersectionality, in the case of this study, begs us to carefully consider the cost of neglecting the uniqueness of the population.

Recommendations for Practice

Educators in the field of healthcare professionals should train their students in the practice of effective communication. The effects of race on a non-verbal bias when communicating in medical settings could be in direct correlation with the life experiences of this patient demographic (Stepanikova et al., 2012). Effective communication is imperative to quality care, especially to such a vulnerable population. Productive communication with older patients may result in increased satisfaction as well as better outcomes. It is important to have students studying literature about how non-verbal expressions may be interpreted differently depending on the patient's culture.

Current practices should not conform to a "one-size fits all" model that generalizes older people into broad categories. As shown in this dissertation, Black older

women' stories are diverse and complex. Educators should shift their curriculum towards a more encompassing model that takes into consideration these individual stories to better serve this community.

Students should be trained before going into the field of practice, so they are able to relate to diverse cultures and backgrounds. Students should avoid assumptions or stereotyping individuals who may not appear to have the same privileges as the common population. Some of the participants in the study were low income and rely on government assistance and did not benefit from certain insurance perks such as being able to choose their healthcare providers. Therefore, students need to be educated on how to treat those who may be considered as less privileged. Future professionals in the field will deem information gained at their internship assignments as a valuable while learning communication strategies they can adopt for their day-to-day practices. For example, it is important for them to acknowledge the desire of Black older women to articulate their own needs, make decisions, and gain respect for managing their own lives. A psychological climate must be created that communicate acceptance, respect, and support for the patient. Students should help Black older women feel comfortable in taking chances and expressing their thoughts and ideas without fear of embarrassment. Black older women are motivated to learn when they feel respected and acknowledged.

As illustrated in chapter 4, limited communication occurred when Black older women experienced feelings of being disrespected and dismissed. As novice practitioners, students should be aware of the generational gap. To establish good rapport with their patients, they should show respect and care as expected by these patients.

Healthcare professionals should identify and adopt effective strategies to help them get to know their patients. The best practice is to build trusting relationships as it allows Black older women to feel more comfortable communicating concerns about their healthcare. This results in the appropriate communication styles being selected for each patient while expanding the patient's ability to manage their own care. For example, all the study participants noted that communicating with their healthcare professionals face to face was essential. A seated position directly opposite the patient improved communication by reducing distractions and sending the message that the care provider was engaged. Maintaining eye contact was also important and helped Black older women decipher facial cues.

When healthcare professionals are aware of their patients' communication preferences, they can be more equipped to efficiently comply to the needs of Black older women. Their practices will become more generationally friendly and contribute to a better quality of life. The narrative of Black older women will be changed to, they really care about us and our wellbeing as old people, instead of, they forgot about us old people.

Future Research

The first recommendation for future research is to conduct a study involving the experiences of Black older men in the same age group to explore their communication strategies at routine doctors' appointments. This research could focus on gender and investigate if older men are treated differently than older women during healthcare encounters.

Another idea for future research would be a comparison study done with

another minority group of older women of the same age (e.g., Asian, Latina). Such project would include collecting stories from each cultural group and documenting the commonalities and differences. In addition, a different type of qualitative study could include collecting data from healthcare professionals regarding communication strategies with patients of color (e.g., Black, Asian, and Latina). This study could bring light to the healthcare professionals' experiences and practice.

Closing Thoughts

As a Black woman and adult educator of healthcare professionals, this research created a major paradigm shift and learning experience. Listening to the experiences of Black older women was truly an emotional rollercoaster. During the interviews, there were times I felt excitement, distress, disappointment, irritation, and hope. This caused me to reflect in my field notes. This was a process where I chuckled and cried as I reflected on my relationship with my elderly grandmother.

This dissertation process was an experience in itself, a journey of its own. I started with a very modest idea –I wanted to simply hear stories that were like my Granny's. I wondered if there were others out there with experiences similar to hers when communicating with healthcare professionals. Learning from the study participants' journeys –their challenges, successes, and realizations from their own lived experiences, transformed me in many ways as a researcher and as an educator. Their stories have inspired me to continue this research beyond this dissertation and bring back the urgency of what I learned into the classroom and community.

When reflecting on how the study participants lived through a time when hatred for African Americans was at its most violent and powerful, it became evident that the

social and political context matters when working with older adults. For example, older patients who lived through this era are now reporting less satisfaction when visiting with physicians or healthcare providers (Stepanikova, Zhang, Wieland, Eleazer, & Stewart, 2012). Overlooking the traumatic racially based discrimination experience, would eliminate an important factor contributing to why Black older women may encounter doctor visits differently.

Through this research, I was able to offer a meticulous description of the lived experiences of Black older women communicating with healthcare professionals. It is an eye opener to educators, students, and practitioners in the field of healthcare professions. My intention is for this research to serve as motivation for those in my generation to band together and do our part for the present and also equip the generations after us to better serve the elderly.

Although this dissertation has ended, there is still plenty of work left to be done. Communicating effectively with Black older women and people of diverse backgrounds remains an urgent concern. The quest for equality and fairness continues. I will draw upon this research to work towards improving the current situation for this forgotten generation. This research has truly influenced me and opened my eyes to new perspectives.

APPENDIX SECTION

APPENDIX A

DEFINITION OF TERMS

Black – Person having origins of the Black racial groups of Africa (e.g. Haitian, Panamanian, Kenyan, Cuban, etc.). Adapted from the U.S. Census Bureau.

Black Feminist- A woman classified as black who endorses feminism under the guise of seeking equality with black men within the non-existent black male patriarchy archetype (Urban Dictionary, 2016).

Black Feminist Thought- Demonstrates Black women's emerging power as agents of knowledge. By portraying African-American women as self-defined, self-reliant individuals confronting race, gender, and class oppression, Afrocentric feminist thought speaks to the importance that oppression, Afrocentric feminist thought speaks to the importance that knowledge plays in empowering oppressed people (Collins, 1990).

Communication- The process of exchanging information in such a way that mutual understanding is achieved between two or more people about related issues (Dunn, 2010).

Communication Strategies- Basic skills used to make a connection with the intended audience. Advices such as sitting face to face, maintaining eye contact, listening, speak slowly and clearly, and focus on one topic at a time (Robinson et al., 2006).

Culture: Refers to the beliefs, values, and attitudes that structure the behavior patterns of a specific group of people (Merriam, 2009).

Healthcare Professionals: Physicians, Occupational/Physical Therapist, counselors, social workers, psychiatrist, and nurses.

APPENDIX B

INTERVIEW SAMPLE QUESTIONS

1. Tell me a little bit about yourself and your background.
2. How did you select your primary healthcare professional? (i.e. age, sex, gender)
3. Please tell me about your healthcare professional you frequent the most.

    - What do you like about them?
    - What don't you like about them?

4. How do the doctor and nurses speak to you?
5. Please describe your experiences during routine doctors' visits.

    - Have you felt stereotyped when you walked in the door (i.e. due to age, gender, or race)? Please explain.

6. Describe your recent experiences receiving medical instructions from your healthcare professional you frequent the most.
7. What communication strategies do you prefer when your primary healthcare professional is speaking to you?
8. What would you tell your primary healthcare professional about your communication preference?
9.   How do you want to be spoken to?
10. Sometimes I have heard women say that they had to have a "Come to Jesus" talk with their doctor. Have you ever had that kind of talk with any healthcare professionals?
11. What do you think is important for health professionals to know about Black older women? What advice would you give to healthcare professionals when dealing with Black older women?
12. What do you think should be done about training doctors and nurses support when dealing with older patients who are of a different race than they are?

What advice would you give to enhance the training of healthcare professionals when dealing with older patient who are a different race than they are?

13. Please explain how you think the care of Black older women should change to make it better.

14. What would you say frustrates you most during your doctor's visits?

15. Describe a time when you demanded something be done (a test) or gone for a second opinion.

16. Tell me about a time when you withheld information from your doctor.

17. Do you prefer to be accompanied by a friend or relative in the examining room? Please explain.

18. What cultural differences do you think exist between you and your healthcare professional you frequent the most?

19. Describe a time when you experienced good and bad communication with your primary healthcare professional. What was different?

20. Can you give me an example of a challenge or barrier that hindered good communication between you and your primary healthcare professional?

21. Can you give me an example when good communication occurred between you and your primary healthcare professional?

22. When medical instructions are unclear, how do you follow-up or communicate with healthcare professionals for clarification (i.e. patient portal, emails, phone calls, etc.)?

23. Are you satisfied with this mode of communication when clarification is needed?

24. What advice would you give to healthcare professionals to encourage clarification of treatment plans and return follow-up visits of older Black women?

25. Is there anything you would like to say or add that we have not discussed?

Research Questions	Interview Questions

What are the experiences of the study participants navigating interactions with healthcare professionals?	1. Tell me a little bit about yourself and background.
	2. How did you select your healthcare professional? (i.e. age, sex, gender)
	3. Tell me about your healthcare professional.
	  • What do you like about them?
	  • What don't you like about them?
	4. Please describe your experiences during routine doctors' visits.
	  • Have you felt stereotyped when you walked in the door?

How does communication and transfer of information occur between Black elderly women and their healthcare professional?	1. How do the doctor and nurses speak to you? 2. Describe your recent experiences receiving medical instructions from your healthcare professional you frequent the most. 3. What would you tell your doctor about your communication preference? 4. Tell me about a time when you withheld information from your doctor.
What communication strategies do Black elderly women prefer to use while interacting with healthcare professionals?	1. What communication strategies do you prefer when the healthcare professional is speaking to you? 2. Tell me how you think the care of Black older women should change to make it better. 3. What would you say frustrates you most during your doctor's visits? 4. Do you prefer to be accompanied by a friend or relative in the examining room? Please explain.
What is the role of culture when examining rapport and communication between Black elderly women and healthcare professionals?	1. Sometimes I have heard women say that they had to have a "Come to Jesus" talk with their doctor. Have you ever had that kind of talk with any healthcare professionals? 2. What do you think is important for healthcare professionals to know about Black older women?

	3. What do you think should be done about training doctors and nurses when dealing with older patients who are of a different race than they are? 4. What cultural differences do you think exist between you and your healthcare professionals?

INDIVIDUAL INFORMED CONSENT

Study Title: Narratives of Black Older Women Communicating with Healthcare Professionals

Principal Investigator	**Faculty Advisor**
Danette L. Myers	Clarena Larrotta
Email: dm19@txstate.edu	**Email:** CL24@txstate.edu

This consent form will explain why this research study is being done and why you are being invited to participate. It will also describe what you will need to do to participate as well as any known risks, inconveniences or discomforts that you may experience while participating. We encourage you to ask questions at any time. If you decide to participate, you will be asked to sign this form and it will be a record of your agreement to participate. You will be given a copy of this form to keep.

PURPOSE AND BACKGROUND

You are invited to participate in a research study to share your lived experiences and perceptions of interactions with healthcare professionals. To also report on the healthcare professional's communication strategies used during these encounters. The information gathered will be used as research data in a doctoral dissertation. You are being asked to participate because you are an active participant in the healthcare system.

PROCEDURES

If you agree you will be expected to participate in one 60-minute interview and follow-up interview if needed.

The interviews will be audio-recorded and will take place at a time and location where you are comfortable answering the questions.

During the interviews, you will be asked questions related to:

- Experiences during encounters with healthcare professionals
- Perception of your healthcare professionals
- Communication preferences
- Expectations of healthcare professionals
- Opinion about how to enhance this relationship

RISKS/DISCOMFORTS

There is minimal risk in participating in this study.

If some of the interview questions make you uncomfortable, you are always free to decline to answer any question, take a break, or stop your participation at any time without consequences.

BENEFITS/ALTERNATIVES

The information that you provide will improve our understanding of your preferred strategies and expectations of communications.

EXTENT OF CONFIDENTIALITY

Your name will not be used in any written reports or publications which result from this research. The information you provide in the interview will not be shared with your doctor or healthcare professionals. Any information you provide will be kept confidential. Data will be kept in a password protected file in the researcher's personal computer.

The members of the research team and the Texas State University Office of Research Compliance (ORC) may access the data. The ORC monitors research studies to protect the rights and welfare of research participants.

PAYMENT/COMPENSATION

You will not be paid for your participation in this study.

PARTICIPATION IS VOLUNTARY

You do not have to be in this study if you do not want to. You may withdraw from the study at any time without consequences of any kind.

QUESTIONS

If you have any questions about your participation in this study, you may contact the principal investigator or faculty advisor shown at the beginning of this document.

This project was approved by the Texas State IRB on July, 2018. Pertinent questions or concerns about the research, research participants' rights, and/or research-related injuries to participants should be directed to the IRB Chair, Dr. Denise Gobert 512-245-8351 – (dgobert@txstate.edu) or to Monica Gonzales, IRB Regulatory Manager 512-245-2334 - (meg201@txstate.edu).

DOCUMENTATION OF CONSENT

I have read this form and have decided that I will participate in the project described above. Its general purposes, the particulars of involvement and possible risks have been explained to my satisfaction. I understand I can withdraw at any time.

_____   _____   _____
Printed Name of Study   **Signature** of Study   Date
Participant   Participant

_____   _____
Signature of Person Obtaining Consent   Date

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