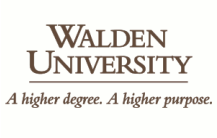

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The Experiences and Perceptions of African American Women Who Reside in Nursing Homes

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
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Abstract

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by

Lakeisha Riley

MA, University of Denver, 2014

BS, Strayer University, 2012

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The purpose of this qualitative case study was to examine the experiences and perceptions of African American women who reside in a nursing home and to understand African American women's decisions for admitting to the facility. Social Learning Theory was applied to answer the question of how African American women's experiences and perceptions toward long-term care influence healthcare decisions and admission to a nursing home. Eleven participants interviewed in the study were at least 60 years old, admitted into the facility within the past two years and who had not previously resided in a nursing home. Yin's five step approach to data analysis, NVivo and Microsoft Office to gather data from African American women who live in a nursing home. Participants in this study described their perceptions of nursing homes as places they never thought they would reside in and expressed that African American families traditionally "took care of their own." As a result, participants stated nursing homes were not an option normally considered within their families. Decisions to admit to a nursing home were based on family work schedules which resulted in lack of supervision at home, increased nursing care, and financial reasons. Cultural competence was an important factor in helping them adjust to a nursing home environment despite cultural norms. This research can contribute to social change by providing awareness and identifying health behaviors and cultural beliefs regarding the use of long-term care facilities by African American women despite cultural norms. The findings of this study can also create positive social change movement in nursing homes to deliver resident-centered care and empowering staff.

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Chapter 1: Introduction to the Study

Introduction and Background

The United States Census Bureau projects that by the year 2030, 20% of the population will be 65 years of age or older (U.S Census Bureau, 2014). The United States population continues to become diverse over time (U.S Census Bureau, 2016). Demographic shifts are increasing the older minority population overall and in nursing homes (Thomeer, Mudrazija, & Angel, 2015). Cai and Temkin-Greener (2015) affirmed that African Americans and Hispanics remain in the community longer than Whites before a nursing home admission. According to Herrera, George, Angel, Markides, and Torres-Gil (2013), African Americans utilize less in-home services and try to maintain their independence if possible. Herrera et al., (2013) examined racial and ethnic variations and found that resources such as Medicaid's Home and Community-Based Services (HCBS) were less consumed by African Americans and Hispanics. HCBS provides long-term supports for the functionally impaired, elderly, blind and disabled who require long-term supports to help them remain in a community setting (Herrera et al., 2013).

In addition to staying longer in their communities prior to a nursing home admission, African American elders were found to be more impaired than White elders in physical and cognitive functions upon short-term and long-term nursing home admissions (Cai & Temkin-Greener, 2015). Cai and Temkin-Greener (2015) concluded that these differences might imply racial and ethnic disparities in access to nursing homes and cultural differences that affect long-term care choices. A recent health and retirement

study which assessed racial differences and cognitive impairments found that African Americans suffer from a greater risk of moderate to severe cognitive impairment at baseline and follow-up and experienced childhood adversity (Zhang, Hayward & Yu, 2016). These early difficulties can significantly indicate a higher risk of cognitive impairment of adult African Americans and are not reduced when controlling social and environmental factors combined with biological, behavioral or psychological issues (Zhang et al., 2016).

Correlation and regression analyses of demographic information and measures of depressive symptoms and financial stress uncovered that perceived financial distress is directly related to depressive symptoms (Starkey, Keane, Terry, Marx & Ricci, 2012). Wiltshire, Elder, Kiefe, and Allison (2016) evaluated differences in African American and White medical debt among elderly adults. African Americans incurred more medical debt compared to Whites, and more than 40 percent of African American medical debt accrued was due to health status, income and insurance disparities (Wiltshire et al., 2016). Per Sullivan and Meschede (2016), in the United States African Americans are more likely than Whites to live in poverty in old age. Financial discrepancies were discovered among African American women compared to White women regarding retirement resources such as Social Security, savings, annuities, 401K retirement plans and stocks (Sullivan & Meschede, 2016).

Individuals who meet age or income requirements are eligible to apply for Medicaid for financial assistance to help with the cost of long-term care; however, Chisholm, Weech-Maldonado, Laberge, Lin and Hyer (2013) found that economic

outcome and quality performance of nursing homes differed between facilities who had high proportions of African Americans than facilities with few or no African American residents. Higher revenues, larger profit margins, financial viability and the quality of care of nursing homes used in the study were influenced by the racial composition of the residents (Chisholm et al., 2013).

Problem Statement

According to Harris-Kojetin et al. (2013), approximately 10% of nursing home and home health patients are non-Hispanic African Americans. According to Black et al. (2013), 90 percent of persons living at home in the community with dementia had unmet safety needs, more than 50 percent had unmet needs for daily activities, and 30 percent had not received a previous diagnosis. Increased unmet needs were associated with persons with dementia of non-White race, lower income, less impairment and higher depression (Black et al., 2013).

While researchers have shown that the number of African Americans admitted to long-term care is increasing, there are disparities in long-term care for African Americans (Li et al., 2015). Freedman and Spillman (2016) asserted that African Americans have fewer economic resources, are uninsured earlier in life, and are more likely to be dually eligible for Medicare and Medicaid than their White counterparts. Sury, Burns, and Brodaty (2013) reported that nursing home admissions are becoming prevalent due to increased behavioral symptoms, decreased cognition, frailty and frequent dementia-related falls. Individuals who are not able to manage at home have been transitioning to long-term care to sustain a better quality of life (Sury, Burns & Brodaty, 2013). Nikmat,

Hawthorne, and Al-Mashoor (2015) stated nursing homes are necessary because they provide a broad range of benefits such as 24-hour skilled medical care for patients who are unable to live at home. Families who fail to cope with their loved one's symptoms of progressing dementia utilize nursing homes as interventions (Nikmat et al., 2015). A nursing home may be necessary based on an individual's needs.

Over the past 30 years, there has been an increasing emphasis in aging studies related to racial and ethnic groups due to demographic shifts (Thorpe & Whitfield, 2017). Gerontology researchers have found a distinct need to understand better issues related to ethnic and racial groups by focusing on factors that contribute to life course decisions (Thorpe & Whitfield, 2017). Although research was found that included individuals and their families of different races and ethnicities who entered long-term care, I have discovered few research studies that have explored the attitudes and perceptions of African American women towards nursing homes and describe how they feel after admitting to a nursing home. Brandburg et al. (2013) found that transitioning into a nursing home for older adults can be an overwhelming life change and that people adjust to differently over time. Given that people adapt differently to living in a nursing home, further research is warranted that could examine the attitudes and perceptions of African American women who live in a nursing home.

Purpose

The goal of this qualitative study was to explore the attitudes and perceptions of African American women who reside in a nursing home and their decision to self-admit to the facility. Participants who self-admit do not have a legal guardian or a legal Power

of Attorney solely responsible for decision-making. The participants were their own legal responsible party. The participants have not designated decision-making capabilities to another party and have not been deemed incapacitated by a Colorado State court. The findings of this study are intended to contribute to current knowledge concerning African American women in long-term care skilled facilities. Upon reviewing available literature, I have found many studies which identified factors that influence long-term choices such as finances, stigmas, religion and perceived racism. However, I found limited research that described how African American women residing in a nursing home feel about nursing homes. Available literature identified racial disparities in health care and skilled long-term care facilities for African Americans. The results from this study can provide insight into the experiences of African American women who live in long-term care facilities.

Conceptual Framework

According to Bandura (1989), people may learn by observing, imitating and modeling other people within their systems. Bandura believed that learning was established by behaviors or other social factors in conjunction with the environment. "The qualities that are cultivated and the life paths that realistically become open to them are partly determined by the nature of the cultural agencies to which their development is entrusted" (Bandura, 1989, p.75). Bandura argued that observational learning was not based on positive or negative reinforcements (Bandura, 1989). Wahl, Iwarsson and Oswald (2012) discovered that it is essential to continuously monitor theories of aging individuals regarding their capability to accurately display ongoing cultural change which

is critical for aging. An individual's environment was found to influence aging within a historical, cohort-related and cultural context (Wahl et al., 2012). "Social systems that cultivate generalizable competencies create opportunity structures, provide helpful resources, and allow room for self-directedness increase the chances that people will realize what they wish to become" (Bandura, 1989, p.75). Bandura emphasized the concept of self-efficacy as the key to lucrative learning and that people learn from watching others in a knowledge acquisition process called modeling (Bandura, 1989). Bandura argued that an individual's behavior is not only the product of its environment but may also influence it.

The Social Learning Theory was applied to the question of how do African American women's experiences and perceptions of long-term care, influence health care decisions and admission to a long-term residential facility. Bandura (1989) stated that environmental influences that shape attitudes for individuals intersect and can be social (friends and family), cognitive, behavioral, and physical. The constructs of the Social Learning Theory that are relevant to health behavior change and this study is observational learning, reinforcement, self-efficacy and self-control (Bandura, 1989). The concept of self-efficacy defined by Bandura (1989) refers to an individual's confidence one's ability to initiate change despite challenges. Self-efficacy was important when answering the research question because it helped determine what influenced healthcare decisions and nursing home admissions. Bandura (1989) suggested that a person can both promote change and respond to change. Environmental changes and reinforcements can

encourage healthier behaviors. Bandura's Social Cognitive Theory was discussed further in Chapter 2.

Research Questions

Two questions were created from the problem statement.

RQ1. How do African American women's experiences and perceptions toward long-term care influence self-admission to a nursing home?

RQ2. How do African American women describe living in a nursing home after admission?

Nature of the Study

This case study utilized qualitative methodology. Characteristics or qualities of phenomena can be considered subjectively by using qualitative research. Data gathered from case studies seek to identify themes or groups of behaviors instead of substantiating relationships or testing a hypothesis (Yin, 2013). A case study allowed the researcher to formulate questions and comprehend observations. Case study analysis is relevant to the study because it allowed guidance through the process of design selection, collection, and analysis of multiple sources of data.

According to Yin (2013), case studies provide in-depth data regarding individuals during a specific timeframe. Information is standardized for comparison and requires the flexibility of the researcher. This case study used a natural approach through observation, conversation, and semi-structured interviews consistent with qualitative research. The robust data was collected from predetermined open-ended questions derived from experience and will allow the researcher to observe and look at trends. To

determine how African American women, feel regarding long-term care, a small sample of participants who have self-admitted to a nursing home will be interviewed. The sample will contain participants who are deemed competent to make decisions regarding their care.

Definitions

African American or Black: Any individual who identifies as having origin of any Black racial groups of the United States, Africa or any other country (U.S. Census Bureau, 2013).

Cognitive impairment: A decline in mental abilities which may include memory and thinking skills of individuals over 65 years of age (Claxton et al., 2015).

Culture: Beliefs, attitudes, values and learned behaviors shared collectively among members of a group and passed on from generation to generation.

Cultural attitude: The mindset for an individual to act in a certain way as result of their beliefs and customs.

Cultural norm: Standards that individuals of a group embrace that are considered normal among the group (Minkov, Blagoev, & Hofstede, 2013).

Demographic shifts: Changes or growth in population, ethnic, and racial diversity.

Disparities: Differences in which disadvantaged groups such as racial, ethnic, minorities and women experience poorer health and difficulty obtaining health services.

In- home services: Medical or nursing services provided by home health agencies.

Nursing home: Facility that provides 24- hour skilled medical and nursing care for individuals who are not able to take care of themselves in the community (U.S. Department of Health and Human Services, 2013, p. 53).

Assumptions

The participants who participated in this study were assumed to be competent with no diagnosis of Alzheimer's or Dementia as they would possess the ability to make decisions regarding their care. According to the Alzheimer's Association, dementia symptoms can vary and at least two essential memory functions must be severely impaired to be diagnosed with the disease (Alzheimer Association, 2017). These functions include memory, communicative language, concentration, reasoning, logic and visual perception. The Global Deterioration Scale for Assessment of Primary Degenerative Dementia (GDS) widely used by health professionals within the last five years, separates the stages of Dementia into seven steps (Choi, Won, Kim, Choi, Kim, Jeon, & Park, 2016). According to the GDS or also known as the Reisberg Scale, the first three stages of dementia are not given a diagnosis of dementia (Reisberg, Ferris, de Leon, & Crook, 1982). Individuals in the fourth stage of dementia are considered as to having mild cognitive decline which includes symptoms such as forgetfulness, minimal difficulty in concentrating and decreased task performance (Reisberg et. al, 1982). The onset of stage four may take up to seven years (Reisberg et. al, 1982). One in ten people age 65 years of age and older progress to have Alzheimer's disease (Alzheimer Association, 2017). Cognitive decline may start to be noticeable as individuals have difficulty expressing themselves (Choi et al., 2016). However, not all individuals who

experience memory loss experience early stages of Alzheimer's disease (Alzheimer Association, 2017). Downer, Thomas, Mor, Goodwin and Ottenbacher (2017) found that only 21.7 percent of individuals who admitted to the nursing home in their study had mild cognitive impairment. Individuals who are diagnosed with stage five dementia through a detailed medical exam, laboratory work and medical history, are determined by a physician to have major memory deficits and mental capacity issues (Alzheimer's Association, 2017). The characteristics of the participants of the sample who are not diagnosed with stage four dementia are appropriate for this study. Everyone participating in the study had a genuine interest and no other intentions for partaking in this research. It is believed that each question answered during the interviews was answered truthfully and that the participants have the knowledge to assist and provide robust data.

Scope and Delimitations

This qualitative study only includes African-American women currently residing in a 160-bed nursing home located in Denver, Colorado. The letter of agreement for the participating facility can be found in Appendix A. The sample is delimited to women who are at least 60 years old, who self-admitted to the facility within the last two years, and who had not previously resided in a nursing home. Kraijo, Leeuw, and Schrijvers (2015) found that nursing home admission decisions developed in phases over time and continued after admission to a facility. The range from newly admitted up to 2 years was chosen to give adequate time to experience the adjustment process based on the findings of Kraijo, Lueeuw, and Schrijvers (2015). The reasoning for excluding residents under 60 years old is because the focus of the research is to identify the perceptions of the elderly.

Although there is no standard age, the term elderly is often associated with the chronological retirement ages of at least 60 years of age in developed countries (World Health Organization, 2014). Residents who live in a nursing home can experience the adjustment process well over six months (Lee, Yoon, & Bowers (2015). Rodraquez-Martan et al. (2014) discovered that residents possessed negative and positive preconceptions regarding nursing homes before admission to a nursing home despite having any previous facility admissions. Stress, loss of identity and a decreased control over one's life negatively influenced participant's views while good family support, adequate knowledge regarding nursing homes and encouragement helped participants adjust to a nursing home (Rodraguez-Martan et al., 2014). Skilled nursing home patients with no personal previous nursing home experience were selected to increase the probability that perceptions and experiences discovered would pertain primarily to their current admission. Psychosocial theories suggest that as individuals age, their behaviors, interactions, and activities change.

Limitations

This study includes African-American female participants who reside in one nursing home in Denver, Colorado. The results of this research may not be generalizable because little is known if the cases explored in this study would be an accurate representation of individuals with similar circumstances. While this study is suggestive to the experiences of people admitting to nursing homes, further research would need to be done to verify if results from this research can be applied elsewhere. The self-reported data collected through interviews could obtain potential bias such as exaggeration,

selective memory and inaccurate recollection regarding time. Access to participants is limited to those who are their own responsible party. Individuals who are required to have a power of attorney may have cognitive deficits which could affect the validity of this study.

Significance

This research could contribute to social change by providing awareness and identifying health behaviors and cultural beliefs regarding the use of long-term care facilities by African American women. As nursing homes become increasingly more diverse, nursing home staff will see an influx of residents with health perspectives influenced by their social and cultural backgrounds. Previous research has found that poorer health outcomes result from sociocultural differences between providers and patients (Cai & Temkin-Greener, 2015). The expectations residents have regarding their individual care, thresholds for seeking care and unfamiliar beliefs can impact their ability to adhere to treatments and housing recommendations. Key determinants of social networks that affect health behaviors in the elderly are belief systems and tradition (Herrera et al., 2013). Studies have shown that some African Americans view receiving healthcare as a degrading and a humiliating experience due to racism, segregation, and powerlessness (Cai & Temkin-Greener, 2015). If the number of African American nursing home admissions increase as Thomeer, Mudrazija, and Angel (2015) suggested, then it is important to understand how African American women feel after being admitted to a nursing home and the perceived effect on their general well-being and quality of life.

This study could help promote cultural competence and assist with staff training that could impact nursing home transitions for African American woman.

Although cultural norms may influence health decisions, factors such as demographic shifts, economical changes and caregiver stress increase nursing home admissions (Thomeer, Mudrazija, & Angel, 2015). The purpose of this qualitative study was to describe the attitudes and perceptions of African American women who reside in a nursing home and to understand the experiences of African American women who admit to a nursing home if admission goes against their cultural norms. This research addressed the gap in the research literature about African Americans' long-term care decisions by identifying cultural barriers and improved understanding of the decision-making process of African American women who admitted to a nursing home.

Summary

Recent research has found that cultural dynamics continue to pose issues for African Americans who are considering residential long-term care placement (Pharr, Francis, Terry & Clark, 2014). African American history, beliefs, attitudes, and practices, especially toward health care is important in understanding why African Americans reside in their homes longer than any other ethnicity. Over the past several years, the number of African Americans admitting to nursing homes has increased. Furthermore, less is known regarding how African Americans feel after admitting to a residential nursing home. The purpose of this qualitative study was to understand the attitudes and perceptions of African American women towards nursing homes and to understand the influences and experiences of African American women who decide to

self-admit to a residential nursing home despite cultural norms. The results of this study could contribute to social change by identifying cultural beliefs that may be detrimental to African American women's well-being.

Chapter 2 will provide an in-depth review of the literature on African American history, beliefs, practices, attitudes toward health care and perceived financial distress. Recent findings related to barriers to entering a nursing home and caregiver influence will also be reviewed. The literature review supports the need for further research in understanding African American culture and the decisions of African Americans to enter a nursing home.

Chapter 2: Literature Review

Introduction

As demographic shifts increase the older minority population, many minorities decide to admit to a long-term facility (Thomeer, Mudrazija, & Angel, 2015). Historically, African Americans choose to reside in their homes longer than any other ethnicity and utilize fewer in-home services compared to Whites (Cai & Temkin-Greener, 2015). Upon a nursing home admission, African American elders were found to be more cognitively impaired than White seniors (Cai &Temkin-Greener, 2015). Differences in cognitive status may imply racial and ethnic disparities regarding access to long-term care facilities and cultural differences that may affect decision-making. Factors that also influence long-term choices are finances, stigma, religion and perceived racism. Sullivan and Meschede (2016) reported that more African Americans live in poverty at old age than non-minorities. Although Brandburg et al. (2013) found that transitioning into a long-term nursing facility could be overwhelming for older adults, more research is needed that examines the attitudes and perceptions of African American women who live in skilled long-term care facilities. According to the Centers for Disease Control and Prevention National Center for Health Statistics (2017), women constitute 70.2 percent of the nursing home population. The purpose of this study was to examine the attitudes and perceptions of African American women towards long-term care and the effects of their decision to admit to a nursing home.

This literature review begins with a description of the demographic shifts affecting African American long-term care admissions. The key focus was on literature

that captured African American culture, beliefs, and practices. Insights on African American women's experiences with health care, racial disparities, community long-term care services and cognition from previous research were provided to obtain a description of what is known regarding African American women and cultural factors that affect their decision to admit to a nursing home. This chapter will conclude by describing how this study will address the gap by identifying cultural barriers and improve understanding of the decision-making process of African American women who admit to a nursing home despite cultural norms.

Literature Search Strategy

Research on African American women and their culture, beliefs, and practices has resulted in the utilization of current studies and historical contexts for this literature review. Online databases such as Psych INFO, Google Scholar, Pub Med, Science Direct and ProQuest Central was used with an assortment of keywords: Black, African American, long-term care, nursing home, nursing facility, elderly, retirement age, geriatric, culture, stigma, racial disparities, finance, poverty, health care, decision-making, in-home services, admissions, depression, dementia, family, women, cognition, racism and religion. Additional references were discovered within these sources and examined for optimum matches for this study. No searches produced studies on understanding how African American women feel about admitting to a nursing home despite cultural norms.

Conceptual Framework

Albert Bandura developed Social Cognitive theory as an expansion of development theories which contained cognitive theories (Bandura, 1989). Bandura changed the name of his Social Learning Theory to Social Cognitive Theory to include the perception of reality, cognition, and self-regulation. Bandura agreed with behavioral theories that proposed that learning was associated with conditioning, reinforcement, and punishment (Bandura, Ross & Ross, 1961). However, he also believed learning could occur by observing the actions of others. There are several concepts that are at the center of the Social Cognitive Theory.

Bandura's Bobo doll experiment found that children learn and replicate behaviors they observe (Bandura, Ross & Ross, 1961). Three basic models of observational learning evolved from his research. The models of observational are learning from an active model which consists of watching a behavior, learning from a verbal coaching model through descriptions or explanations and learning through symbolic models such as media, T.V, books, and movies (Bandura, Ross & Ross, 1961). Bandura explained that learning is dependent on one one's mental state and that external and internal forces influence learning and behaviors (Bandura, 1965). Although people can learn and change their habits, Bandura's observational learning suggests that people can learn new information without altering their behaviors.

In a process called modeling, steps must be taken to ensure that social learning is successful (Bandura, 1989). First, the learner must pay attention to learn (Bandura, 1989). Distractions can interfere with processing and deter learning. Second, retention is vital to

modeling (Bandura, 1989). The ability to retain what is learned affects how people act on those behaviors (Bandura, 1989). Once information is kept, a person must be able to replicate and model the behavior (Bandura, 1989). Lastly, an individual must be motivated to continue to model the behavior (Bandura, 1989). Modeling can be concrete or abstract. For example, a person can replicate a witnessed modeled behavior and apply it to a different situation. This replication is essential in explaining how people respond to situations they have not personally experienced.

The framework for this study was based on the Social Cognitive Theory. The theory suggests that individuals possess the ability to exercise control over their thoughts, feelings, and behaviors (Bandura, 1998). Per the Social Cognitive Theory, people, behavioral factors, and the environment influence each other (Bandura, 1998). Su-Hsien and Ching-Len (2013) found that family members, elders, and staff at long-term care facilities must work together to enhance an elder's self -dependence. Su-Hsien and Ching-Len (2013) found that to promote self-independence, it is imperative to comprehend elders' attitudes regarding their care.

I employed Bandura's cognitive behavioral theory for this study because the theory suggests that learning originates through the observation of another individual's behavior. Environmental, behavioral and cognitive influences occur through interactions between people (Bandura, 1968). Influences such as friends and family or the physical environment can affect decision-making and behaviors. Behavioral influences are defined as observed behaviors with consequences, and cognitive factors refer to an individual's learning thought processes and whether they comprehend their observations (Bandura,

1968). Tylor (1958) was one of the first anthropological works to state culture is learned. Bandura's theory helps to understand the attitudes and perceptions of African American women who reside in a long-term care skilled facility and their reason for admitting to the facility.

Racial, Gender, and Cultural Differences in Long-term Care

The literature within this section describes racial, gender and cultural differences in long-term care. The growing diverse elderly population is affecting community home based services and long-term care use (Spetz, Trupin, Bates & Coffman, 2015). If the current trends continue, between 2014 and 2060 it is projected that the non-Hispanic Black population will increase from 42 million to 60 million which is an increase of 42 percent (Colby & Ortmen, 2014). However, African Americans remain in the home longer than any other ethnicity (Herrera, George, Angel, Markides, &Torres-Gil, 2013). Thomeer, Mudrazija, and Angel (2015) recognized that there might be a disparity in health care among African Americans and Hispanics. Warner and Brown (2012) explored how childhood life experiences and adversity created disadvantages in relationships during a person's life and ultimately have significant effects on their health over time. Warner and Brown (2012) discovered that African Americans are disadvantaged compared to Whites, and their disadvantage is attributed to gender. Warner and Brown (2012) explained how race, ethnicity and gender intersect simultaneously to help define availability to the resources that promote health risks and identify exposure to risk over a person's individual life course.

According to Warner and Brown (2012), early socioeconomic status, marital status and health behaviors help to define racial-ethnic and gender disparities in functional limitations. Warner and Brown (2012) found African American men had more strained relationships during their lifetime than the African American women. The purpose of the study by Thormeer, Mudrazija, and Angel (2015) was to identify factors that lead to increasing nursing home admissions. Warner and Brown's (2012) study suggested different pathways connecting stress to health disparities for black individuals. Warner and Brown (2012) argued the importance of understanding race and gender disparities in health. It was suggested that future research consider the protective roles family and friends play in African American families (Warner & Brown, 2012).

Thormeer, Mudrazija, and Angel (2015) and Warner and Brown (2012) agreed that African Americans and Hispanics were less likely than whites to enter nursing homes and that racial and ethnic differences in nursing home admissions are widespread after health and disability factors are assessed. Of those who enter long-term care, African American women are most likely to be discharged to home from a long-term facility (Thomeer, Mudrazija & Angel, 2015). Campbell and Young (2014) showed that low levels of awareness among racial and ethnic minority groups about disparities disproportionately affected their communities. Campbell and Young's (2014) study explained how an African American individual's awareness of cultural differences affect health decisions. Like Campbell and Young (2014), Thomeer, Mudrazija and Angel (2015) explored the different preferences of nursing home care because of unmeasured cultural factors. Campbell and Young (2016) believe that awareness of disparities is

critical in changing behaviors that are detrimental to an individual's well-being. The authors suggested further research in culture, religion, transitional services and health care policy.

The study by Pickett, Greenburg, Bazelais, and Bruce (2014) contributed to knowledge on how African Americans are often unaware of the disparities. The authors implied that policy makers should make it their duty to increase and deliver valuable data on racial and ethnic health disparities to develop educational campaigns to raise cultural awareness (Pickett, Greenburg, Bazelais & Bruce, 2014). Racial and ethnic health disparities are a significant public health problem in the United States (Dutta & Kreps, 2013). Picket et al. (2014) validated that further research is needed to measure the awareness of health disparities and feelings regarding health care among African Americans. Pickett et al. (2014) showed that racial and ethnic differences in depression treatment continue to exist among home health patients specifically with African American and Hispanics. Previous research concluded that African Americans remained at home longer than any other ethnic group (Cai & Temkin-Greener, 2015). African Americans are less likely to be depressed while living at home and less likely to utilize medications for depression (Pickett, Greenburg, Bazelais, & Bruce, 2014). Further research is necessary to understand disparities and to explore if depression is a symptom that is reported or increased as an individual is admitted to a long-term residential facility.

Also, racial composition and age will create challenges for minority populations because African Americans have a higher risk of developing Alzheimer disease than non-

Hispanic Whites (Barnes & Bennett, 2014). Since Alzheimer's is related to age, and the elderly population is growing and living longer, people with dementia is expected to increase as people get older (Pierce & Kawas, 2017). African American women were found to be at a greater disadvantage regarding the number of years to be living with a disability (Freedman & Spillman, 2016).

Bliss, Harms, Garrard, Cunanan, Savik, Gurvich, and Virnig (2013) examined incontinence as a factor for nursing home admissions. Their results showed that fewer Blacks, Hispanics and Native Americans have completed high school than Whites and they were more debilitated compared to Whites with deficits in activities of daily living, vision and other comorbidities. The sample contained individuals age 65 years and older; 65 percent were African Americans and 67 percent Asians (Bliss et al., 2013). However, African Americans also had a higher percentage of individuals who were bedfast or required mechanical lifts. Cognitive functioning for African Americans, Hispanics, and Asians was found to be worse compared to White residents (Bliss et al., 2013). Hurd Martorell, Delavande, Mullen and Langa (2013) agreed with Bliss et al. (2013) and found that older females of non-White race or ethnic groups, single status, lower educational level, and lower household income were associated with an increased likelihood of dementia. White Americans and Native Americans exhibit a greater number of depressive symptoms and discomfort behaviors compared to any other group, and White individuals have higher mortality rates than any other ethnic group found in nursing home locations in communities with working middle-class populations (Bliss et al., 2013).

Bliss et al. (2013) determined that it is important to consider sociodemographic and social economic factors when analyzing differences among subgroups of elderly in nursing homes. Like Bliss et al., (2013) Thormeer, Mudrazija and Angel (2015) concluded that African Americans reside in their own homes longer than Whites. The authors found that at admission, African Americans are more cognitively declined than Whites because they enter long-term care facilities during the later stages of life (Bliss et al., 2013). Bliss et al. (2013) discovered the need for more services before a nursing home admission, especially for African Americans. Black, Johnston, Rabins, Morrison, Lyketsos, and Samus (2013) used in-home assessments to determine unmet clinical and safety needs of individuals with dementia living in the community. Unmet needs were committed to being elevated with early-stage dementia in minority and low-income communities with caregivers who are less educated (Black et al., 2013). African American historical events, beliefs, practices and attitudes toward health care are imperative to understanding why African American women remain in the home longer than their White counterparts.

Culture, Stigma, and Health

Bliss et al. (2013) found that cultural factors were less often considered to pose issues for admittance to long-term care facilities. Historically, elder African Americans are the foundation of knowledge and are often obeyed and respected in the community (Stuckey, 2013). To reach old age is regarded as a milestone and is reflective of great faith, strength, and ingenuity (Stuckey, 2013). Understanding African American history can help explain current behaviors. Stuckey (2013) stated that despite being forced not

outwardly to display their African heritage, African slaves worked together to survive slavery. African slaves had to suppress their culture and adapt to western culture, beliefs and practices. Cooperation was imperative, and the slaves usually cared for their own sick, elderly, and disabled (Stuckey, 2013). A lesson that has been handed down from generation to generation in African American culture is to make use of resources that the environment has provided and for African Americans to take care of themselves. Stuckey determined that the helping tradition and the strong sense of family explained why slaves worked to free their kin and risk their lives and freedom to rescue family. The traditional African family included more than the father, mother, and dependent children. Aid from relatives and friends was crucial to survival and is still apparent today (Stuckey, 2013). Stuckey believed slave children were taught that their actions could affect the group. He noted that older children were taught to take care of the younger ones despite family relation and elders taught the younger generation obligation for the entire group and religious values that reinforced caring and helping.

Similarly, Pharr, Francis, Terry, and Clark (2014) developed a qualitative study with a goal of discovering how culture impacts caregiving. The authors acknowledged that caregiving experiences differ among ethnic groups. However, they wanted to enhance knowledge regarding cultural differences, experiences, and expectations of caregiving. These researchers concluded that "African Americans depicted caregiving as a part of cultural/family history that has been passed on for generations" (Pharr et al., 2014, p.3). Therefore, like Stuckey (2013), caregiving came "naturally" and was

"nothing new" (Pharr et al., 2014, p.3). African Americans saw caregiving as a responsibility embedded in their culture (Stuckey, 2013).

Black heritage evolved from this caring, helping, and commitment. Conner and Chase (2016) described caregiving and decision-making roles and discovered sub themes which included preordained role assignments, challenged societal norms, valued relationships versus personal cost, and feelings of African Americans towards healthcare. Participants in this study favored family relationships more than money or job status (Conner & Chase, 2016). African American participants in the Conner and Chase study (2016) explained that there is an underlying belief that they were repaying a debt to the person who was dying. Nuclear family members understood the commitment and took on supportive roles which allowed the participant to care for their loved one without consequence. Roth (2015) stated that African Americans reported more often than Whites that caregiving gave them purpose, appreciation, and a more positive outlook on life. Roth (2015) did not state if African American caregivers were giving appropriate care or if their loved ones felt they were receiving adequate medical care.

Sirey, McKenzie, Ghosh, and Raue, (2014) examined anticipated stigma and mental health among elderly clients with depression who were participating in a home delivery nutrition program. Clients were assessed for depression, cognitive impairment, and anticipated stigma (Sirey et al., 2014). In this study, anticipated stigma was defined as a public stigma that is created by the beliefs of family and friends (Sirey et al., 2014). It is important to understand whether one's group would negatively react because of treatment or services needed if the treatment is outside of the group's norm. Sun et al.

(2013) interviewed White participants and found that potentially harmful behaviors were directly related to caregivers' wanting to institutionalize the family member. Sirey et al. (2014) hypothesized that African Americans were more likely than Whites to report high anticipated stigma and were found to be correct. Cuevas, O'Brien, and Saha (2016) found that poor communication with health care providers, perceived discrimination when accessing health care and medical mistrust are barriers to quality patient-physician rapport and medication adherence for African Americans. Also, African American men reported less anticipated stigma than women

Sirey et al. (2014) only captured a single referral in an extensive process of referring for mental health treatment. Data did not contain interactions between staff and clients to determine how stigma, gender, race or age affected the referral process. Characteristics such as finance, functional status, and medical burden may have changed the outcome of successful referrals. The authors' measurement of anticipated stigma has also not been tested across different cultures. According to Sirey et al. (2014) and Cuevas, O'Brien, and Saha (2016), anticipated stigma hinders older adult decision-making and the process of referral for treatment. Sirey et al.'s research (2014) helps in the understanding of how anticipated stigma affects decision making about admitting to a nursing home.

Caregivers and Stress

Sun, Durkin, Hilgeman, Harris, Gaugler, Wardian, and Burgio (2013) explained the role of quality care and mediating between caregiver stresses in their desire to admit a loved one to a nursing home. The sample contained 601 family members from several

different racial and ethnic backgrounds using data from a previous research project (Sun et al., 2013). The sample included a population that was majority Caucasian. The authors found that potentially harmful behaviors such as caregivers yelling at the loved one or threatening to abandon them were directly related to caregivers wanting to institutionalize the family member (Sun et al., 2013). Sheppard et al. (2013) also sought to determine if symptom burden was a predictor of nursing home admissions. Sheppard et al. (2013) defined symptom burden as a measurable number of symptoms that present a physiologic burden on patients which result in negative emotional or physical behaviors. In the study, the symptom of burden independently predicted nursing home admission. Only symptoms from baseline were used, and selection bias for participation in the overall study may have obtained individuals who were already experiencing symptoms or diseases that were predictors of nursing home admission (Brown et al., 2013). Sheppard et al. (2013) provided insight into symptom burden in a different context despite terminal disease, as it occurs before a disease process. Sheppard et al. (2013) added to the literature by concluding that symptom burden affects patient outcomes, functional status, quality of life and nursing home admissions. Previous coping experience and family relationships were not included in the Sun et al. (2013) study. Sun et al. (2013) only showed how behaviors are directly related to the decisions of caregivers and how caregiver stress influences an individuals' decision to admit to long-term care. Iwelunmor, Newsome, and Airhihenbuwa (2014) confirmed the conclusions of Sun et al. (2013) by stating that family systems play a critical role in enabling or nurturing positive health behaviors and health outcomes. Sheppard et al. (2013) recommended that further

research is performed to discover whether symptom burden delays or limits transitions into nursing home facilities.

Cognition and Cognitive Decline

Turner, Capuano, Wilson, and Barnes (2015) explored a link between cognition and cognitive decline. Using the Depression Scale (CES-D) which is primarily used with non-Hispanic White participants, researchers Turner, Capuano, Wilson, and Barnes (2015) examined African Americans. The authors stated they chose to study African Americans because most studies of depression do not include African Americans and the cognitive decline in elderly African Americans remains unclear (Turner, Capuano, Wilson, & Barnes, 2015). Previous research has found that African Americans were at a greater risk for cognitive decline than other races (Pickett et al., 2014). Shankar, Hirschman, Hanlon, and Naylor (2014) agreed that African Americans are more at risk of dementia and suggest that the elevated risk could be the result of the disease being underdiagnosed. As noted previously, Sirey et al. (2014) found that stigma can negatively interfere with health care decisions and prevent individuals from getting medical care.

Zang, Hayward, and Yu (2016) stated that it is important to understand early how African American disadvantages in comparison to Whites, influence racial differences in cognitive impairment. Zang, Hayward, and Yu (2016) used the life course perspective to draw on prior research to investigate the hypothesis that African Americans' higher risk of cognitive impairment will be reduced if conditions are controlled for early in life. Zang, Hayward, and Yu (2016) like Shankar et al. (2014) found that African Americans suffer from an increased risk of higher impairment at baseline and during follow-up.

Another significant finding is that adults who had proxies were part of a very disadvantaged group of people with higher rates of cognitive impairments and mortality and were also more prone to drop out of the study (Zang, Hayward & Yu, 2016). The assessment used in Zang et al. (2016) does not take into consideration the quality of education the respondents have received and the cultural attitudes towards cognitive impairment (Zang et al., 2016). Zang et al. (2016) and Shanker et al. (2014) addressed the gap in the literature regarding racial disparities in cognitive impairment. Cognitive impairment may be an influencing factor for African Americans to admit to a nursing home.

Finances

Chisholm et al. (2013) asserted that financial resources that are available to nursing home patients, such as Medicaid, may contribute to ethnic and racial disparities and that the sense of quality care is associated with the availability of resources. Chisolm et al. (2013) found that facilities that were Medicaid dependent were more likely to exhibit financial challenges due to lack of funding. Consequently, nursing facilities with a high population of African American residents may lack the resources needed to invest in items aimed at improving quality care such as training and improvement initiatives. Wiltshire, Elder, Kiefe, and Allison (2016) implied that African Americans who are low-income with poor health status should be protected from cost-reduction financial strategies such as decreased hospital length of stay or decreasing health care benefits. Chisolm et al. (2013) measured financial performance to examine the link between the racial composition of nursing home residents and financial stability. The study also

explored whether financial stability increases the quality of care and nursing homes. The results of the study indicated that nursing home performances differed between nursing homes that housed predominately black residents in those with little or no African American residents (Chisholm et al., 2013). The nursing homes which had high percentages of black residents also ranked low for financial stability (Chisholm et al., 2013). The nursing facilities which had no black residents had higher revenues and could secure other means of finance and provide better care. The higher the Medicaid census, the lower the financial performance and the lower the quality of care (Chisholm et al., 2013). Peterson, Burns, Cocamide, Mason, Henderson, Wells, and Powell (2014) stated that nursing homes lack the resources needed to invest in and promote quality of care. Chisholm et al. (2013) suggested that while financial factors may contribute to the link between racial composition and nursing home quality, other factors may also influence disparities and quality of care. Wiltshire, Elder, Kiefe, and Allison (2016) identified factors such as health status, income, and insurance disparities. Chisholm et al. (2013) indicated that African-Americans are a greater risk of being in nursing homes with little financial viability and a decreased quality of care. Thus, African Americans may decide not to enter long-term care based on reduced quality of attention.

Starkey, Keane, Terry, Marx, and Ricci (2013) examined the relationship between financial distress and depression. According to Wiltshire et al. (2016), African Americans gain substantial medical debt compared to Whites. Sullivan and Meschede (2016) revealed that wealth is not evenly distributed throughout the United States and those most affected are African Americans, women, the disabled and the elderly. African

American households are more likely to live in poverty in old age and women are more apt than men to live in poverty (Sullivan & Meschede, 2016). Starkey et al., (2013), like Sullivan and Meschede (2016), wanted to identify priorities that may contribute to financial distress in women. Perceived financial distress associated with depression was found using correlation and regression analysis. The researchers found significant differences between women who were experiencing moderate to a very severe level of depression and women who were experiencing no depressive symptoms.

Starkey et al., (2013) suggested that financial distress is an important factor that should be taken into consideration when working with African American women. A little over half of the women responded that assistance when experiencing financial difficulties such as housing, food, medical insurance, money, child care, loan forgiveness education, and transportation would be beneficial. Seventy-one percent of responses were related to money management (Starkey et al., 2013). The authors used the knowledge of identifying needs and priorities to provide insight in improving the mental health of African American women. They used the rationale that if financial distress is an important risk factor for depression and then decreased financial distress will lessen depression and thus the mental health of African women that will improve. The authors urged that further research be completed to provide awareness that would increase the overall health of African American women. Based on the results of the study, finances are important to African American women.

Hurd, Martorell, Delavande, Mullen, and Langa (2013) reported that dementia is a very costly disease to society. Seventy-five to 84 percent of attributable costs include

institutional and home-based long-term care rather than health services (Hurd, Martorell, Delavande, Mullen & Langa, 2013). Further research needs to be done to identify if financial concerns regarding an admission to a nursing home prevent admission to the facility or contributes to depression after admission.

Religion

Chatters, Taylor, Woodward, and Nicklett (2015) explored the influence of the African American family and church support networks on depressive symptoms and psychological distress. The positive and negative aspects of church networks were investigated to identify unique associations by control for the impact of informal social support and family systems (Chatters et al., 2015). Church-based support networks have been a primary outlet for older African Americans for years (Holt, Wang, Clark, Williams, & Schulz, 2013). The church family in many cases has been the only family for individuals with limited contact or estrangement from family members. The authors found that older Americans attending religious services a least a few times year had emotional support from the church members protecting them against depressive symptoms and severe psychological distress (Chatters et al., 2015). Controlling for family support did not affect the support from church members on the depressive symptoms and severe psychological distress (Chatters et al., 2015). However, negativity was associated with family members, which increased depressive symptoms and severe psychological distress (Chatters et al., 2015). The findings of this study are consistent with Holt et al., (2013) which indicated that the church-based support system has protected influences on physical and mental health particularly with older African Americans (Chatters et al.,

2015). The authors also found that religious service participation was not associated with depression but was directly associated with acute psychological distress. Participants in the study who attended church daily had lower levels a psychological distress than those who attend a church at least once a week (Chatters et al., 2015). The researchers concluded that elderly African-Americans rely on emotional support from church members for their mental health. Further research is warranted to discover if admitting into a nursing home contributes to declining in a long-term care placement for fear of losing a church support network.

Holt, Roth, Clark, and Debnam (2014) found that African American women were more religious than African American men and had higher disease burden. Racial and ethnic identity was positively related to life satisfaction and religion (Ajibade, Hook, Utsey, Davis & Van Tongeren, 2015; Holt et al., 2014). Holt et al. (2014) also indicated that aspects of the African American religious experience are related to life satisfaction. Holt et al. (2014) determined that having a personal relationship with God and praying influence healthier behaviors, increase self-advocacy and self-esteem. Holt et al. (2014) indicated that religious beliefs have positive relationships with dietary practices due to higher levels of self-esteem and self-efficacy. Chatters et al. (2015) agreed that religious behaviors have a profound effect on health behaviors. Attending church can be used as a coping method. These findings are relevant to the current study because they suggest religion could be a factor in health decision-making and coping.

Perceived Racism

Hansen, Hodgson, and Gitlin (2016) examined the perceptions of older African Americans' experiences with health care providers and ways to increase trust. All 53 African Americans who were interviewed believed that adequate communication could only occur when health providers viewed them as individuals with unique experiences and cultural backgrounds (Hansen, Hodgson & Gitlin, 2016). Participants expressed that communication with providers would help providers understand medical practices and viewpoints of the participants (Hansen, Hodgson & Gitlin, 2016). Because of the interviews, a common theme of ageism emerged. Participants stated they felt "less than" others because of their age (Hansen et al., 2016). It was also noted that African Americans might experience additional discrimination beyond ageism. African American women in a study by Carter, Walker, Cutrona, Simmons, and Beach (2016) reported that symptoms of anxiety play a major role in the process that develops from an African American women's perception of discrimination to health status. Hansen, Hodgson, and Gitlin (2016) explained how mutual trust is essential for older African Americans to accept that a medical provider can accurately diagnose and provide adequate treatment for their illnesses. All the studies described trust as an important part of African American experiences in health care.

Hall et al. (2015) investigated to what extent implicit racial or ethnic bias present among healthcare professionals. They also wanted to explore the relationships between the healthcare provider's attitudes and outcomes. Hall et al. (2015) implied that implicit bias is greatly related to patient provider interactions, decisions, medical adherence and

overall health outcomes. Chapman, Kaatz, and Carnes (2013) suggested that patients who perceive themselves as infrequently exposed to systemic racism possess the greatest risk for nonadherence to hypertension treatment about increased perceptions of provider racial biases. Smart, Richmond, Blodorn, and Major (2016) agreed with Chapman, Kaatz, and Carnes (2013) and suggested that perceived racism increases the motivation to participate in unhealthy behaviors. Hall et al. (2015) concluded that most health care providers have positive attitudes towards whites and negative attitudes towards African Americans. Mouzan, Taylor, Woodard, and Chatters (2017) suggested that racial discrimination has a negative effect on the physical health of African Americans that medical professionals need to explore in-depth. Hall et al. (2015) attempted to explain why African Americans distrust the healthcare system and how implicit bias contributes to health care disparities for African-Americans.

Summary and Conclusion

This literature review examined the existing research surrounding how African American women's beliefs, practices, and attitudes toward long-term care influence healthcare decisions and admission to a long-term residential facility. The review found that few studies have researched African American women who live in a nursing home. The studies reviewed provided a history of long-term care disparities and factors that influence disparities. Culture was examined to determine what effect it had on nursing home admissions. Caregiver stress and symptom burden were explored as potential predictors of nursing home admissions. The need to understand cognitive decline and its role is important when identifying skilled nursing home admissions. African Americans

were compared to other races and were found to be more at risk for dementia (Zang et al., 2016). Demographic shifts in age and racial composition were found to present challenges for African American women because studies have shown that African American women are at greater risk for cognitive decline (Spetz, Trupin, Bates, & Coffman, 2015). Stigmas, finances and perceived racism were identified as barriers to healthcare and skilled nursing home admissions. The literature on African American family and church support networks provided insight on how they influence depressive symptoms or psychological distress. The body of literature confirms the existence of disparities among African Americans and women. However, there is a gap in understanding beliefs, practices, and attitudes toward skilled long-term care nursing facilities for African American women.

Chapter 3 includes my role as the researcher, participants, research method and design, the sample, data collection and the dependability and credibility of the research. I explain how I used a qualitative multiple case study design to apply to this research. Semi-structured interviews were performed and audio-recorded before transcribing. Included in Chapter 3 is a discussion regarding data organization and analysis.

Chapter 3: Research Methods

Introduction

The purpose of this research was to describe the attitudes and perceptions of African American women towards long-term care and to understand the influences and experiences of African American women who decide to admit to a residential nursing home despite cultural norms. After reviewing available literature, several studies were found on racial disparities of older adults who enter long-term care, but I found few studies that described the influences and experiences of African American women. The findings from this study offered insight into how African American women felt after admitting to a nursing home. Actual experiences from this case study were explored using a natural approach.

Chapter 1 presented the barriers and challenges African American women face in the United States and how those problems add to existing racial, health, and financial disparities in long-term care. Social Cognitive Theory was used to provide an understanding of how American history, beliefs, attitudes, and practices, especially toward health care, influence health care decisions. The theoretical framework contributed to describing how African American women felt after admitting to long-term care. Chapter 2 explored existing literature that summarized African American beliefs practices and cultures. Previous research on African American women's experiences with health care, racial disparities and long-term care was provided to add insight into the cultural factors affect African American women's decisions to admit to a nursing home.

Chapter 2 also identified cultural barriers that influenced the decision-making process African American women who admitted to a nursing home.

In chapter 3, I provided comprehensive information on the research design, role, and the rationale for this study, as well as how data was collected, stored and analyzed. The research question was reiterated to serve as the basis for research follow-up questions from participants' responses. The research approach and rationale for selection was discussed. Ethical considerations, confidentiality, reliability and validity of the study was examined. This chapter concluded with the social impact of the research.

Research Design and Rationale

Characteristics or qualities of a phenomenon was considered subjectively by using qualitative research. Qualitative models use data that cannot easily be placed in numerical form such as information that pertains to an individual's needs, behaviors, processes, and feelings. The qualitative methodology used in this study added knowledge to existing literature by exploring the experiences and feelings of African American women who admitted to long-term care. Several techniques were used to investigate and analyze data during the data collection process. These techniques narrowed the vast amounts of evidence (Marshall & Rossman, 2015). The use of qualitative techniques was important when prioritizing data to meet study objectives. Qualitative research uses a natural approach such as conversation and structured interviews. The data collected from experience can be stronger than quantitative research because it allows the researcher to observe and look at trends. The validity of qualitative research is its strength because findings are based on all parties involved in the study. However, the weakness of

qualitative research methods is that the researcher cannot validate trends by calculating values or population sizes (Miles, Huberman, & Saldana, 2014). Qualitative studies usually contain a small sample size whereas quantitative research can have hundreds of participants. Thus, qualitative research has less statistical influence than quantitative research when trying to determine new trends and problems. A researcher using qualitative research must be aware of personal views and biases so that they do not influence the research.

This qualitative study allowed the participants to tell their story in their words and permitted the researcher to collect data directly from the source. As previously noted, this study was qualitative and employed a case study methodology through semi-structured interviews to explore how African American women feel after admitting to a nursing home despite cultural norms. Case studies provide the researcher with the ability to use several sources of data to explore one or numerous people. The methodology identifies a place, time, or processes that guide the research. A multiple case study focuses on one concern but looked at several cases (Yin, 2014). I utilized several case studies to understand how African American women feel after admitting to a nursing home despite cultural norms.

Role of the Researcher

As a participant-observer researcher, I undertook many roles within this study. I played the role of a human instrument for data collection, analysis, and interpretation. Each position requires the ability to exhibit genuineness, competence, honesty. Effective communication was needed to build a rapport with participants so that they felt

comfortable with sharing their lived experiences. I exhibited a high level of objectivity in this study by recognizing my personal biases and took steps to lessen them by using a reflective journal. A reflective journal helped encourage development, increase judgment, and enhance critical thinking skills (Miller, 2017). I presented the interview questions, concentrated on listening to the responses of participants, and then asked in-depth follow-up questions to gather rich data. All participants were provided informed consent forms prior to participation to establish trust and the expectations of this study.

In qualitative research, researchers should be cognizant of their role to ensure quality and minimize the impact of biases. I mainly wanted to focus on biases which could influence the study during the data collection process such as body language, the tone of voice, and appearance. As an African American, I focused on eliminating personal opinions from this study and asked honest questions using a standard language. Since the setting of this research was my place of employment, I collected data as an insider participant observer. Cloete, Wilson, Petersen, and Kathard (2015) suggested that researchers should explore the experiences of participants through etic and emic perspectives. Cloete et al. (2015) described etic as observable factors in the physical environment that influence behavior and emic considers individual perception and how they express themselves.

Currently, I work as a social worker in a nursing home. The position is a case management position in which I facilitate transitions for individuals who return to the community after a rehabilitation admission. My role as social worker/researcher differed from the role of social worker alone and researcher alone. The advantage of having a

social worker/researcher position provided me with mutual respect and acceptance among the staff at the facility. Although I had insider privileges such as computer access and accessibility to files, permission was obtained from the nursing home administrator. The agreement from the administrator can be found in Appendix A. Although I am an employee of the facility, I facilitated the role of researcher alone when working with the long-term care residents. Participants of this study would not be assigned to the researcher as their social worker. There was no previous established relationships, power, or authority over any of the participants. I work in a separate division of the facility from the residents and social workers who were considered as participants in the study.

Methodology

Participation Selection Logic

As noted, this qualitative study included African-American women currently residing in a nursing home in Denver, Colorado. The participants included residents who were at least 60 to 85 years old, who admitted to the facility within the past two years and who had not previously resided in a nursing home. As such, African American women who could express themselves were best suited for this study and no other criteria disqualified them except individuals who have a diagnosis of a severe cognitive impairment. A participant with severe cognitive impairment would have difficulty remembering, concentrating and making decisions concerning their daily life. There are many different ranges of cognitive impairment from mild to severe. People who have mild impairment will have a cognitive decline but may still be able to perform routine activities of daily living. Severe impairment can result in the inability for individuals to

care for themselves, talk, or write. Each participant in this study needed to understand the interview questions and provide informed consent.

Corbin and Strauss (2015) suggested that there is no formal agreement on sample size for qualitative studies. This case study used purposeful random sampling to recruit 11 participants from a nursing home in Denver, Colorado. The sample of African American women was homogenous, and the sample size was small for this study because saturation was achieved. The nursing home had a total of 160 residents. The probability of meeting the sample goal was dependent on participants meeting criteria for the nursing home. Facility census records was used to identify all African American residents who admitted to the facility within the last two years. The facility computer system identified and separated demographic information using different variables such as age, race, gender, diagnoses, admission dates and religion. I did not have to access any charts because the business office manager ran a demographic report. The demographic report included race and gender but excluded severe cognitive diagnosis for those admitted to the facility for long-term care. Personal medical information was not initially known. Any personal information known by the researcher was disclosed by the participant as she wished. The data use agreement stated that the data provider would prepare and furnish data to me in accord with any applicable HIPAA or FERPA regulations. I received only a list of names. Each person was given an identifying number by a computer-generated randomizer based on the absence of a severe cognitive impairment diagnosis. Individuals were asked in-person to request participation in the study. Eligible persons who agreed to participate were scheduled for an interview. I had difficulty

achieving my proposed sample size from participants on the long-term care floor. Therefore, I selected participants who admitted to the skilled floor for rehab who currently live in a nursing home and who met the same criteria for the study. I had no authority over these residents on the skilled floor, so there was no dual role. There were three units in the facility. These residents admitted to the facility for rehab but will return to a nursing home after therapy is completed. Participants were excluded from the study if they previously resided in a nursing home prior to their current nursing home.

Consent Form

An outline of the study and a consent form was explained and signed by the participant (Appendix B). The consent form explained how confidentiality was maintained through the anonymity of names and password protected electronic data files. Questions were asked at the start of an interview to determine competency to sign the consent form. All participants were asked a series of preliminary questions to evaluate declarative memory. For example, I asked their name; where they live; marital status and if they have children. Answers to these questions are already documented on their resident profile page in the facility data system. If the participant had difficulty responding to the question, one more question was asked, and the interview was concluded. Since the participant allowed time for me to conduct my interview, I was respectful and allowed them to share their experience. The participant was thanked, and any information gathered from their interview was discarded. Since the sample consists of elderly participants, it was imperative to thoroughly explain and ensure comprehension

of the procedures of the study. The participants were informed that their participation is entirely voluntary and could be revoked at any time.

Instrumentation

Data was collected in this case study through semi-structured interviews. Self-reports through extended interviews allows for flexibility and adaptability (Wilcox, Bogenschutz, Nakazawa &Woody (2013). Uniformity is established by having predetermined questions. A questionnaire was created to serve as a template for the interviews (Appendix C). Interviews were conducted to identify factors that influence African American women's decisions to admit to a nursing home. No allotted period was given for the longevity of the interviews. I wanted to allow time for follow-up questions and clarifications. Interviews were scheduled at the resident's convenience and audio-recorded with permission. The participant's answers were completed by note-taking and audio-recording. Notetaking was performed so that the researcher can help the participant can feel at ease and less threatened by the interview. A transcription software was used to transcribe the audio recorded data. All interviews were performed in an area to ensure familiarity, comfort, and confidentiality for the participant. No psychometric tools were used in this study. Each participant will be delivered a written summary when results are available.

Procedures for Recruitment, Participation, and Data Collection

A proposal of this study was submitted and explained to the facility administrator. Authorization was obtained from the facility administrator to recruit participants and conduct private in-person interviews (Appendix A). Face-to-face individual meetings

occurred after potential participants are identified using the facility census to explain the study. I met with potential participants in-person to ask for participation in the study in an area that was private and comfortable for the participant in the facility. If they were in a public place, I asked if I could speak with them in private. I asked participants to participate in-person. I gave the participants the option to consider their participation over time if needed. If more time was needed, I scheduled a time to return or asked if it would be more convenient to return in a few days. If a decision was made on-the-spot, I scheduled the interview. I provided a letter of invitation at the time I initially approached potential participants. My contact information was provided on the invite as an option to contact me via phone or email to confirm participation, answer questions or for clarification. Once the participants were selected, consent forms were given and signed for participation in the study. Appointments were scheduled for individuals who needed further clarification or have questions regarding the study. Other facility employees were not notified of the recruitment process or an individual's acceptance to participate in the study. Interviews were the primary sources of data. The consent form, which allowed permission to be audiotaped, was also provided. Interviews were scheduled to explore how African American woman feel after admitting to a nursing home despite cultural norms. Open-ended questions were used to enable comfortable, open dialogue. The questions asked during the interview were clear and concise. Although one meeting was necessary, permission for a follow-up visit with participants was obtained if needed.

To establish comfort and rapport before the interview, an outline of the discussion was presented to the participants. I wanted to create a comfort level with the participants

that allowed them to express in depth their experiences with the phenomena being studied. The use of semi-structured interviews allowed the researcher to be prepared and expand on responses as needed. Semi-structured interviews of African American women exposed their perceptions of long-term care and their decisions to enter a nursing home despite cultural norms.

Data Analysis

Qualitative approaches are chosen regarding the research question and purpose. Moussakas (1994) stated that qualitative research follows a procedure which consists of creating codes, descriptions, and themes. Lawrence and Tar (2013) suggested the goal of researchers is to explore and comprehend meanings from participant stories. Understanding of processes and experiences are desired, and the characteristics of the phenomenon need to be reviewed (Lawrence & Tar, 2013). Studies can consist of extensive data gathering in which data tool software such as NVivo and Microsoft Office could be beneficial. NVivo assists researchers by not analyzing the data for the researcher but increases the effectiveness and efficiency of the process in which researchers learn from the data (Anney, 2014). The benefits of NVivo allow researchers to choose what tools they want to use and others they want to omit.

Data analysis is essential to make complete acceptable conclusions of open-ended data using in-depth interviews (Yin, 2014). I used Yin's five step approach to data analysis, NVivo and Microsoft Office to gather data from African American women who live in a nursing home. The NVivo software helped manage data and ideas through organization (Anney, 2014). I was able to keep track of all my interviews and information

about the data sources. NVivo organized data files that contained audio (Anney, 2014). Accessibility was comfortable, and data support for theoretical knowledge was available as needed. NVivo allowed me to be able to query, visualize and report on the data entered into the software (Anney, 2014). For example, I could ask a specific question of the data and have the software reclaim all information from the database that was relevant to my question. My searches were also saved. The saving feature allowed me to investigate further so I could continue the ongoing inquiry process. I had an opportunity to visualize the data I collected. I could demonstrate structure, ideas or sampling strategies at different points throughout my research and identify relationships (Anney, 2014). Miles et al., (2013) stated the researcher should continually read and reread data to uncover themes. By using data information from the database, I read and reread to reach an outcome that was desirable. I was responsible for analyzing the data. Microsoft Office was used to turn audio into text for easier transcription.

Yin's (2015) process included compiling data, disassembling data, reassembling data and the interpreting data. First, I gathered and grouped data. Then, I examined the data to reduce and eliminate themes. The data was reassembled and clustered in core themes. Patterns were checked against transcripts and notes to interpret the meaning of that data. To ensure accuracy and an unbiased view in this research, protocols such as triangulation were utilized (Stake, 2014; Yin, 2014). Hogue, Convalesce, and Generate (2013) explained that to confirm that the reliability of data and reduce uncertainties of interpretation two or more data collection methods must be used. Denzin and Lincoln (2011) identified methodological triangulation which uses two or more sources of data. In

this current study, methodological triangulation was applicable because I plan to use data from interviews.

Interview questions were constructed to support the research questions. To test the Social Cognitive theory, questions were asked in this study that relate to family traditions, beliefs, and practices. To tap into the participant's emotions, questions were asked that describe their attitudes towards long-term care and what influenced their decisions to admit to a long-term facility. Yin (2014) suggested data analysis should be conducted with organized data from recordings, notes, and transcripts. Once all the interviews were transcribed, responses were coded based on themes as recommended by Yin (2014). Data analysis consists of identification and selection of themes, coding and connecting themes to the phenomena of the study (Silverman, 2013).

Issues of Trustworthiness

Venkats, Brown, and Bale, (2013) defined validity as the extent to which data is trustworthy, credible and plausible. Lincoln and Guba (1985) developed four criteria for evaluating the soundness of qualitative research. The research must have credibility, transferability dependability and comfortability (Lincoln & Guba, 1985). In qualitative studies, trustworthiness is obtained by member checking, protocols, audits and data triangulation (Venkats et al, 2013). Reliability is defined as to the extent the results of a study can be duplicated and confirm or deny results from the data (Prosome, 2014). I used Grossoehme's (2014) approach of ensuring reliability by aligning the interview questions with the central research question, documenting, storing and securing confidential data.

Lincoln and Guba (1985) encouraged an activity called member checking to guarantee the credibility of research. Participant validation or member checks give participants the opportunity to correct misinterpretations and volunteer additional information by reviewing their transcribed interview (Reilly, 2013). Member checking clarifies data and deepens the researcher's analysis (Reilly, 2013). Interviewees are given the time to assess whether the researcher's report is an accurate representation of their lived experience. As Lincoln and Guba (1985) suggested, I asked participants to enhance the credibility of my conclusions by reviewing my comments and findings. The participants are the only ones who can rightfully critique the credibility of this research (Reilly, 2013). NVivo assisted by documenting the process of my data analysis in which enabled me to review data continuously and crosscheck developing codes to decrease errors.

Venkatesh et al. (2013) reported that data collection and interpretation of results must be consistent to ensure dependability in qualitative research. In this study, I emphasized the need to account for the consistently changing context of this research. I took responsibility in identifying any changes that occurred in the nursing home and how the changes affected the angle of the study. A guide was prepared, and notes were used for each interview. Each interview and notes were compared for consistency or differences. Venkatesh's (2013) suggestion of creating an audit trail was used in this study. I described the purpose of this study, the participant selection process, data collection, discussion of findings and discussed the credibility of the data for the study.

Per Tong and Dew (2016), strategies to improve conformability may include triangulation, peer review, clarifying researcher bias and member checking. Conformability guarantees that the results of the research mirror the views of the participants and are not influenced by the researcher (Tong & Drew, 2016). Triangulation was used to cross examine the validity of data (Anney, 2014). If disparities were found, I performed another check as recommended by Anney (2014). The use of NVivo and a reflective journal are steps that were taken to decrease personal bias. Lincoln and Guba (1985) stated that member checking is the most important tool to use to gain trustworthiness. Thus, I personally hand-delivered my interpretations of the participant's responses to each participant in the study. All participants were involved in member checking because it allowed participants to correct errors and question what was perceived as wrong interpretations. Transcripts were checked while listening to audiotapes. Participants had the opportunity to assess the adequacy of the data and volunteer additional information. Participants were given the opportunity to check my interpretations of the content of their statements. I wanted to determine if I could capture an accurate representation of their lived experiences. I addressed any concerns the participants had regarding the transcription.

The extent to which the result of qualitative research can be generalized to transfer from one group to another is call transferability (Vaismoradi, Turunen, & Bondas, 2013). Per Anney (2014), transferability requires researchers to provide a detailed explanation of all research processes throughout the study. In this research, I used purposeful sampling to acquire access to participants and I provided detailed

accounts of all the research procedures and methods by adhering to an interview protocol checklist, having consistency with interview questions, using a journal for reflective thoughts and uploading all pertinent data into the NVivo database as recommended by Anney (2014). Ultimately, transferability was left to the reader (Vaismoradi et al., 2013).

O'Reilly and Parker (2013) stated that to ensure adequate and quality data in a study, saturation must be reached. When a researcher analyzes data and can no longer include new information or identify a new data, themes, and codes, data saturation is said to have occurred (O'Reilly & Parker, 2013). As advised by Zheng Guo, Dong and Owens (2015), I compared themes within each interview. I repeatedly analyzed participant responses and admission documents until saturation was obtained (Senden, Vandecasteele, Vandenberghe, Versluys, Piers, Grypdonck, & Van Den Noortgate, 2015). Per Prendergast and Maggie (2013), this measure of data saturation is acceptable for researchers who use interviews as the fundamental approach to data collection. I interviewed African American women at the nursing home until data were sufficient for saturation.

Ethical Procedures

Before initiating contact with the facility administrator, the Institutional Review Board (IRB) of Walden University approved this study. The IRB required a detailed application specifying any risks, benefits, the informed consent, certain protections that the participant may decline from participation at any time. The nursing home administrator in Denver, Colorado was contacted to attain authorization to recruit and interview African American residents. Letters were hand-delivered to potential

participants. The researcher had no previously established professional relationship with the participants chosen for this study. Nursing home employees were not informed of who decided to participate in the study. Confidentiality of the participants was upheld per requirements by the American Psychological Association (APA, 2011). During the interview process, time was allowed for intermissions, privacy, and comfort. Because of interviewing the elderly population, no time limit was placed on the length of each interview. I wanted the participant to feel comfortable. The patient was informed that they could reach out to their unit social worker if they were unable to manage feelings that may potentially occur because of this study. As a social worker, I am a mandatory reporter. I planned to notify adult protective services for Denver county for any cases of elder abuse. I would also have informed the social worker at the facility and the administrator, so an internal investigation could be done. Participants are assigned a social worker upon admission to the facility and there were no charges as it is a service the facility provides. There are three social workers in the facility that are available seven days a week. Contact information for the IRB and my chair were given for added support.

Summary

The purpose of this case study was to describe the attitudes and perceptions of African American women towards long-term care and to understand the influences and experiences of African American women who decide to admit to a residential nursing home despite cultural norms. Twelve African-American women currently residing in a nursing home in Denver, Colorado; those who are at 60-85 years old, who admitted to the facility within two years, who had not previously resided in a nursing home without a

diagnosis of severe dementia participated in this study. Walden University's Institutional Review Board (IRB) approved participant recruitment. Once permitted, letters were hand-delivered to participants at the nursing facility. Once confirmation of participation was achieved, a date and a time was scheduled to complete an interview. Chapter 3 included my role as a researcher, the participants of the study, the population and the sample, data collection and analysis. Approaches such as audits, conformability, credibility, transferability, and dependability were employed to gain validity and reliability (Lincoln & Guba, 1985). I identified how a case study research design relates to the manner of this study. Semi-structured interviews and open-ended questions were utilized, recorded and transcribed. In the data analysis section, data collection, instruments, and techniques were described in detail.

Chapter 4: Results

Introduction

The purpose this qualitative study was to explore the attitudes and perceptions of African American women who reside in a long-term care skilled nursing facility and their decision to self-admit to the facility. Bandura's Social Learning theory was applied to help understand how African American women's experiences and perceptions of long-term care, influence health care decisions and admission to a long-term residential facility. Chapter 4 describes the qualitative analysis and addresses the results in relation to these research questions:

RQ1. How do African American women's experiences and perceptions toward long-term care influence self-admission to a nursing home?

RQ2. How do African American women describe living in a nursing home after admission?

Interviews were conducted with 11 African American women who are at least 60 years old, who admitted to the facility within the past two years and who had not previously resided in a nursing home. Chapter 4 includes discussion about participant demographic and characteristics data relevant to the study, the collection and analyzation process including theme identification and interpretation, evidence of trustworthiness, and the means used to safeguard the data.

Setting

The interviews took place privately in the participants' private rooms within the nursing home located in Denver, Colorado. Face to face interviews were conducted and

recorded using a hand-held recording device. Interviews took place during times that did not interfere with the daily activities of the participant. Therefore, each meeting was achieved without any interruptions. The interviews were held privately with no facility staff or family members in attendance.

Demographics of Participants

Eleven women participated in this study. All participants were African American and residents of Denver, Colorado for more than five years. Each participant admitted to the nursing home within two years of the interview. One participant was 60 years old; two were 68 years old; one was 69 years old; two were 74 years old; one was 75 years old; one was 78 years old, one was 82 years old; one was 84 years old, and one was 85 years old. Half of the participants were widowed; two never married; two were divorced, and one was currently engaged. Seven participants had three or more children, two had only one daughter and two participants had no children at all. Nine participants shared a room with an individual whom they identified as White. Two participants were roommates. Table 1 represents participants' age, the number of children, the amount of time since admission to the nursing home and marital status.

Table 1
African American Demographics

Participant	Age	Number of children	Months in nursing home	Marital status

1	74	7	24	widowed
2	74	7	12	never married
3	68	5	24	divorced
4	68	5	18	widowed
5	60	0	6	never married
6	75	1	12	divorced
7	85	0	24	widowed
8	69	1	14	engaged
9	84	2	13	widowed
10	82	2	5	widowed
11	78	3	9	divorced

Data Collection

Twenty-two African American residents out of 160 total residents were identified by the facility who met the following criteria: (a) African American women who were at least 60 years old; (b) who self-admitted to the facility within the past two years; (c) who had not previously resided in a nursing home; (d) who do not have a diagnosis of a severe cognitive impairment; (e) who were willing to participate in an interview lasting 35-40 minutes; (f) who do not have a power of attorney and (g) who signed the research consent form. Twenty-two residents were contacted, and eleven residents agreed to participate in the study. One person had difficulty signing the consent form due to physical limitations of the dominant right hand and asked a family member to witness the signature for legibility purposes. All participants spoke English, and the interviews were conducted in English. Each participant admitted within two years to the nursing home.

The admissions department of the home provided a copy of facility census records. The facility data system was used to generate a census report which identified all African American residents who were admitted to the facility within the past two years

and included demographic variables such as age, race, gender; individuals with severe cognitive diagnosis were excluded.

Personally, I met with everyone individually in a private area to explain the study and ask for their participation. I discussed the informed consent procedures and allowed the individual as much time as necessary to decide on participation. An outline of the study was provided to the individuals for clarification. Six individuals stated they didn't need time to think about participating and signed the consent forms immediately. I left my contact information with five participants and offered to return in one weeks' time to check in on the decision-making process. The five individuals agreed to the return visit. After one week, I returned, and three individuals stated that they would participate in the study. Two individuals who admitted to the facility earlier in the week who met the research criteria and were informed of the study and were asked to participate in the study. The newly admitted individuals did not need time to think about participating in the study and signed the consent forms immediately. Semi-structured interviews were conducted for all individuals who participated in the study. Interviews were scheduled at the participant's convenience and more time was allotted for participants who needed more time or wanted to add additional information. All interviews were less than the allotted time of 45 minutes, as outlined in Chapter 3. The average length of interviews was 35 minutes.

The face-to-face semi-structured interviews allowed participants to describe their experiences and perceptions in an environment that was comfortable for the participant. All the residents chose to interview in their own rooms, without their roommate present

and with the door closed. Each participant requested privacy. Two participants stated they feared retaliation if any of the staff heard their comments about the facility. Although I informed the participants that I would be audio recording the interview with a hand-held recording device, I reassured them that all identifying information would be removed. The audio recordings were transcribed, summarized and stored on a password-protected computer in a secured folder located in a secured location in my home office. All notes and hand-written documents were locked in a file cabinet in which I was the only key holder.

Data Analysis

Process for Developing Codes, Categories, and Themes

Coding and identification of concepts were based on the research questions, interview questions, and the literature review. Microsoft Office was used to turn audio into text for easier transcription, and NVivo software was used to manage data and ideas. Audio recordings and transcripts were listened to several times to accurately identify data that related to the research questions. All files were kept in a password protected computer and locked in a file cabinet. NVivo organized data that I entered into the software. I followed Yin's process of compiling data, disassembling data, reassembling data and the interpreting data. Hand-analyzed data were read, reread and coded to identify themes (categories).

Patterns were checked against transcripts and notes to interpret the meaning of that data. I was the only one analyzing the data. An analysis was performed using organized data from recordings, notes, and transcripts which were coded based on themes

recommended by NVivo. The developed codes represented concepts. Diagrams and tables were used to help visualize each developing theme (Appendix E). I also searched for themes in the data for each interview question to help answer the research questions (Appendix F). The themes included care, family structure, family culture, feelings about nursing homes, family support, emotions and decisions to move to a nursing home, family tradition, work, previous thoughts about nursing homes, family structure, current feelings about nursing homes, prior living status, prior family support, current family support, emotions, decisions to move to a nursing home and thoughts of who should take care of the elderly (Appendix G). I reviewed connections between all derived codes and narrowed it to nine major themes by examining relationships and similarities and grouping them together to answer the research questions.

Themes

The African American women offered a view into their experiences and perceptions of nursing homes. As presented Appendix E, the subsequent themes emerged: (a) care, (b) family structure, (c) family culture, (d) feelings about nursing homes, (e) family support, (f) emotions and (g) decisions to move to a nursing home.

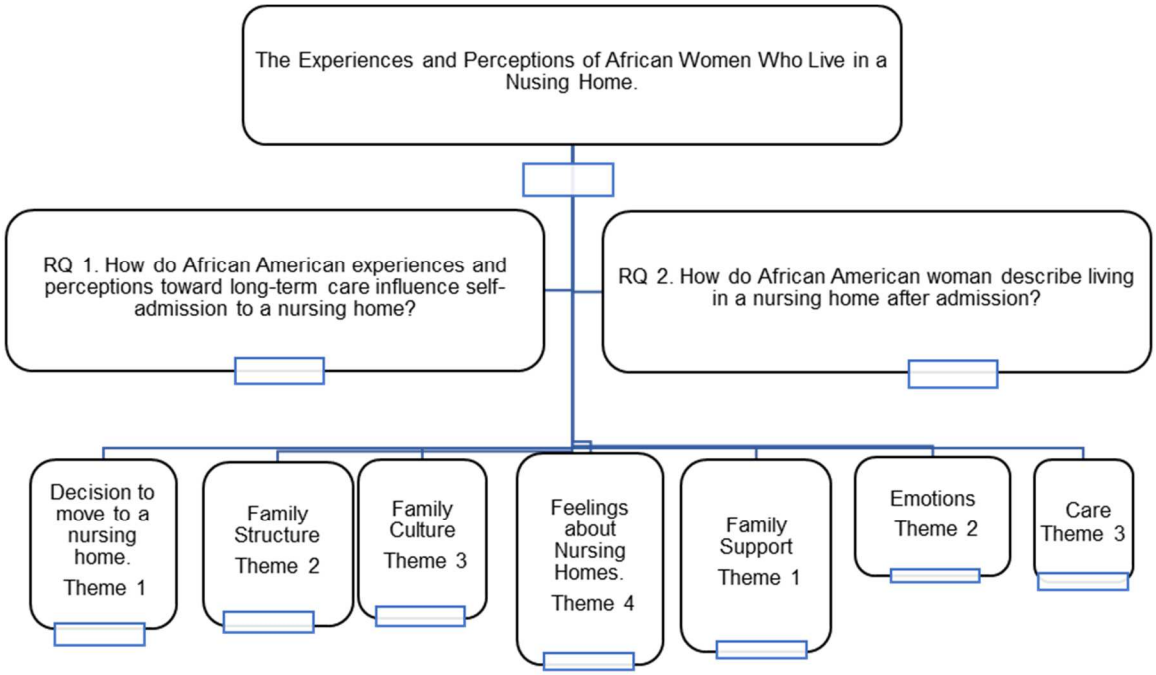

Figure 2. Theme construction.

The decision to move to a nursing home. This theme evolved from four categories, illness, the inability to take care of self, the ability to make own decisions, and finances (Appendix H). Codes were developed from participant data directly entered into NVIVO. Common words were categorized (Appendix G). Participants 1-11 (P1-11) stated they ultimately decided to move into a nursing home because they were financially and physically unable to take care of themselves in their own home.

P1: I made the decision to move here because I didn't have anyone to physically take care of me. I couldn't afford to stay home.

P2: I needed help. I had to come to a nursing home.

P3: I was unable to take care of myself, so I had to come to a nursing home because my kids could not take care of me.

P4: I felt I needed help and I couldn't do things for myself.

P5: I needed help, and I didn't have much money.

P6: My daughter could not take care of me anymore because she had to work.

P7: I can make my own decisions, and this is where I chose to be. Everyone is living their own lives, and I needed more help. I didn't want to be a burden.

P8: I needed more help than my daughter could give so I decided to come here.

P9: I was too sick to stay at home. I made the decision to come to a nursing home because I couldn't be home alone, and I didn't have much money.

P10: I was ill, and I needed a nurse 24 hours a day. I couldn't pay for a daily private nurse, so I decided to come here.

P11: I made the decided to a nursing home because I was falling a lot at home and I was alone a lot. I needed more help.

Participants #1, #2, #4, #6 and # 9-11 stated they made a choice to move into a nursing home because the family was unable to take care of them due to their work schedules.

P1: My daughter had to work, and I couldn't be alone.

P2: My kids couldn't give me the help I needed because they had to work.

P4: My kids had to work and couldn't be home with me.

P6: My daughter said she had to work and I was too weak to leave alone.

P9: My family had to work, and my daughter had small children.

P10: My son and daughters' work schedule would result in me being home alone.

P11: They worked too much, and no one would be at home to care for me.

All the participants stated that ultimately it was their decision to move into a nursing home. However, participants #1, #2, #8-11 reported they received input from their families but still made the decision to admit to a nursing home themselves.

P1: My daughter thought it would be a good idea because she could not help me.

P2: My family wanted me to take turns living at their house, but I wanted to be stable, so I made the decision to move to a nursing home, and they stood by my decision.

P8: My daughter got engaged, and I decided not to be a burden on her since she was getting married. She agreed with what I wanted.

P9: My children support the fact that I decided to move to a nursing home.

P10: I asked my son what he thought about me going to a nursing home, and he said he knew he couldn't take care of me and wanted me to be safe. So, I decided to go to a nursing home.

P11: My family stood behind my decision. No one made me do anything.

All participants stated they were not financially able to hire help at home and remain in their previous setting prior to admitting to the nursing home because they only had Social Security income. Participants #5, #7 and #8 stated their financial difficulties prevented the in-home care choice as an option.

P5: Prior to living in the nursing home, my mom and I had trouble getting food. We barely had enough to live.

P7: I had no money saved for my future. I was a housewife with no children.

P8: I was already using low-income resources. I couldn't afford to live alone, and my family couldn't afford to pay for a nurse to come to take care of me.

Family Structure. This theme consisted of three categories which included children, marital status and living situation as presented in Appendix I. Participant #5 and participant #7 had no children. Participant #7 lived independently prior to admitting to the nursing home. Participant #5 lived at home with her mother. All other participants lived at home and were cared for by at least one of their children.

P5: I was never married, and I never had any children, so my mother and I took care of each other.

P7: I am widowed, and I never had any children. I have a niece that will be in my corner if I need her to be. I never wanted kids because my husband used to drink a lot. After he died, I lived on my own and took care of myself.

Participant	Living Arrangement
1	Lived with Family
2	Lived with Family
3	Lived Alone
4	Lived with Family
5	Lived with Family
6	Lived with Family
7	Lived Alone
8	Lived with Family
9	Lived with Family
10	Lived with Family
11	Lived with Family

Table 3. Living arrangement prior to admission.

Family Culture. This theme consisted of family beliefs and traditions. Common words were highlighted in NVIVO and categories were created (Appendix J). All participants believed that families should take care of each other. However, participant #7 stated although no one in her family ever had to admit to a nursing home, she was okay with admitting to one because she had no children.

P1: In my family, we didn't think about putting family members in a nursing home. We took care of our own.

P2: The younger family members took care of the elderly. It was something that we knew from an early age; we just didn't think about it.

P3: In my family, we did not go to nursing homes. For example, my stepson took care of his mother, and my mother helped. When my mother was unable to take care of herself, he took care of her. My mother took care of her mother.

P4: Both of my parents stayed home; we took care of them. It's not a belief in my family that membership goal to a nursing home.

P5: In my family we take care of our own. When my mother needed more help, my aunt used to come over to help me take care of her. My mother did not want to go to a nursing home. That's not what we do in our family.

P6: Families are supposed to take care of their own. It has been that way in my family for generations.

P7: I feel the families should take care of their own. Both of my parents were taken care of in their own home. I also had six siblings who could help take care of my parents. This type of helping has always been in my family. I never had

any children, so my nieces and nephews have always been by my side. They did not want me to admit to a nursing home. I did not want to be a burden on anyone, so I chose to agree to move to a nursing home.

P8: We always took care of each other. I took care of my mother, and she took care of her mother.

P9: It was taboo to even think about sending a family member to a nursing home. It was unheard of amongst my family.

P10: I would have never dared to put my mom in a nursing home. I was taught from an early age what my responsibilities were to the elders in my family. We were responsible for each other.

P11: My mother took care of her mother, and my grandmother took care of her mother. We just did not think about nursing homes. It was not an option.

Eight participants felt that it was the responsibility of a person's family to take care of the elderly.

Feelings about nursing homes. This category was created by grouping key terms that described each participant's feelings about nursing homes before admitting to a nursing home (Appendix K). The codes were taken directly out of the participants' statements. Participant #4 thought nursing homes were bad because she and her mother worked as nurses and experienced firsthand the care individuals received in nursing homes. Several participants reported they had no thoughts about nursing homes because they did not think they would ever have to admit to a nursing home. Some thought

nursing homes were places where individuals were placed when they had no family. Some believed the care at nursing homes was substandard.

P1: I didn't think about it. If I did and I was going to end up here at all.

P2: I thought nursing homes would be OK, but not anything more than that.

P3: I didn't want to come to a nursing home, but I felt that I didn't have a choice. I don't think they're going to be bad; I didn't think it was for me.

P4: I did not think that nursing homes were great. I don't believe that people are treated with dignity and respect. I think the elderly are treated like children. I don't want anyone to tell me what time to eat and what time to go to bed.

P5: I thought nursing homes were great places. People can get the care that they deserve and need. I do not have to worry about my basic needs because I have help.

P7: I think nursing homes are great. I never thought I would live in one, but my feelings had not changed from before I moved to the nursing home.

P8. I think nursing homes were OK and I still think the same now.

P9: Prior to moving here, I thought nursing homes were terrible. I did not want to live here, and I still would rather be in my own home. I thought nursing homes were places where people want to die.

P10: I didn't like nursing homes before moving here, and I still do not like that I don't have privacy.

> P11: I did not like nursing homes before because I felt like people didn't have any control. I feel that I don't get good quality care based on my insurance. If I had more money, then I think I would have better care.

Family support. This theme was developed by grouping common words together using NVivo and highlighting words directly from participants' statements that described types of family support received before and after admitting to the nursing home (Appendix L). All participants except for participants #3 and #5 stated they had good family support before and after admitting to the nursing home.

> P3: After I moved to the nursing home, I receive few visits from my family. It appears no one has time for me.
>
> P5: I hardly ever hear from my family, and I get depressed. This is not how my life should be. They are supposed to look after me.
>
> P2: I have excellent family support. My family did not want me to live in a nursing home. I didn't want to stay with them, so I chose to admit to a nursing home.
>
> P1: My family was very supportive in my decision to move to a nursing home. They knew that they were unable to provide the care that was needed at the time.
>
> P6: My daughter has done a great job supporting me throughout my transition process. Moving into a nursing home has been very difficult for us both.

Although participants decided to move to a nursing home, many participants felt that they did not have an alternative other than to move to a nursing home. Many participants felt

that their families were pushing them to move to a nursing home because they stated that they were not able to take care of them.

> P4: I had no choice but to admit to a nursing home. Everyone in the family had to work, and there would not be anyone at home and take care of me. They visit and help me cope with living here.
>
> P9. My daughter is always here, and she helps me manage my care. She encouraged me to admit to the nursing home. I didn't want to live here, but I didn't have an alternative because I was unable to live with my daughter.
>
> P10: I felt like I had no choice but to admit to a nursing home whether I like it or not because I was sick and needed daily care. My family has supported my decision because they can't provide the care I need in their home.

Emotions. This theme developed from categories which included symptoms of depression, grief, isolation and dignity (Appendix M). Codes were created directly from participant statements by highlighting words grouped by NVIVO. Several participants explained how they were either happy or regretted their decision to admit to the nursing home. Several participants stated they had increased stress and had a decreased sense of individuality. According to participant #6; she was tricked into self- admitting to the nursing home. She stated she thought she was admitting temporarily to receive rehabilitation services. After participant #6 admitted to the nursing home, she said her daughter told her that she was unable to care for her at home because of her health decline. Participant #6 and #4 expressed hurt, anger, depression, and frustration.

Participant #4 stated she felt isolated and alone after having to admit because of her disabilities.

P4: I was independent before moving here. This has been a huge adjustment for me. I used to feed myself, but I must have someone help me with feeding because of my condition. It bothers me. I pray a lot. My children don't even come to see me. I took care of my mother before she died. Living here has been very hard for me.

P1: I am sad because my family should have taken care of me. I don't think I made a good decision by admitting to a nursing home. I am frustrated because this is not where I wanted to be. I sometimes cry.

P5: I am happy I am here. I am getting the help that I need.

P7: I don't have much family, but I do have nieces and nephews that visit me often. I feel alright about living here. I am not a burden and I am not interfering with anyone's life.

P8: Although I thought I would never be here, I am grateful. I met my fiancé here at the facility, and we live in the same room. I do regret not having privacy. We both get the care we need, but I feel there is a lack of dignity and privacy.

P9: I get depressed because I feel uncomfortable. I can't get the foods I like to eat, and I don't think people of other cultures know what I am going through as I live here. When I was younger, we couldn't drink out of the same water fountain. Now, I can live with people who are not minorities and forget the past? How can I feel comfortable? I have difficulty sleeping here.

P11: Sometimes I feel like staying in my room and not coming out. I don't think I get the respect that I need, and I deserve.

Care. This theme developed from categories which included mental, physical and social needs (Appendix N). Codes were created directly from participant statements by highlighting words grouped by NVivo. All participants said they chose to admit to the nursing home because they needed more medical care than what they could afford or be provided by family at home. All participants stated that their medical needs met. However, several participants revealed they didn't feel the nursing home cared about their cultural differences. All participants indicated they experienced a loss of autonomy over activities of daily living (dressing, feeding, and bathing), as well as anxiety about the care they would receive in the nursing home.

P1: I get proper medical care here. I only moved here because I was sick.

P2: Sometimes I feel like I have no control.

P4: I am taken care of, and I don't have to worry about much. The worst thing is that I cannot take care of myself.

P11: I have not participated in any groups that were designed to help me as a Black woman adjust to living here. It was tough for me as an independent, strong Black woman to ask for help with getting dressed. I was raised to be strong, and I felt like I was losing myself. I still do at times.

P10: I must share a room with a woman who is not of my race. We have different cultures and backgrounds. It has been challenging for us to room together because I was raised Catholic and my roommate is an Orthodox Jew. Also, few

staff members who look like me, who can understand where I come from and know what is like to be African American. If I express myself, then I think staff believes I am angry or I am complaining.

P6: I had so much anxiety moving here. I continue to have concerns. I constantly remind people that I am not a child and I deserve to be treated like an adult when providing care to me.

Analysis of Results by Research Question

The results of the data analyses disclosed seven themes: (a) care, (b) family structure, (c) family culture, (d) feelings about nursing homes, (e) family support, (f) emotions and (g) decisions to move to a nursing home. These themes are thought to reflect the experiences and perceptions of African American women who live in a nursing home. The research questions were used to direct this study.

Research Question #1

Research Question #1: How do African American women's experiences and perceptions toward long-term care influence self-admission to a nursing home?

Interview questions relating to research question #1.

Describe your living situation prior to admitting to a nursing home. All participants described their living situation as good prior to moving to the nursing home. Nine of the 11 participants lived at home with their families. They stated family members pitched in and helped take care of the participant's needs. Five participants were widowed, two were never married, and three participants were divorced. Two participants had no children and the other participants had a range from one child to seven children.

P1 stated, “I had seven children. I had plenty of people to take care of me.” All participants who lived at home with their family agreed that as their health declined, their families were unable to meet their needs due to the demands of their occupations. P2 stated, “Everybody had to work.” P9 revealed “I liked my home environment. I just got too sick to stay home, and they were worried about me.” P5 and P7 did not live with family and had no children; each stated they loved being able to take care of themselves. P7 stated, “I like to do what I want when I want.” P5 revealed she did not need any assistance from family until she became disabled and could not manage her health on her own.

What are your family cultures or traditions regarding elderly care? Who typically cared for the elderly in your own family? Who do you think should care for the elderly? All participants believed that their families were responsible for taking care the elderly. There was a shared belief that the elderly should be respected and taken care of only by family or extended family. P4 stated, “My mother took care of her mother, and I expected my children to take care of me.” P11 revealed, “In my family, it was the oldest child who was responsible for taking care of the parents. If the oldest child was not capable, then it was the next child in line and so forth. If there were no children, nieces and nephews came into play.” All participants shared that family members or extended family typically care for elderly family members. P4 revealed, “this was the way we provided for our elderly for generations.” P10 stated, “This is just what we (African Americans) do, we don’t care who it is, but someone is supposed to take

responsibility for us. We don't even worry about going to a nursing home for that reason."

Tell me what you believed about nursing homes before admitting to this facility. Describe what your feelings are now. There were mixed emotions among the participants. Many participants believed nursing homes were places with below standard care. P3 stated, "It was usually a place where I thought old people went to die." P4 stated, "I heard stories of how people were mistreated. I did not want to come here." Most participants stated they had never thought about going to a nursing home and nine stated that if she could go back in time, they would have never admitted to the nursing home. Two participants who have no children, P5 and P7 revealed that they would admit to the facility again if they had a choice to readmit to the facility. P5 stated "I would have no place to go and I wouldn't be able to take care of myself. There would be no one to help me. Although this isn't the best place for me, it is the best place for me right now." P7 stated, "I have no problem living in a nursing home. I had no children so who will take care of me? I have a niece that I am close with, but I do not want place any more burden on her because she already helps me out a lot."

Why did you decide to admit to a nursing home? Every participant stated she admitted to the nursing home for two reasons. (a) They were unable to live at home because they needed a higher level of nursing care and (b) Their family members had to work and were unable to provide supervision at home. P1 revealed "My husband died, and I couldn't take care of myself. My daughter told me my care needs where too much for her to handle." P2 explained she "had no choice because everyone was working." P3

stated, “I was really sick, and my sons could not take care of me.” P4 stated, “My children felt I needed more help. I didn’t want to live in a nursing home. They convinced me to stay here for a little while to get stronger. My goal was to participate in therapy and go home. A few weeks after my arrival, they told me they couldn’t safely take care of me, and I remained at the nursing home.” P7 stated, “I needed more help at home because I was falling.”

All participants stated that their family culture consisted of the family taking care of elderly family members. Admitting to a nursing home was “unheard of” in their families. There were many reasons why participants decided to admit to a nursing home. However, not having someone at home to care for them while family members were at work was a deciding factor for many participants.

Research Question #2:

Research Question #2: How do African American women describe living in a nursing home after admission?

Interview questions relating to research question #2.

How do you feel about your decision to move into a facility? How did your family and friends feel about that decision? Six participants revealed they perceived that they made a mistake admitting to a nursing home. Five participants revealed they were content with their decision to admit to a nursing home. All participants stated that friends and family were supportive of their decision to admit to a nursing home. P11 stated, “I felt pressured to decide because I was sick.” P10 stated, “I never wanted to come to a nursing home. I can’t get the ethnic foods I normally eat, I have little social

support because I don't get visitors. I have been depressed on and off. I guess you can say I am not comfortable." P8 revealed "I am happy with my decision to live here. I met the man I am going to marry in the nursing home. I am happy. I do realize that not everyone here has the companionship that I do. My family is happy for me."

What's the best thing about living here? What is the worst thing about living here? Most participants agreed the best thing about living in a nursing home is getting their nursing and medical needs met. P3 stated, "You are taken care of, and you don't have to worry about much." P4 revealed, "The best thing is that I am on my own." P4 stated she still felt independent and was able to make her own decisions without family interference. P8 revealed, "You get the care that you need." Several participants mentioned the lack of privacy, sharing rooms, and decreased family support as negative aspects of living in a nursing home. P3 revealed, "The worst part about living in a nursing home is not being able to take care of myself and relying on others to help with basic needs."

How do your family and friends feel about you living here now? Participants revealed that their families were supportive of their decision to admit to a nursing home. Many participants stated that their families encouraged them to admit to a nursing home because they were not able to provide the necessary nursing care. P2 indicated her family wanted her to go live with them, but she declined the offer. P2 explained that she would have to stay part of the year at her son's and the latter part of the year at her daughter's house. She wanted more stability, so she decided to go to a nursing home. P8 and P10 stated their families thought moving into a nursing home was a good idea.

Describe your support from friends and family while you are living in the facility. Most participants revealed that family and friends were very supportive. However, P3 and P5 revealed that they do not have much outside support. P3 has not seen her twin sons in six months. P3 stated, "I don't have much connection with anyone outside of this facility. I have not seen my sons in a very long time. It bothers me that I don't have the support I need. I feel isolated from the world." P5 stated, "I don't have much family support. My mother is in a nursing home too and my aunt does not visit me." P2 revealed, "My family is very involved." P11 stated, "I see my family very often." P7 stated, "I see my niece very often. She has her own life, but I see her a lot." Everyone stated they wished they could see their friends and families more but understood it was not feasible due to their busy schedules.

What was your family support like when you lived outside the facility? Only one participant described their support outside the facility as minimal. P5 revealed she didn't have ongoing family support when she lived with her mother. P5 explained she helped take care of her mother while needing services herself. She stated her aunt came over sporadically to aid, but it was primarily P5 and her mother. P5 stated, "It was just my mother and me. We took care of each other. However, we needed more help. We had trouble getting meals." P6 and P2 revealed living at home were great and everyone worked together to meet their needs. P2 stated, "I had seven children, someone had to take care of me. It was too many of them to do nothing." P1 also revealed she had seven children and received shared care services from her family after her husband died. P1

stated, “I lived at home with my children, and they took care of me. After having seven children, I did not think I would be in a nursing home today.”

Although many participants didn’t plan on admitting to a nursing home, some felt it was necessary to get their care needs met. Feelings of isolation decreased family support and participants expressed a pressure to admit to a nursing home.

Evidence with Trustworthiness

The goal of this qualitative study was to explore the attitudes and perceptions of African American women who reside in a nursing home and their decision to self-admit to the facility. The research was entirely reliant on data collection, the analysis of data and the validation of the findings. I followed specific data collection and data analysis procedures throughout the study. Member checking, audits and, triangulation were used to gain trustworthiness.

Process for Credibility

A method of member checking was used to guarantee the credibility of the research. Participant validation or member checks gave the participants opportunity to correct misinterpretations and volunteer additional information by reviewing their transcribed interview. Member checking allowed the clarification of data and deepened my analysis. Participants were given as much time as needed to evaluate my hand delivered printed transcripts and assess if my report was a true representation of their lived experience. I reviewed the data continuously and crosschecked developing codes to decrease potential error. My daily activities were recorded, and notes were taken through the interview process. Since the goal of the study is to view the phenomena from the

participants' perspective, only the participants can genuinely determine the credibility of the results.

Process for Confirmability

I ensured the results of this study were not influenced by me and mirrored the views of the participants. Data source and method triangulation was used to cross-examine the validity of data and rechecked as needed. The facility provided demographic data and interviews were used to gather information regarding the phenomena. Semi-structured interviews, notetaking and audio recordings were completed at various times and in different places throughout the facility. A reflective journal and NVivo was used to decrease personal bias. My interpretations of the participants' responses were hand delivered to participants for member checking. There were no pre-determined outcomes to this study. The responses to each interview in this study represented the perceptions and experiences of the participants. Direct quotes were used to reflect participants' answers using their own words. My personal experiences were not included during any stage of this study.

Process for Dependability

In this study, I emphasized the need to account for the consistently changing context of this research. Data collection and interpretation of results were consistent to ensure dependability. There were no identified changes that affected the angle of this study. Interview questions and notes were used for each audio-recorded interview. An audit trail was created and used to help describe the purpose of this study, the participant selection process, data collection, discussion of findings and will discuss the credibility of

the data for the study. The subject matter and methodology expert reviewed and approved the methodology of this study. Categories and codes were reviewed numerous times to confirm the development of themes.

Process for Transferability

I used purposeful sampling to acquire access to participants, and I provided detailed accounts of all the research procedures and methods by adhering to an interview protocol checklist, having consistency with interview questions, using a journal for reflective thoughts and uploading all pertinent data into the NVivo database. The findings of this study can be used to understand the experiences and perceptions of African American woman. However, transferability was left to the reader. Words, phrases and repetitive statements used by participants were consistent in all themes identified.

Summary

Chapter 4 described data collection derived from face-to-face interviews. Vast data was obtained from African American women who live in a nursing home. Each participant shared their lived experiences and perceptions about nursing homes. Chapter 4 reviewed participant demographics, the data collection process, and procedures, data analysis, and resulting theme identification from participant interviews. The seven themes developed included (a) care, (b) family structure, (c) family culture, (d) feelings about nursing homes, (e) family support, (f) emotions, (g) decisions to move to a nursing home and (h) thoughts of who should take care of the elderly. Themes such as the decision to move to a nursing home, family structure, family culture and feelings about nursing homes addressed the research question of how do African American women's

experiences and perceptions toward long-term care influence self-admission to a nursing home? The themes family support, emotions and care address the research question of: How do African American women describe living in a nursing home after admission?

Participants described the reasons why they decided to move into a nursing home. Each participant explained they were financially and physically unable to take care of themselves. Most participants had children except two participants. Eight participants lived at home before admitting the facility with help from family and friends. Two participants lived independently with family assistance. Traditionally, all participants felt that their families were responsible for taking care of the elderly. Many participants had stigmas before to self-admitting to the nursing home. Some participants felt pressured by family due to their financial hardships, family work obligations, and declining personal health status to admit to a nursing home.

Many participants revealed they experienced decreased family support after admitting to the nursing home while other participants still maintain good relationships with their families. Some participants expressed making positive new support systems while other participants stated they had increased stress and had a decreased sense of individuality. Isolation, hurt, anger, depression, and frustration were other negative feelings expressed after admitting to the nursing home.

Their social and cultural backgrounds influence nursing home residents. The expectations African American women have on their care, thresholds for seeking care, and unfamiliar beliefs can affect their ability to adhere to treatments and receive adequate housing and nursing care. Belief systems and traditions impacts the African American

community (Herrera et al., 2013). Participants described the nursing home admission experience as a humiliating and unsettling experience due to early racism, segregation, family discord, and powerlessness. Chapter 5 will discuss an interpretation of the study results, findings, limitations, recommendations, implications, and conclusions.

Chapter 5: Discussion, Conclusion, Recommendations

Introduction

Due to increased demographic shifts in nursing homes, African Americans are admitting to nursing homes despite cultural norms. By exploring the cultural attitudes, values and financial status of African American women entering long-term care facilities, it may be possible to assist African American women who transition into a nursing home, adjust to their new life change. The goal of this study was to explore the attitudes and perceptions of African American women who reside in a nursing home and their decision to self-admit to the facility. It is essential to understand how African American women feel after admitting to a nursing home and the perceived effect on their general well-being and quality of life. This study could help promote cultural competence and assist with staff training that could impact nursing home transitions for African American women.

The study's two research questions addressed how African American experiences and perceptions toward long-term care influenced self-admissions to nursing homes and how African American women describe living in a nursing home after admission. To respond to the research questions, a case study methodology with semi-structured in-person interviews with eleven African American women who reside in a nursing home in Denver, Colorado. The interviews were audio-recorded, transcribed and member checked for accuracy. Data analysis concluded with the identification of categories and seven themes: (a) care, (b) family structure, (c) family culture, (d) feelings about nursing homes, (e) family support, (f) emotions, (g) decisions to move to a nursing home and (h) thoughts of who should take care of the elderly.

Chapter 5 contains the interpretation the findings based on the themes identified and presented in Chapter 4. Limitations of trustworthiness, recommendations for further research and implications for social change were discussed in this chapter. Furthermore, I will close with a conclusion and summary of Chapter 5 and the entire study.

Interpretation of the Findings

This study described the experiences and perceptions of African American women who live in a nursing home in Denver, Colorado. Eleven African American women who admitted to a nursing home within two years discussed their experiences. Each participant identified as African American and residents of Denver, Colorado for five years or more. Participants' ages ranged from 60 to 85 years old. Half of the participants were widowed; two never married; two were divorced, and one was currently engaged. Seven participants had three or more children, two had only one daughter, and two participants had no children at all. Nine participants shared a room with an individual whom they identified as White. Two participants were roommates. A brief overview was obtained from each participant by asking demographic questions (see Table 1).

Changing demographics and financial stability have been identified as barriers to nursing homes. Factors that pose issues for admittance to long-term care facilities which are less considered are cultural. African American historical events, beliefs, practices and attitudes toward health care is imperative to understanding why so few African Americans remain in their homes longer than their white counterparts and why the number of African Americans residing in long-term care has been increasing in recent years (Thomeer, Mudrazija, & Angel, 2015). The results of this study support the

findings of Thomeer, Mudrazija, and Angel (2015) and underline the importance to improve the understanding of how African American women feel about nursing homes. This research identifies cultural barriers to help improve access to long-term care and provides further discussion.

Research Question 1: Perceptions Toward Nursing Homes

Experiences Prior to Admitting to a Nursing Home

In-depth interview analysis revealed African American women in this study believed that families should be responsible for taking care of the elderly. Although the participants explained their perceptions of nursing homes and their experiences before admitting to the nursing differently, they expressed similar barriers. Agreeing to a nursing home was a difficult choice for several reasons. Family tradition played a significant role as to why African American women remained in the home. For generations, each of the women explained how it was the responsibility of the family to meet the care needs of their aging population. The thought of admitting to a nursing home was obsolete. Most participants lived at home with at least one family member or lived alone with family assistance before admitting to the nursing home. All participants agreed they didn't want to be a burden on their families, but firmly believed it was their birthright. As participants fulfilled their expectation of taking care of their parents, they expected their children or extended family members.

Perceptions of Nursing Homes and Admission

Many participants believed nursing homes were places where individuals went to die. They perceived nursing homes as facilities where individuals received inadequate

care and experienced decreased autonomy. Participants thought residents were mistreated in nursing homes, were abandoned by their families, and the thought of admitting to a nursing home was non-existent. Admitting to a nursing home was not an option until family members with whom they lived with were unable to provide 24-hour care at home. All participants stated they had to admit to a nursing home because their caregivers had to work and could not afford to stay at home and provide care. The inability to take care of one's self and increasing health care needs forced participants to decide to admit to a nursing home despite their better judgment. One participant decided to admit to the nursing home because she wanted to participate therapy in therapy. However, once therapy was completed, her family told her it was best that she remained in the nursing home because they could no longer meet her needs at home. This participant felt as though she was tricked and abandoned.

Research Question 2: Feelings after Admitting to a Nursing Home

Adjustment and Support

Of all the participants, six participants believed they made a bad decision by admitting to the nursing home. Five participants were content with their decision because they felt they made the best decision regarding their circumstances. Most participants revealed their families were supportive after admission to the nursing home. Nine participants believed their families were supportive during the decision-making process because they anticipated the participants removal of the home. Six residents felt their families were over supportive and possibly felt guilty for not having the time or the finances to take care of them. Two participants had little or no family involvement and

experienced depression. All residents felt uncomfortable and nervous initially moving into a nursing home. The pressure to move to a nursing home due to declining health have contributed to depression with all the participants at various times during their nursing home stay. More than half of the participants revealed they had difficulty adjusting to the nursing home culture. It was difficult for participants to live in a facility with individuals who was not familiar with African American culture. Nine participants stated living in the nursing home felt odd because not so long ago they were not treated as equals and were not allowed to use the same restroom, eat in the same establishments or ride in the front of the bus. One participant stated, "Now you expect me to live with white people and just forget and live together like nothing ever happened?" Two participants were roommates and stated being roommates made the living adjustment better for them. However, all residents agreed the nursing home did not provide the cultural foods that they were used to. One resident revealed a schedule that she said was like a prison. She stated, "They tell me what to eat, when to eat, and tell me when I have to go to bed. I have very little choice here."

Positive Experiences

Although some participants describe a problematic experience, others were happy they made the decision. Three participants were able to build social relationships within the facility. Two of the three participants who developed a small network of friends in the facility did not have any children or extended family that frequently visited the facility. One participant met her fiancé who is African American in the facility, and they help each other adapt to the nursing home environment. Positive attributes of the nursing

home voiced by most residents is the ability to get their medical and nursing needs met. However, they all wish they didn't need the help and hoped they could take care of their basic needs themselves. The stress of worrying about who would take care of them at home did not exist after admission. Two individuals express a sense of relief because they were not a burden on their families. Independence was a characteristic that was discussed throughout the interviews. Some felt they were able to maintain their independence after admission while the majority felt they lost all control. One participant stated she was happy because she was able to make her own decisions without family interference. Half of the participants report decreased family involvement while other participants report excessive involvement while living in the nursing home.

Future Recommendations

The findings of this study could contribute to social change by providing awareness and identifying health behaviors and cultural beliefs regarding the use of nursing homes by African American women. Identifying cultural beliefs may be detrimental to maintaining African American women's well-being.

The Need to Practice Cultural Competence

The results revealed African American women in the study admitted to the facility despite cultural norms. Cultural competence is defined as a set of behaviors, policies, and attitudes that enable a system, group or organization to work effectively in environments that have many different cultures. As nursing homes become more diverse, the need to practice cultural competence has become urgent. It is imperative to get to know the values, beliefs and customs, of African American women who reside in nursing homes.

Cultural competence taught in employee orientation sessions and annually could help residents feel more comfortable during their transition period after admitting to the nursing home. Cultural competence can help employees understand the behaviors and attitudes of African American women. “Cultural competence requires social workers to examine their own cultural backgrounds and identities while seeking out the necessary knowledge, skills, and values that can enhance the delivery of services to people with varying cultural experiences associated with their race, ethnicity, gender, class, sexual orientation, religion, age or disabilities” (NASW, 2015, p.65) There is a need for social workers to provide or make available 1:1 or group counseling sessions to help African American women deal with racial issues, feelings of loss, depression, and loneliness. This research can assist nursing homes with promoting resident-centered care. Nursing homes would be able to tailor their services to meet the social, spiritual, mental health and emotional needs of the residents on an ongoing basis. Nursing home social workers will be able to identify evidence-based mental health interventions and help provide input into the nursing home administration that will lead to culture change and an improved quality of life.

Culturally Competent Nursing Care

Nursing home staff should consider several factors when providing care to African American women. Staff should have the ability to respect diverse groups and adapt to different situations that involve African American women and be able to resolve cultural differences (Horevitz, Lawson & Chow, 2013). It is essential to gain knowledge regarding racism, inequalities and health disparities to provide adequate care and support

African American women. A culturally competent nursing home environment could create better health outcomes for residents due to nursing home staff having a better understanding of African American women's cultural history, values, beliefs and experiences with racism and segregation (Oelke, Thurston & Arthur, 2013). Nursing home staff who take the initiative to value diversity, have awareness of cultural dynamics when different cultures interact could increase cultural competence. Learning African American women's history, beliefs, religious and cultural background could aid in building a better repor with African American women who fear admitting to the nursing home. Individualized care plans could be written culturally specific instead of generalized for all cultures.

Medical and Mental Health

Research has shown that there has been a gap in the treatment of medical and mental health for African American Women. Barriers that prevent African American women from obtaining medical and mental health treatment prior to moving into a nursing home included resource accessibility and finances. Barriers that were found in this study that affected African American woman before and after moving into the nursing home were an individualized stigma, support system changes and perceptions involving nursing homes and mental health. To reduce these barriers for African American women, nursing homes should shift their treatment plans to provide culturally competent staff, encourage and promote family involvement and offer mental health treatment to improve the quality of life for the residents. Improving the cultural competence of employees has been promoted as a "way to reducing ethnic and racial

inequalities and service outcomes" (Owiti, Ajaz, De Johngh, Bhui, Ascoli, & Palinski, 2014, p.814). Medically, all participants agreed they were getting quality care that they may not have received if they were in the community with their families. However, several participants stated their emotional, social and religious needs have not been met. Depression, loneliness, isolation, regret, loss of autonomy and anger were expressed after participants admitted to the nursing home. There is a need for nursing homes to provide counseling and therapy or help provide access to mental health treatment while residing at the facility. Kohn-Wood and Hooper (2014) suggested facilities should acknowledge the culturally specific aspects of a resident's care to improve the plan of care and resident outcome.

The Need for More Research

Further research is needed to determine how families feel after African American women admit to a nursing home. The findings of this study offer suggestions for research in other areas such as cultural competence. This study described the experiences and perceptions of African American women who live in a nursing home, but more research is needed to understand why African American women disengage from their families and become depressed after admitting to the nursing home. Further research is required in order to determine what training programs for employees or resources could impact African American women and determine what nursing home services could meet the needs of African American women.

Limitations

This study had several limitations and included African-American female participants who resided in one nursing home in Denver, Colorado. The results of this research are not generalizable because little is known if the cases explored in this study would be an accurate representation of individuals with similar circumstances. The small sample size of 11 makes it difficult to generalize the findings in other areas. This study was suggestive of the experiences of people who admitted to the nursing home in Denver, Colorado. Further research would need to be done to verify if results from this research could be applied in other nursing homes. The self-reported data collected through interviews could have obtained potential bias such as exaggeration, selective memory and inaccurate recollection regarding time. Access to participants was limited to those who had no power of attorney. One individual who did not participate in this study was identified during recruitment to have cognitive deficits which could have affected the validity of this study.

Implications for Social Change and Policy

The research shows that African American women feel cultural competence is an important factor in helping them adjust to a nursing home environment despite cultural norms. Possibly, the findings of this study can create positive social change movement in nursing homes to deliver resident-centered care and empowering staff. The results of this study contribute to existing data about the lived experiences of African American who admitted to nursing homes and may provide awareness and understanding of the barriers African American women face before and after admitting to a nursing home. Policy for

more mandatory training related to African American culture within nursing homes would be a great way to guarantee that not only do African American women and families feel comfortable but also the nursing home staff feeling comfortable providing care to African American women. I intend to share the results of this study with the nursing home in which participants were recruited, local and national health care organizations and peer-reviewed journals.

Researcher Experience

Personal thoughts, opinions, feelings as an African American woman and perceptions of nursing homes before collecting data and completing the recommendations were monitored and journaled to decrease researcher bias. I was cognizant of my role to ensure quality and minimize the impact of biases. I focused on biases which could have influenced the study during the data collection process such as body language, the tone of voice, and appearance. As an African American, I focused on eliminating personal opinions from this study and asked honest questions using a standard language. I discussed my thoughts, beliefs, and feelings with my chair and fellow social workers to separate any defined ideas that could have interfered with participants' responses to the interview questions.

Summary

The study described the attitudes and perceptions of African American women towards long-term care and attempted to understand the influences and experiences of African American women who decided to admit to a residential nursing home despite cultural norms. The findings in this study have implications for social and policy

changes. This study contributes to existing data about the lived experiences of African American who admit to nursing homes and provides awareness and understanding of the barriers African American women face before and after admitting to a nursing home. The first research question explored how African American women's experiences and perceptions toward long-term care influence self-admission to a nursing home. It was found that African American women in this study believed that families should be responsible for taking care of the elderly. Family tradition played a significant role as for why African American women remained in the home.

The second research question explored how African American women felt after admitting to a nursing home. Findings revealed that participants felt pressured to move to a nursing home due to declining health, family member work obligations, and financial reasons. All participants at various times during their nursing home stay experienced depression. While many participants regretted their decision to move to a nursing home, other participants felt their decision was the best decision at the time for themselves and their families.

The framework for this study was based on the Social Cognitive Theory. The theory suggests that individuals possess the ability to exercise control over their thoughts, feelings, and behaviors (Bandura, 1998). I employed Bandura's cognitive behavioral theory for this study because the theory suggested that learning originates from the observation of another individual's behavior. Influences such as friends and family or the physical environment can affect decision-making and practices. Bandura's theory helped

to understand the attitudes and perceptions of African American women who reside in a long-term care skilled facility and their reason for admitting to the facility.

Chapter 5 discussed recommendations to contribute to social change by providing awareness and identifying health behaviors and cultural beliefs regarding the use of nursing homes by African American women, the need to practice culture competence in nursing homes, the need to provide culturally competent nursing care, the need for equal access to medical and mental health and the need for more research regarding African American women and my experiences as the researcher. Findings from this study could contribute to social change by providing awareness and identifying health behaviors and cultural beliefs regarding the use of long-term care facilities by African American women.

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Appendix A: Consent to Approach Research Participants

Date: October 3, 2017

Dear Facility Administrator,

I am a student undertaking a Ph.D. in Human Services at Walden University. I am conducting a research study titled: The experiences and perceptions of African American women who reside in a nursing home. The purpose of this qualitative study is to describe the attitudes and perceptions of African American women towards long-term care, and to understand the experiences of African American women who admit to a nursing home. Prior to conducting the research, I need your permission to approach African American women residing in long-term care within your facility to participate in the study. I will recruit the African American women by meeting with them individually, providing a letter explaining the study and providing interview consent form. I hope to recruit 12 participants.

I can guarantee that I will make every effort to ensure the research does not interfere with the working environment and that any information will remain confidential. Ethical approval for the study is from the Walden University Institutional Review Board (IRB). Dr. Lillian Chenoweth supervises my research.

Yours Sincerely,

Lakeisha Riley MSW, Ph.D. candidate

Lakeisha.Riley@waldenu.edu

Appendix B: Interview Consent Form

You are invited to take part in a study which interviews African American women who live in a nursing home. This form is part of a process called "informed consent" to allow you to understand the intent of this interview before deciding whether to take part.

This interview is being conducted by the student named Lakeisha Riley who is a doctoral student at Walden University. You may already know the researcher as an employee, but this study is separate from that role.

Background Information:

The purpose of this qualitative study is to describe the perceptions of African American women towards long-term care, and to understand the experiences of African American women who reside in a nursing home.

Procedures:

If you agree to participate, you will be asked to be part of an individual interview for approximately 30–45 minutes. A follow-up to the interview may be needed.

Here are some sample questions:
Describe your living situation prior to admitting to a nursing home.
What are your family cultures or traditions regarding elderly care?

Voluntary Nature of the Study:

This interview is voluntary. Everyone will respect your decision of whether you choose to be in the study. No one at the long term-care facility will treat you differently if you decide not to be in the study. If you decide to be interviewed now, you can still change your mind later. You may stop at any time.

Privacy:

Any information you provide will be kept confidential. The researcher will not use your personal information about you or your organization for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you or your organization in the study reports.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via Lakeisha.riley@waldenu.edu. If you want to talk privately

about your rights as a participant, you can contact Lillian Chenoweth. She is the Walden University instructor of who can discuss this with you. Her email address is lillian.chenoweth@mail.waldenu.edu

Statement of Consent:

I have read the above information and I feel I understand the interview purpose and process well enough to decide about my involvement. By signing below or replying to this email with the words, "I consent," I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix C: Interview Questions

1. How old are you? (cognition question)
2. Are you married? (cognition question)
3. How many children do you have? (cognition question)
4. Describe your living situation prior to admitting to a nursing home.
5. What are your family cultures or traditions regarding elderly care? Who typically cared for the elderly in your own family? Who do you think should care for the elderly?
6. Tell me what you believed about long-term care facilities before admitting to this facility. Describe what your feelings are now.
7. Why did you decide to admit to a nursing home?
8. How do you feel about your decision to move into a facility? How did your family and friends feel about that decision?
9. What's the best thing about living here? What is the worst thing about living here?
10. How do your family and friends feel about you living here now?
11. Describe your support from friends and family while you are living in the facility. What was your support like when you lived outside the facility?
12. Are there any other experiences that you would like to share with me now?

Appendix D: Participant Invitation Letter

Dear (Participant),

This letter is an invitation to consider participating in a study I am conducting as part of my Doctoral degree from the College of Social and Behavioral Sciences at Walden University under the supervision of Dr. Lillian Chenoweth. I would like to provide you with more information about this study and what your involvement would entail if you decide to take part.

The purpose of this qualitative study is to examine the experiences and perceptions of African American women who reside in a nursing home and to understand their decisions to self-admit to the facility.

The interview takes around 30 minutes and is very informal. I am simply trying to capture your thoughts and perspectives on residing in a nursing home. Your responses to the questions will be kept confidential. Each interview will be coded to ensure that personal identifiers are not revealed during the analysis and write up of findings.

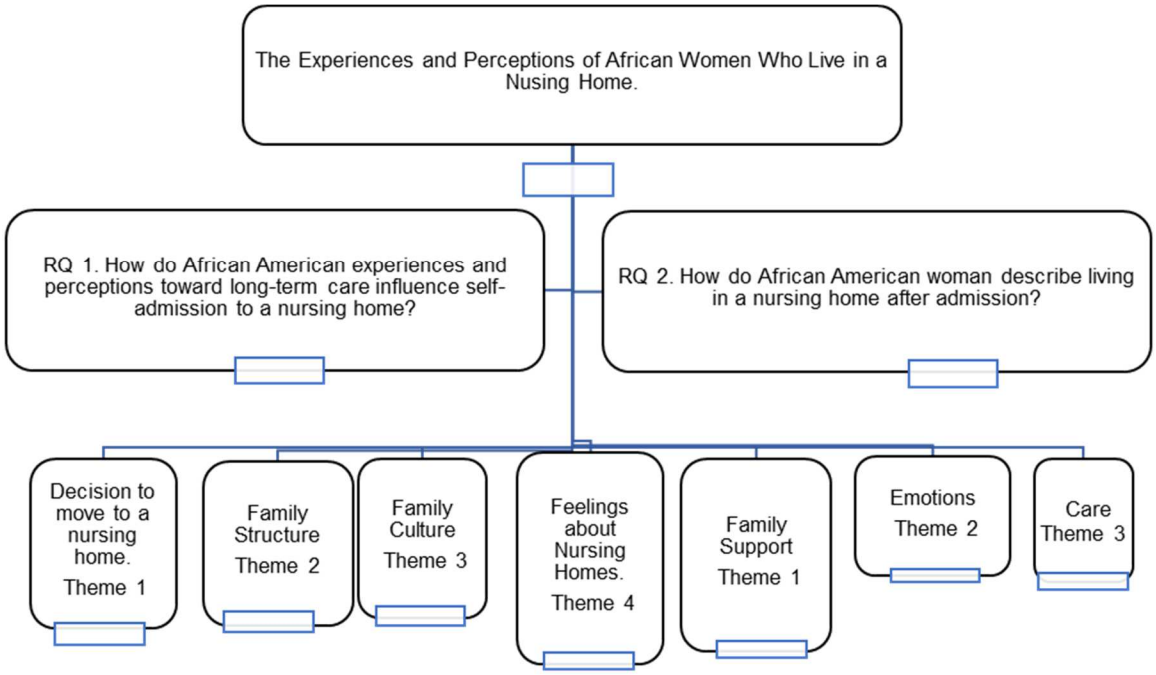
There is no compensation for participating in this study. However, your participation will be an important addition to my research and findings could contribute to social change by providing awareness and identifying health behaviors and cultural beliefs regarding the use of nursing homes by African American women.

If you are willing to participate, please suggest a day and time that suits you and I'll do my best to be available. If you have any questions, please do not hesitate to ask. I can be reached anytime by email at Lakeisha.Riley@walden.edu or you can call me at [redacted]

Thank you,

Lakeisha Riley

Appendix E: Themes



Appendix F: The Experiences and Perceptions of African American Women Who Reside in Nursing Homes

RQ 1. How do African American experiences and perceptions toward long-term care influence self-admission to a nursing home? Themes: Decision to move to nursing home, Family structure, Family culture, Feelings about nursing homes.	• How old are you? • Are you married? • How many children do you have? • Describe your living situation prior to admitting to a nursing home. • What are your family cultures or traditions regarding elderly care? • Who typically cared for the elderly in your own family? • Who do you think should care for the elderly? • Tell me what you believed about nursing homes before admitting to this facility. • Describe what your feelings are now. • Why did you decide to admit to a nursing home?
R.Q 2. How do African American women describe living in a nursing home after admission? Themes: Family support, Emotions, Care	• How do you feel about your decision to move into a facility? • How did yourfamily and friends feel about that decision? • What's the best thing about living here? • What is the worst thing about living here? • How do your family and friends feel about you living here now? • Describe your support from friends and family while you are living in the facility. • What was your support like when you lived outside the facility? • Are there any other experiences that you would like to share with me

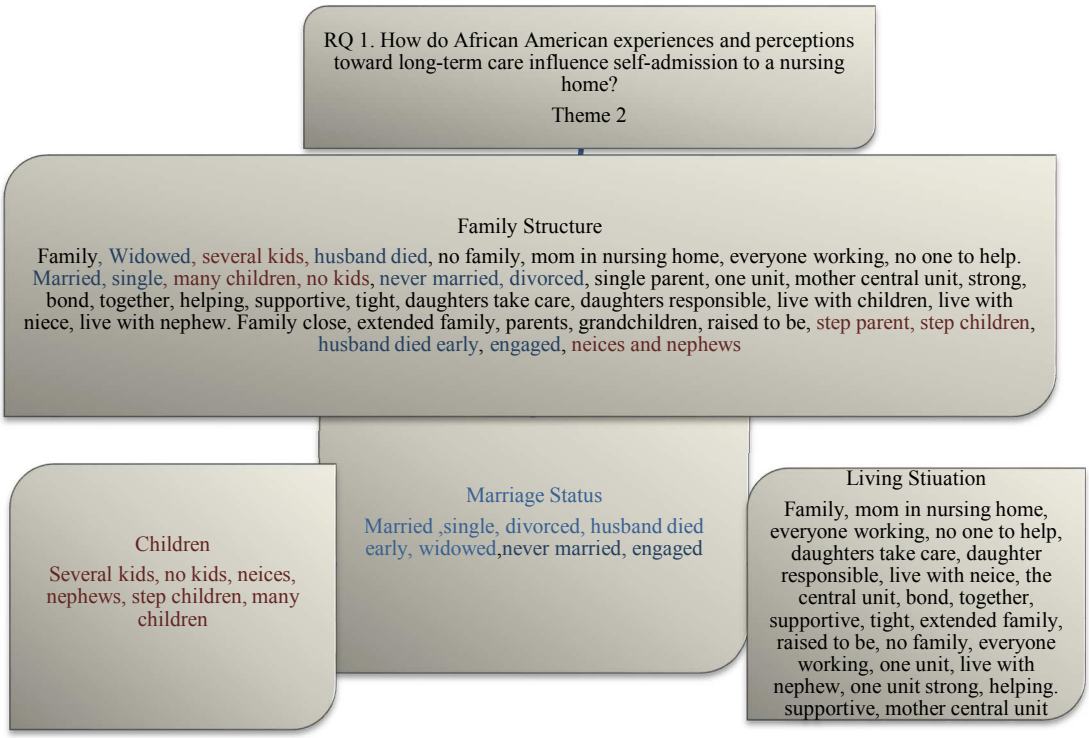
Appendix G: Themes from Research Questions

RQ 1 Decision to move to a nursing home	RQ 1 Family structure	RQ 1 Family Culture	RQ 1 Feelings about nursing homes	RQ 1 Family support	RQ 2 Emotions	RQ 2 Care
My husband passed away, didn't intend on moving here, got sick, family unable to take care of me, lacked independence, difficulties, stress, pressure, had to work, no choice, jobs, kids couldn't take of me. Not working, not independent, disabled, stroke, wheel chair, unable to feed self, it's hard, unable to travel, unable to do, get a little better, help, therapy, want to walk better, income, can't drive, choices, stability, weakness, lived at home alone, falling a lot, don't want to be a burden, busy career, children living their lives, health issues,	Widowed, several kids, husband died, no family, mom in nursing home, everyone working, no one to help. Married, single, many children, no kids, never married, divorced, single parent, one unit, mother central unit, strong, bond, together, helping, supportive, tight, daughters take care, daughters responsible, live with children, live with niece, live with nephew. Family close, extended family, parents, grandchildren, raised to be, step parent, step children, husband died early, engaged,	We didn't think about putting family in a home, we took care of our own, husband took care of his parents, family should take care of family, stay home. I took care of my mom. Didn't go to nursing homes, my parents took care of their parents, faith, prayer, strong, bond, together, helping, supportive, tight, daughters take care, daughters responsible, live with children, live with niece, live with nephew. Family close, no	Wasn't thinking about it, had not thoughts at all, I don't know who should take care of elderly, no previous thoughts, I thought it would be nice, still think it is nice, will not make same decision, my parents were in a home, family should care for old people, used to work in nursing home, nothing bad, never want to go, no privacy, place to die, smell bad, only old people, strange people, different food, roommates,	Lived at home with family, own apt., good situation at home, lived OK, kids help, make own decision, still involved, good support system, kids help, in community had good support, in home little support, lived with family, live with son, lived with daughters, live alone, help from children, convince to stay, f eel ok, family fine with me being in nursing home, They don't have to deal with me, get few visitors, don't see family as much as I want to, talk to a lot, encouragement, being available to listen,	Sad, Frustrated, angry, worried, lonely, scared, lost, no choice, tricked, thought ok, not bad, hate it, don't know worst thing, don't think nursing homes ok, feeling different now, no friends, little visitors, the don't see me, never wanted, ended up here, wouldn't go, don't like being around people. Upset, talked to like children, respect, old fashioned. Hate male staff. Never wanted to be here. nurses that help, don't like being here, different uncomfortable, racism, history, difficulty forgetting past, times have changed, bad memories,	Able to get needs met, get the care I need, nursing care, medical care, physical help, not able to care for self, need help for bathing, eating, medication, adequate meals, no worries, help when I need it, therapy, helpful, no privacy, don't have to worry about medications, don't get care like your family, it is only a job to them, lack of respect, won't do it again, help, schedules, have to wait for help, many people and little staff makes it

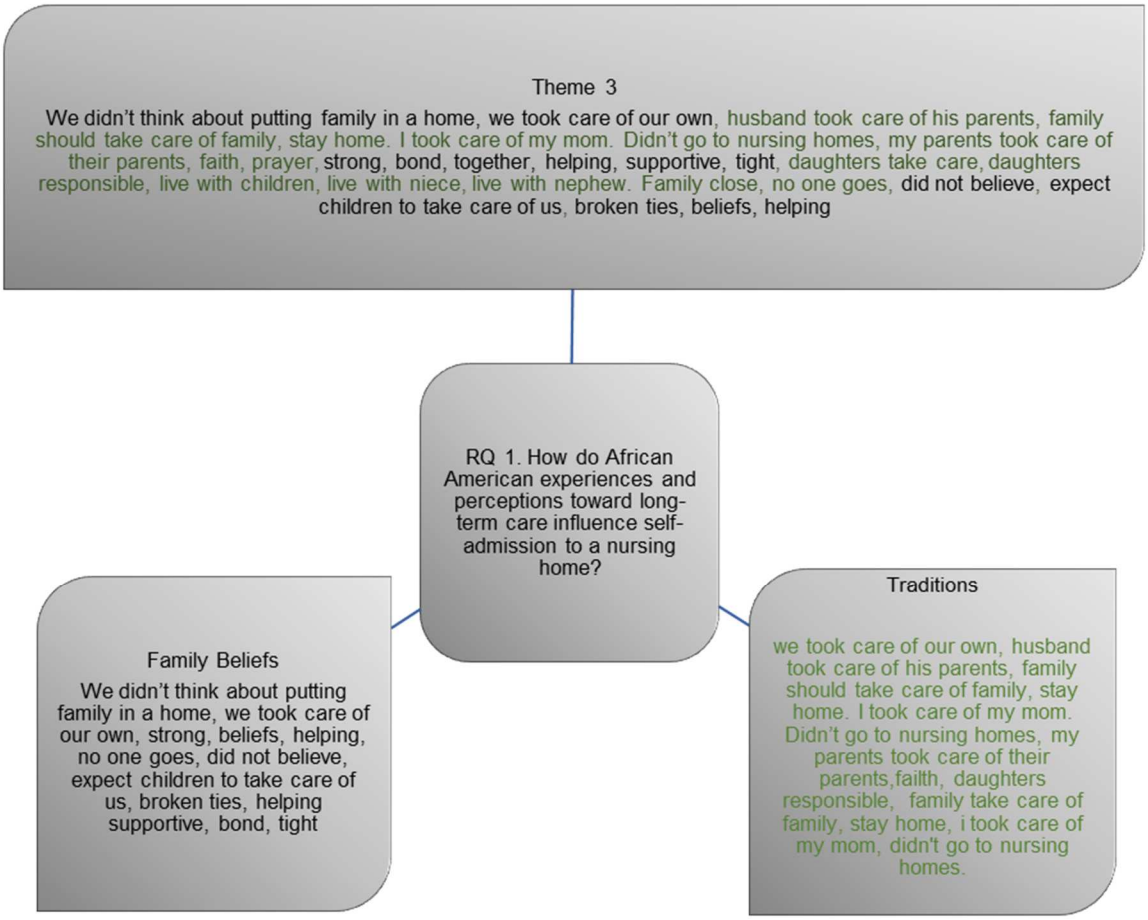
home alone. Not close with neighbors, difficulty cooking, difficulty cleaning, Fear of injuries, loneliness, stroke, mental illness,		one goes, did not believe, expect children to take care of us, broken ties	schedules, strict, lack of freedom to eat what you want and when you want, lack of freedom to leave the facility when you want and go where you want, can't invite people over when you want, freedom, losing my home, you have to change your doctor		loss of control, loss of power, embarrassed, not do it again, painful, upset over loss of belongings, hurtful, adjusting, Loss of independence, decreased self-esteem, regret, feelings of losing your life, loss of joy in the little things such as taking to neighbors, going to church, placing blame on others, guilt, animosity towards children, feelings of wanting to change me, negativity, acceptance, wanting to die	difficult to care for me at times, staff may not attentive, able to socialize, little choice on what to do and how to do it, patient caregivers, inpatient caregivers,

Appendix H: Theme Development: Decisions to Move to a Nursing Home

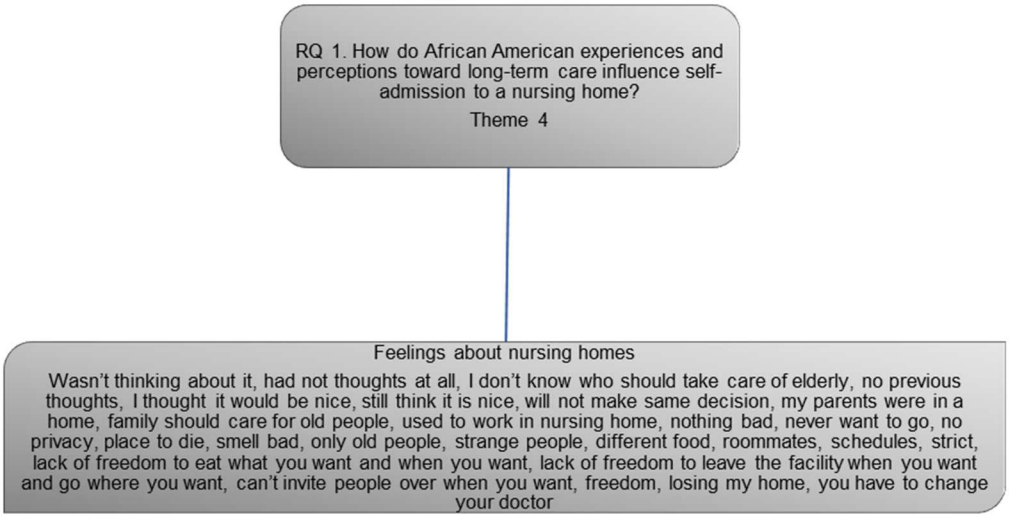
Appendix I: Theme Development: Family Structure



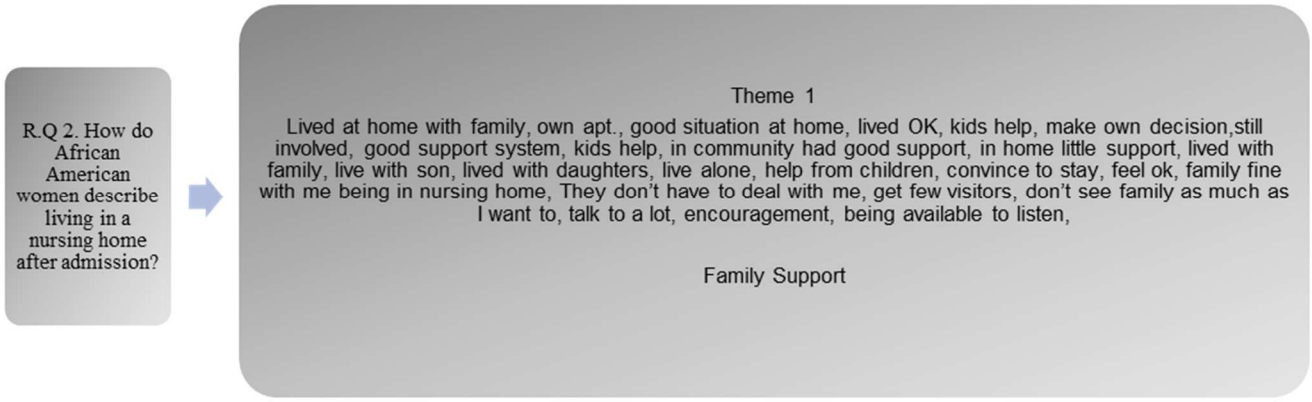
Appendix J: Theme Development: Family Culture



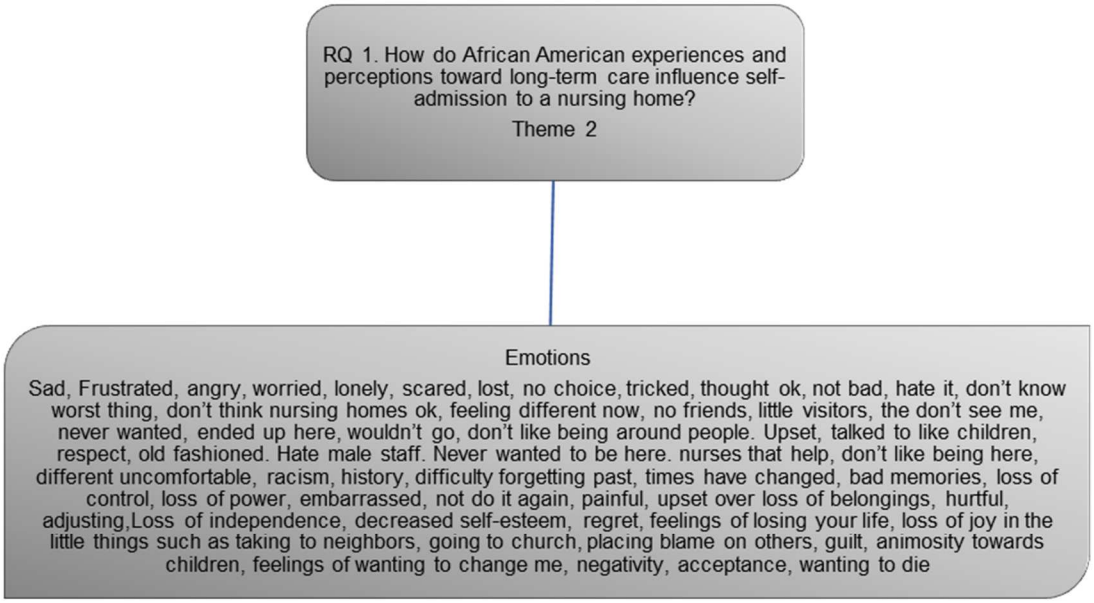
Appendix K: Theme Development: Feelings about Nursing Homes



Appendix L: Theme Development: Family Support



Appendix M: Theme Development: Emotions



Appendix N: Theme Development:Care